MEETING OF THE PARLIAMENT

Wednesday 14 November 2001
(*Afternoon*)

Session 1

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by The Stationery Office Ltd.

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Scottish Parliamentary Corporate Body publications.

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Scottish Parliament

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(*Afternoon*)

[THE PRESIDING OFFICER *opened the meeting at 14:30*]

Time for Reflection

The Presiding Officer (Sir David Steel): To lead our time for reflection this afternoon we welcome Father Michael Bagan, parish priest of St Margaret of Scotland Roman Catholic church in Stirling.

Father Michael Bagan (Parish Priest of St Margaret of Scotland Roman Catholic Church, Stirling): Good afternoon, members of the Scottish Parliament. I feel privileged to be here to lead your time for reflection. In our busy lives, pausing for reflection helps us to choose the way forward, no matter our personal creed or background.

Our diverse world has many causes for concern, and we must face that reality with courage and determination. Friday 16 November is the feast of St Margaret, Queen and patroness of Scotland; 30 November is the feast of St Andrew, patron of Scotland.

Let us focus on St Margaret. Scotland was one kingdom in name only when she arrived, and tribal feuds prevented true unity. Her future husband, Malcolm, frequently raided the north of England for territory and booty and for political reasons. The church was monastic. Isolation prevented progress.

Margaret was cultured and was filled with sensibility. She lived in a Scotland described as dull and colourless. As a listener and teacher, she had sympathy for her people, bringing changes in attitude and behaviour, giving them her time, and helping them feel worth while. Her faith in God brought hope through care and concern for all. Marriage to Malcolm began a process of change in his life and thinking. Warlike and wild, he soon became gentle, even refined. They found happiness in each other.

Margaret tells us that love is not just an emotion, but a decision of the mind. She was a happy mother of eight children. Perhaps happiness for her was found just a few short yards from this chamber, in Edinburgh Castle. She spent long periods in prayer, perhaps at St Margaret's well. Today, people from all over the world visit the little St Margaret's chapel.

Margaret was a patron saint of mothers and she is an example to all of us. She had genuine sympathy for the poor and worked tirelessly to ensure some basic education. She encouraged her husband and king to be aware of his people and their problems, to act justly, and especially to care for the poor and vulnerable. She taught Malcolm to respect the dignity of his office of king, while administering its authority with love and compassion.

We can learn much from St Margaret to ensure that our leadership continues to thrive among local, national and international concerns and worries, among conflicts and in crisis. Crucially, she encourages a vision of the true worth of each individual. Following that example could achieve much for the good of the people of Scotland and the world.

St Margaret died on 16 November 1093. Many would say that our Scottish history changed with St Margaret. We are the product of our history.

Let us pause for a moment in prayer.

> Lord, you gave St Margaret, Queen of Scotland, a special love for the poor and concern for the well-being of all. Inspire and encourage us to remember the values of her life. Help us to imitate her principles in this chamber for the continued growth of Scotland in the society of today and of all our tomorrows.

Amen.

The Presiding Officer: Before we start our business this afternoon, I would like members to acknowledge the hon Michael Polley, Speaker of the House of Assembly of Tasmania, and to welcome him to our Parliament this afternoon. [*Applause.*]

I inform members that tomorrow I am to fly to New York to speak at the annual dinner of the St Andrew Society. During my short visit I will also lay a wreath at ground zero on behalf of the Scottish Parliament and carry out other engagements. The two Deputy Presiding Officers have agreed to chair proceedings tomorrow. I trust that the chamber will grant me leave of absence.

Business Motion

14:35

The Presiding Officer (Sir David Steel): Our first item of business is consideration of business motion S1M-2441, in the name of Mr Tom McCabe.

The Deputy Minister for Parliament (Euan Robson): Before moving the motion, I should explain to members that it alters the business that was agreed last Thursday to allow for the debate on renewing mental health law to take place today. The debate on the Sewel motion on the Anti-Terrorism, Crime and Security Bill, which is scheduled as the first item of business tomorrow, will continue until around 11 am.

Motion moved,

That the Parliament agrees—

(a) as a revision to the Business Programme agreed on 8 November 2001:

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after the first Parliamentary Bureau Motions, delete

followed by	Executive Debate on the Scottish Youth Parliament

and, insert

followed by	Executive Debate on Renewing Mental Health Law

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delete all and insert

9.30 am	Executive Debate on Anti-Terrorism, Crime and Security Bill—UK Legislation
followed by	Executive Debate on its Vision for the Protection and Promotion of Scotland’s Natural Heritage
followed by	Business Motion
2.30 pm	Question Time
3.10 pm	First Minister’s Question Time
3.30 pm	Stage 1 Debate on the School Education (Amendment) (Scotland) Bill
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members’ Business—debate on the subject of S1M-2260 Miss Annabel Goldie: Rural Economy, and

(b) that Stage 1 of the School Education (Amendment) (Scotland) Bill be completed by 16 November 2001.—[*Euan Robson*.]

Motion agreed to.

Mental Health Law

The Presiding Officer (Sir David Steel): The next item of business is a debate on motion S1M-2438, in the name of Susan Deacon, on renewing mental health law, together with an amendment to that motion. I ask members who would like to take part in the debate to press their request-to-speak buttons, so that we can work out the order of speakers. I call Susan Deacon to speak to and to move her motion.

14:37

The Minister for Health and Community Care (Susan Deacon): I am pleased to speak to the motion and proud to lead a debate on such an important issue.

This afternoon we are debating the Executive’s proposals for renewing mental health law. Those proposals were set out in full in a policy statement published on 18 October. Legislation in this area is a difficult and often complex subject, but it is vital. I hope that the chamber will give a clear signal that it takes the matter very seriously.

Rightly, mental health is one of the three clinical priorities for the national health service. The Executive has worked hard to ensure that it is made a priority in practice. Sadly, for too many years the approach to people with mental illnesses or learning disabilities could be summed up as one of “out of sight, out of mind”. Thankfully, that is changing. People with mental health problems want to be part of the community and have a right to be part of it. That has meant huge changes in services: more community-based care, more flexible services and more recognition that the people who use services should have a say in what happens to them.

However, services are only one part of the equation, because in one vital respect mental illness is different from other forms of ill health. A person who is mentally ill—for example, with manic depression—may not appreciate the nature of their illness or the need for treatment. Sometimes treatment must be imposed, rather than agreed. That is why we need effective legislation that balances the needs of patients with their rights as citizens.

The current basis for legislation in this area is the Mental Health (Scotland) Act 1984, which is based largely on an earlier act dating back to 1960. In its day, the act was a huge step forward, but now our mental health law is out of date. My predecessor, Sam Galbraith, recognised that. That is why in 1999 he invited Bruce Millan, the former Secretary of State for Scotland, to chair a committee to conduct a fundamental review of our mental health law. In January this year, Bruce

Millan delivered his committee’s report to ministers. The Millan report is a landmark. It is a very thorough and robust piece of work, stretching to some 520 pages and 416 recommendations.

I would like to place on record our thanks to Bruce Millan and the members of his committee for their immense contribution. We are determined to do justice to their work, which is why we have been carefully considering the committee’s recommendations since January. To help us in that task, we set up a reference group and involved a wide range of individuals and organisations. I express my thanks to the Scottish Association for Mental Health and to all the other people and organisations—too many to mention—that have helped us in our on-going work.

The feedback from the seminars and the advice from the reference group have greatly informed the development of our proposals for a new mental health act, which is set out in the policy statement “Renewing Mental Health Law”. Quite simply, the proposals represent the most fundamental overhaul of mental health law in a generation. Our mental health bill will provide clearer, fairer and safer mental health law and will underpin best practice in delivering mental health care.

Time does not permit me to go into the detail of our proposals, but I will highlight some of the most important. The new bill will establish a clear set of principles that must be taken into account by service providers and by courts and tribunals. The principles include: equality and diversity, to ensure that people with a mental disorder receive appropriate care and support whatever their race, gender, sexual orientation, ethnic group or social, cultural or religious background; participation, to allow service users to be as fully involved as possible in all aspects of their treatment; and respect for carers, to ensure that account is taken of the views and needs of those who provide care informally.

The bill will apply to people with all kinds of mental disorder, including mental illness, learning disability and personality disorder. That does not, of course, mean that any person who has such a diagnosis will be liable to compulsory treatment. One of our fundamental aims is to set out more precisely when and why such compulsion is justified. Although personality disorder will be retained as a category that is covered by mental health law, that does not mean that we anticipate any increase in the numbers of people who are detained with such a diagnosis.

Some have argued that people with learning disabilities should not be dealt with in a mental health act. We understand that the needs of those with learning disabilities are different, but we agree with the Millan committee that it would be wrong to remove learning disability from mental health legislation at this stage. However, we are reviewing how well the legislation meets the needs of people with learning disabilities and we will continue to give that careful consideration.

Provisions for compulsory care and treatment are at the heart of all mental health law. We believe that the law must state more clearly why it is right that, in individual cases, the law should be able to require a person to accept medical treatment that has not been agreed to.

The other fundamental change that we propose is that compulsion will be tailored to the needs of the individual patient and will be the least restrictive intervention that is necessary to meet those needs. At the moment, compulsion quite simply means admission to hospital. However, that one-size-fits-all approach is no longer good enough.

Compulsory treatment in the community is a controversial and sensitive issue. We agree with the conclusion of the Millan committee that it should not be necessary to detain people in hospital if the necessary care and treatment can be provided in the community, closer to an individual’s home and family. We will ensure that any order for long-term compulsion—whether in the community or in hospital—is rigorously scrutinised and regularly reviewed. We need to balance the rights of the patient with the safety of the community. Compulsory treatment in the community will clearly not be a cheap option. Services will have to put forward a plan of care that demonstrates that the patient will receive the proper support to back up the compulsory treatment. Services will also be under a legal obligation to ensure that the support is delivered.

One of the main areas of concern about the current system is its reliance on the sheriff court. Many service users and carers gave evidence to the Millan committee about the shame and distress they felt at being required to attend a mental health hearing in a setting that seemed to them to be for dealing with criminals. That is no criticism of the courts. Some sheriffs go to great lengths to meet the special needs of that kind of case. However, our new system will be radically different; we have concluded that it needs a different kind of legal forum. We therefore intend to establish a new mental health tribunal system. Each tribunal will have three members with expertise in the law, medicine and social care. The arrangements for a tribunal will encourage real participation from patients and families. They will be more informal, more accessible and less bureaucratic.

There are, of course, some treatments for mental disorder that require extra safeguards. The Mental Health (Scotland) Act 1984 provides that certain treatments cannot be given unless the patient has consented or an expert second opinion has been obtained. We will extend that protection to treatments such as forcible feeding and medication above the recommended dosage. We are also increasing the safeguards for electroconvulsive therapy—ECT.

Our proposals are not only about compulsory treatment. They are also about strengthening the rights of all patients. The 1984 act contains important duties on local authorities to provide care and support to people with mental health problems and learning disabilities. We will update and extend those duties to reflect the range of community-based services that all mental health service users should be entitled to expect.

A major area of concern for many families is whether services will respond quickly enough if a family member who has had mental illness before begins to deteriorate again. We will create a new right for users and carers to request, in such circumstances, that the NHS and the local authority carry out an assessment of their needs.

The ability of the patient to make their voice heard is essential in any patient-centred system. That is why we will create a new legal duty on NHS boards and local authorities to support independent advocacy services for mental health service users. This will be the first time that such a requirement has been enshrined in legislation. It will provide a catalyst for our wider aim of ensuring access to independent advocacy for all patients who need it.

The principles that we have set out include, as I said earlier, respect for carers. That is in recognition of the invaluable contribution made by family members and informal carers in Scotland. The greater rights to assessment and the reforms to the legal process that I have outlined will benefit carers as well as service users. That, alongside other measures that the Executive is introducing, is further evidence of our commitment to acknowledge and support the vital contribution that informal carers make.

The Mental Welfare Commission for Scotland will continue to play a key role in protecting the interests of service users. As its recent annual report shows, it needs no encouragement from ministers to do so—but it does need powers that fit the new legal framework. We intend to clarify and strengthen the commission's powers to encompass both hospital and community services. The commission will be the guardian of the principles of the new act but will retain its focus on individual patients. To ensure that it is best equipped to carry out its vital role, we will initiate a review of its management and organisation.

Our proposals include additional protections against abuse and neglect for people suffering from mental disorder. For the first time, there will be a clear statutory responsibility on local authorities to make inquiries where there is evidence that a mentally disordered person may be at risk of neglect or abuse. We will strengthen the powers of local authorities to intervene, building on proposals made by the Scottish Law Commission. It is a sad fact that people with learning disabilities and people with mental illness may be victims of sexual abuse. Our bill will update the special offences laws designed to protect people with mental disorders from such abuse and will ensure that the punishment fits the crime.

We acknowledge that mental health law has a crucial role to play in protecting public safety. However, we should remember that people with mental health problems are often at more risk from society than the other way round. Nevertheless, a small minority commit offences and may present a risk to others.

The Millan committee did not recommend major changes in the disposals already available to the criminal courts, but we will implement its proposals for better arrangements for the management of risk, including a greater use of options such as interim hospital orders and hospital directions. Those disposals allow more time for the courts to make decisions, provide additional safeguards and allow for offenders to move between hospital and prison to serve out their sentence after treatment is complete. Those changes do not exist in isolation and will complement the measures being brought forward in the criminal justice bill to provide better public protection from serious violent and sexual offenders.

Members will recall that the last debate of this length on mental health law was during the passage of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999—the so-called Ruddle act. At that time, ministers gave a commitment to review the emergency legislation in the light of the Millan and MacLean reports. We have done so and we have taken careful note of what the Millan committee had to say on the emergency legislation. The changes that it proposes should help to ensure that the situation that arose in the Ruddle case does not occur again. However, we have decided to retain a provision that an offender who has been made subject to a hospital order, which includes special restrictions, may not be discharged from hospital if they continue to suffer from a mental disorder and present a high risk to public safety.

I recognise that some in the mental health field will be disappointed with that decision. They will say that such a provision in legislation is no longer needed. However, although there are few, if any, patients who would be detained by such a provision who are not detainable under the normal criteria, we have concluded that a provision of this kind should remain, for the rare case in which the need might arise. Once again, I stress that we are looking to strike the right balance between the rights of the patient and the safety of the community.

We have also considered carefully the other Millan proposals in relation to high risk patients. We have concluded that Millan was right to recommend that ministers should no longer be responsible for decisions on the discharge of restricted patients. That is a judicial and clinical issue, not a political one. It is already the case that patients may apply to the sheriff for discharge. In future, however, the new mental health tribunal, chaired by a sheriff, will be the only route for discharge of restricted patients.

Ministers will, however, continue to exercise a clear responsibility for overseeing the day-to-day risk management of restricted patients. Ministerial approval will be necessary for decisions such as allowing a patient to spend periods out of hospital. The Millan committee suggested that the risk management authority, which is being established by the criminal justice bill, might take on that role. Having considered the matter carefully, we have concluded that it would not be right to do that at this stage. However, we will review the situation once the authority is better established.

We also feel that there are problems with Millan's recommendation that patients should have a legal right to appeal to be transferred to a lower level of security. We agree, though, that more needs to be done to develop the full range of secure services, and to ensure that patients can move to the level which best meets their needs. We are keen to make progress in this area and accord with the spirit of the views of the Millan committee. To that end, we will discuss with the service ways in which we can deliver on those aims.

Our proposals, which are contained in our policy statement "Renewing Mental Health Law", are a significant step forward. We have come a long way, but there is much more still to do. The new act will bring about major changes in mental health law and practice, but we must continue to work on other fronts as well, to build wider awareness and understanding of the issue of mental health. So too must we work to tackle the stigma and prejudice that is still all too common in this area.

We agree with the Millan committee that services and facilities on the ground must be adequate to meet the modern demands of delivering mental health care. That is why investment in mental health is increasing. Last year alone, more than £500 million was spent on mental health in the NHS, which is an increase of 9 per cent, but money alone is not the answer and we must not pretend that it is. Changes in the law, changes in culture, changes in ways of working and changes in the way that mental illness is perceived and reported in this country must all be driven forward. That should be our focus for debate today.

I look forward to the debate. I assure the chamber that we will listen carefully to the contributions that are made, and will reflect on them as we prepare draft legislation. That legislation, in the form of a mental health bill, will be brought before the Parliament early next year. That will fulfil a key programme for government commitment and will be another significant milestone for devolution: clearer, fairer, and safer laws and real and lasting improvements in the way in which we support and protect people who use mental health services. That is a big ambition and an important aim, but it is a prize that together we can achieve.

I move,

That the Parliament welcomes the publication of the Executive's policy statement *Renewing Mental Health Law*; agrees that the statement provides a sound framework for new legislation which responds to the needs, rights and aspirations of people who use mental health services, while having regard to the public interest, and looks forward to the introduction of a Mental Health Bill, thus fulfilling the *Programme for Government* commitment to modernise mental health legislation in the light of the Millan Committee's review of existing law.

The Presiding Officer: Before I call Nicola Sturgeon to move her amendment, once again I ask those who wish to take part to press their request-to-speak buttons, because I have to allocate the time and the batting order.

14:57

Nicola Sturgeon (Glasgow) (SNP): I welcome today's debate. I have no doubt that there will be considerable consensus across the chamber about the Scottish Executive's proposals. I agree with the vast bulk of Susan Deacon's comments.

The Millan committee's report is an excellent and comprehensive piece of work and I am delighted that the Scottish Executive has accepted the vast majority of its recommendations. The Millan committee made a convincing case for a new mental health act. In my previous life as a solicitor, I had some experience of dealing with the Mental Health (Scotland) Act 1984, and I know from that experience that it is riddled with anomalies. More important, as the Minister for Health and Community Care said, things have moved on since 1984, and even more so since 1960, when the last substantive reform of mental health law took place. Many of the principles and assumptions underlying the existing legislation are outdated and no longer valid. There is no doubt that it is time for a fundamental rethink of the legal framework and for the Parliament to put in place a modern piece of legislation that reflects current thinking on the care and treatment of people who suffer from mental illness.

We should not be under the illusion that a new legal framework alone will improve the quality of care and treatment for people with mental illness. Ultimately, the quality and range of services that they have access to will make the difference. A parallel challenge—with which I am happy Susan Deacon agreed—for the Executive and the Parliament as the new mental health bill is considered is to prove that the provision of adequately resourced mental health services is a priority in reality as well as in rhetoric.

The issue of resources is one that I will return to. I begin by highlighting some of the recommendations in the Millan report that have been accepted by the Scottish Executive, and which are particularly important and welcome. The agreement to articulate in the new bill the key principles that underlie it undoubtedly is a positive move. Some may think that stating principles in an act is a cosmetic exercise, but it is much more important than that. It provides guidance on the use and interpretation of an act and helps to ensure that the intentions of the Parliament are upheld. I am glad that in this case that approach has been accepted for the new mental health bill. I hope that, in drafting that bill, the Executive will stay true to the principles that were endorsed by the Millan committee.

I also endorse whole-heartedly the agreement to establish a new mental health tribunal to deal with cases arising out of the new mental health act and to replace the existing sheriff court procedures for the authorisation and renewal of long-term compulsory care orders and for hearing appeals against short-term detentions. The new tribunal will enable a specialist, expert and multidisciplinary approach to dealing with people who might need compulsory care. It will go a long way to removing the unwelcome stigma that many service users feel is attached to them as a result of having to go through sheriff court procedures.

I also welcome the new tests that must be satisfied before a person can be made the subject of a long-term compulsory care order and the move towards orders that are tailored to meet the needs of the individual. One of the most important principles enunciated in the Millan report and the Executive's policy statement is that one size does not fit all. People who suffer from mental disorders are individuals; they are not all the same and they all have different needs. An application for a long-term care order should be accompanied by a care plan that is based on a multidisciplinary assessment of needs and tailored to the circumstances of the service user. That is vital to ensure that the individual's rights are respected and that the principle of reciprocity, which was given such prominence by the Millan committee, has real meaning. I will return to that issue later.

I also support, in principle, the view that, where possible, people should be able to receive compulsory care in the community. The possibility of compulsory care in the community rather than in a hospital is in keeping with the general trend towards community care. It is also in keeping with the principle that the least restrictive alternative should be pursued when determining what care and treatment a person should receive. Later, I will mention my concerns about how orders for compulsory care in the community might be used in practice. We must never forget that the majority of people who receive care and treatment for mental illness do so voluntarily and not by means of compulsion. I welcome the Millan report's recommendations—which were accepted by the Scottish Executive—to strengthen those people's rights.

I was also pleased to see the acceptance of the recommendation to give service users and their carers the right to request an assessment if their condition appears to deteriorate. That right is crucial if we are to ensure that, at the earliest possible stage in their illness, people have access to care and treatment that might reduce the need for more drastic intervention at a later stage.

The final two areas that I want to mention briefly—but positively—are the measures to support carers and the duty to be placed on local authorities to investigate cases where there is evidence of abuse of a person with a mental disorder.

I turn now to the areas about which I have some concern and on which I seek reassurance—where it has not already been given—when the minister sums up. The first issue is advocacy. The Millan recommendations appear to have lost something in the course of their journey to the Scottish Executive policy statement. The Millan report was unequivocal in recommending that mental health legislation should give service users a right to an independent advocate. I have no doubt that everyone in the chamber shares the view that that right is fundamental.

Those who fall within the ambit of mental health legislation are some of the most vulnerable people in our society, who often cannot exercise or defend their rights or make their views be known to and understood by service providers. They are subject to legislation that can—at the extreme—deprive them of their liberty and force them to receive treatment against their will. It is vital that they are able to make their voices heard and understood. The proposed new act would strengthen their rights and build in safeguards, but those measures will be meaningless for many people without the support that would enable them to make and communicate informed choices and, consequently, exercise as much control over their own care as possible.

That is why many service users are disappointed that the right to advocacy that the Millan committee recommended has been apparently—I stress apparently—downgraded to a duty on the NHS and local authorities to ensure that a range of advocacy services is provided. Similarly, the Millan report recommendation that there should be a statutory obligation on service providers to provide support to collective advocacy groups has not found its way into the Executive's policy statement.

I was encouraged by the emphasis placed on advocacy in the minister's opening remarks. However, I urge the minister to signal today that in drafting the new bill there will be a return to—if there was ever a movement away from—not only the spirit but the letter of the Millan recommendations. What the proposed new act could do for those who suffer from mental illness will be undermined if those people do not have the vital support that independent advocacy services can bring. Only a right to those services will ensure that all service users can access them.

While on the general theme of maximising the control over their own lives that users of mental health services can exercise, I make passing reference to advance statements, which allow people, while able, to set out their wishes about their future care. The Executive has been positive about advance statements, while rightly pointing out the difficulties of making such statements legally binding. The Scottish Association for Mental Health has asked whether other ways of affording the statements some formal standing exist, such as allowing only a mental health review tribunal to override them. I hope that the ministers will agree to give that further consideration before the bill is published.

The second issue on which I will touch is compulsory care in the community. I have said that, in principle, I support the view that compulsory care should not necessarily be provided in a hospital. However, the use of community orders in practice will require close monitoring. The danger exists that community orders might be made when community compulsion may not be the appropriate disposal and may not represent the least restrictive alternative. Hospital beds are under pressure and delayed discharge is a big problem. It would concern me—and I dare say everyone—if there were any possibility of people who needed to be in hospital or whose safe discharge from hospital depended on enhanced services in the community that might not exist being given compulsory care in the community simply as a way of relieving that pressure.

That danger also exists at the other end of the spectrum. If advanced services existed in the community, many people would not require compulsory treatment, but because many such services are inadequate, those people may be placed under compulsory orders. In those circumstances, it could not be argued that community compulsion was the least restrictive alternative. It would simply be the least restrictive alternative that resources allowed.

We should support care in the community when it is appropriate for the individual, but we should also be vigilant about ensuring that orders for compulsory care in the community do not become a sticking plaster for service deficiencies elsewhere. I was heartened to hear the minister say that compulsion in the community would not be the cheap option. I hope that that proves true, because it is vital for the quality of care that service users receive that compulsion in the community is not the cheap option.

That brings me neatly to the issue of resources. We are debating a new legal structure, not a package of resources for mental health services, but the Millan committee made it clear that resources could not and should not be divorced from debate about the new legislation. The Millan report says:

> "we have no doubt that the aspirations which underlie our recommendations for new mental health law will not be fully met unless services and facilities are adequate to meet the demands placed on them."

The amendment that the SNP has lodged would ensure that that sentiment is reflected in the motion that the Parliament has been asked to approve, to remind us—if we needed reminding—that although a new legal framework is crucial, it will not in itself ensure high-quality services.

For too long, mental health provision has been a poor relation in the national health service. I appreciate that the Executive wishes to address that and I do not quibble with the minister's assertion that resources have increased, but the Millan report reminds us acutely of the scale of the challenge: persistent underinvestment in maintaining the fabric of in-patient units; a poor-quality environment for patients in intensive psychiatric care units; a dearth of therapeutic and recreational services; and too many patients inappropriately trapped in hospital because of a lack of community services.

People are frustrated that receipts from the sale of psychiatric hospitals have not been reinvested in community care, for example. People are frustrated and concerned that too many services are funded from short-term sources such as the national lottery. There is no doubt that resources must be at the forefront of our minds as we consider the proposed bill.

An underlying principle—arguably the most important principle—of the proposed bill is reciprocity, to which I have referred. Reciprocity is the belief that someone who suffers from mental illness and is deprived of their liberty in order to be treated and cared for has a right to receive appropriate care and treatment. That should be a fundamental principle of mental health law. If it is to mean anything beyond the words in a piece of legislation—or anything in the real world—adequate resources must be put in place.

I will make a final point. I do not want to labour it, but because it has been mentioned to me by a number of service users and service providers, it is worth mentioning. There appears to be widespread opinion that the title “mental health act” is not appropriate for this proposed legislation. The bill will not promote good mental health, but it will deal with the consequences of mental disorder. While there may be consensus that the title is wrong, there is no consensus on what would be the correct title. Even the Millan committee failed to come up with an alternative title. Perhaps the Executive will ponder that further as it goes about drafting the bill. The inclusion of a clear set of principles was mentioned. We want to achieve a bill that in its title reflects accurately the task that we are setting about.

I am happy to support the Executive’s motion, although I hope that the Executive will support the SNP amendment, which seeks to enhance the motion that we are being asked to support. My colleagues on the Health and Community Care Committee and I will scrutinise the proposed bill closely. It is clear that not all of the Millan recommendations can or should be included in primary legislation. However, it is important that the bill stays true to the principles and the key recommendations that are contained in the Millan report.

I move amendment S1M-2438.1, to insert at end:

> “and also supports the view expressed in the Millan Committee’s report that the aspirations underlying its recommendations for new mental health law will not be met unless services and facilities are adequate to meet the demands placed on them.”

The Presiding Officer: Before I call the representatives of the other two parties, I advise members that the time limit on back-bench speeches will be five minutes.

15:12

Mary Scanlon (Highlands and Islands) (Con): As our business today started with a mention of the patron saint of mothers, on behalf of the Scottish Conservatives, I congratulate the Minister for Health and Community Care on the announcement of her new arrival. [*Applause.*]

The Presiding Officer: I do not think that it is an arrival as yet. Is it an arrival?

Mary Scanlon: Did you not know, Presiding Officer? I am not implying anything saintly about the minister, but I am delighted about the news of her new arrival.

We are delighted to participate in the mental health debate. As Nicola Sturgeon said, there is likely to be a tremendous degree of consensus on the issue. However, some concerns have been voiced and, in that respect, I appreciate what the minister said about the on-going reviews. I hope that the clarifications and assurances that I seek on various issues will be taken in the tenor in which they are sought, as they are meant to be constructive points in the debate.

We welcome the opportunity to work towards ending the stigma and the prejudice that surround mental health. The Scottish Conservatives are broadly supportive of the proposals. Mental health legislation is due for an overhaul and we endorse fully the Millan committee in the excellent job that it carried out in evaluating current practice and proposing reforms.

The British Medical Association said recently that at least 30 per cent of general practitioner consultations have a psychological component. I hope that the new system of providing care and treatment for those with mental illness will involve GPs.

We further welcome the inclusion of a statement of principles in the new mental health bill. Today, I will concentrate on three of those principles, which I do not list in order of priority and which were mentioned earlier. The bill will be hugely complex, but the three principles about which I feel most concern are reciprocity, the respect for diversity and the use of the least restrictive alternative. My colleagues will examine other issues, including the proposed mental health tribunal.

In turning to the principle of reciprocity, I will quote from the Executive statement:

> “Where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.”

As the system is not currently in operation, I have difficulty envisaging how it will work. Will the obligation of health and social authorities to provide safe and appropriate services be monitored by the NHS or the new regulation of care commission? How will they be held to account for the delivery of those services? It is also interesting to note that that obligation will apply to patients who receive compulsory treatment without compulsory hospitalisation. Whether a person is cared for at home or in the community, they are undoubtedly entitled to the best standards of care. Our challenge is to regulate, monitor and gain the feedback to ensure that those service users are achieving and attaining the best standards of care.

I welcome the minister's points in the statement that the role of compulsion is to be more fully considered. How will the obligation on the individual at home to comply with a programme of treatment and care be monitored? Will relatives be asked to give an account? Will the individual being treated have to prove compliance? If so, how? I ask those questions because I feel that the issue is likely to be highly subjective.

I welcome the moves to strengthen the role of the mental health officers. To say that their role will be strengthened is an understatement, given the reduction in the use of emergency detention and the proposal to introduce long-term compulsory interventions in a community setting. Will community psychiatric nurses be turned into community custodians, rather than having a therapeutic relationship with the patient and their family? The grounds for compulsion are where

> "the necessary care and treatment cannot be provided by agreement with the patient; the person's decision-making ability is impaired to a nature or degree which would justify compulsory measures; … there is a significant risk of harm to the health or safety or welfare of the patient or a significant risk of harm to other persons if such treatment is not administered."

We begin to get a picture of the enormous responsibility of compulsory care in a community setting.

My next point on reciprocity, which has been more or less covered by Nicola Sturgeon, is about dropping the right to advocacy, as was recommended by the Millan committee, and replacing it with

> "a duty on the NHS and local authorities to ensure that a range of advocacy services are provided."

In its submission, SAMH said:

> "The right to advocacy is a clear principle and a clear right."

I hope that, under the principle of reciprocity, service users will be entitled by right to advocacy services to ensure that they receive the appropriate choice and care for their needs. I also believe that advocacy is essential to protect against neglect and abuse.

The second principle that I want to discuss is respect for diversity. There seems to be an underlying assumption that a wide range of options for care are available. The aim is that service users should receive care that

> "accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account age, gender, sexual orientation, ethnic group and social, cultural and religious background."

These are undoubtedly worthy principles and aspirations, but there is no doubt that, to achieve them—and in order for people to have choice and appropriate treatment—significant resources will need to be reprioritised into the mental health budgets. Any intervention or treatment is only as good as the best possible assessment of need. I am concerned about many of the answers to written parliamentary questions on waiting times and on vacancy rates for clinical psychologists, psychiatrists and the shortage of forensic psychologists.

The final principle that I want to mention is the least restrictive alternative. Again, the policy statement says that service users should be provided with the

> "necessary care, treatment and support … in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe effective care, taking account where appropriate of the safety of others."

A full range and choice of diverse services must be available to exercise and achieve that principle.

SAMH raised concerns about community-based compulsion, saying that the evidence to support that approach has not been provided, despite research into the use of similar orders elsewhere in the world. In fact, SAMH goes further, stating:

> "Until there is a firmer evidence base, the move towards community compulsion should be resisted".

Although I feel sympathetic to community compulsion, I would like some of those issues to be addressed. I would like to be assured that the system has been applied elsewhere and that it is the best system for people with mental illness in Scotland.

Research from other countries seems to show that compulsion in the community, combined with enhanced service, produces better outcomes. Even the enhanced services by themselves produce good outcomes. However, we return to the need for a range of services to allow choice, diversity and appropriate care designed for individual needs.

The basic principles of reciprocity, respect for diversity and the least restrictive alternative can be meaningful in practice only if there is a full range of services, including crisis services, based in the community. The reconfiguration of that wide range of services would also prevent many people from becoming so ill that it becomes necessary for them to be detained in hospital. That is why the Scottish Conservatives will today acknowledge and endorse the SNP amendment.

It is hoped that the range of services would be provided by the public, private and voluntary sectors to enable choice. I have already spoken about resources. It is important to point out that recent community care statistics have compared the average weekly charge per resident in residential care homes for people with mental health problems. The statistics state that the average weekly charge for a private sector place is £254, the average weekly charge for a voluntary sector place is £357, and the average weekly charge for a local authority place is £616. With local authority weekly charges at more than double the cost of the private sector, the cost of treating two people in a local authority home would cover the treatment of five people in private or voluntary sector places. If we are considering a wider and more diverse range of services with limited resources, it is important that we also consider providers.

Delayed discharge has been mentioned in connection with compulsory community orders. Members should note that, in Inverness alone, 38 patients who have been in New Craigs hospital for some time are awaiting discharge into the community. I very much welcome the increase in services in the community.

15:24

Mrs Margaret Smith (Edinburgh West) (LD): I congratulate the minister on her impending happy event and pay tribute to the lengths to which she is prepared to go to scrutinise Scotland’s maternity services framework.

I welcome the policy document “Renewing Mental Health Law”, which is the first major review of mental health law in Scotland for 40 years. I welcome the new focus that the minister outlined not only on mental health services, but on finding a just legal framework that delivers for people who suffer from mental illness and, in particular, for those very vulnerable people who have not agreed or cannot agree to treatment and require the state to take a decision on their behalf.

The Scottish Liberal Democrats recognise that the law must be renewed and reformed to reflect the development of community-based mental health services, the greater involvement of service users and carers in decisions concerning treatment and the greater awareness of—as well as the statutory place of—the human rights of every Scot in our modern society.

I am sure that I speak for all my colleagues on the Health and Community Care Committee when I say that I look forward to considering the policy in detail when a bill is introduced next February.

Members have mentioned the fact that mental health is one of the Executive’s priority areas. One in four Scots will suffer from mental ill health at some point in their lives. The chief medical officer’s annual reports states that 30 per cent of general practice consultations are for mental health problems.

For many, mental health problems may be temporary and mild and may involve stress, depression, anxiety or panic attacks. Nevertheless, such problems bring concern, distress, stigma and a reluctance to tell others. Despite greater recognition of the prevalence of mental health problems and despite greater funding, how many members would be happy to go to their business managers—kind beings though they are—and admit to stress or depression? Many would be happy to say that they had broken a leg, but they might be less inclined to say that they were suffering from mental stress.

The reluctance to come forward to health professionals or in the workplace is all too common. We should do everything that we can to educate people about mental health issues and work closely with all agencies and employers to recognise the impact of this hidden epidemic on Scottish life, businesses and health. According to Depression Alliance Scotland, stress-induced anxiety and depression are responsible for the loss of 6.5 million working days each year at a cost of £3.75 billion. The problem is massive.

Through our constituency surgeries, all members are aware that there are gaps in services, including in the crisis services that Mary Scanlon mentioned. No one should be left as their condition deteriorates from mild temporary problems to something much worse while over-stretched services cannot be accessed until the condition is diagnosed as more severe or enduring.

I welcome the SNP’s amendment and the Executive’s acceptance of that amendment. For too long, the service has been a cinderella service. Undoubtedly, there are resource implications in the policy document in respect of the availability and quality of services in the community and primary care and I trust that the Executive will resource properly. However, almost inevitably, the focus of my speech will be on those who suffer from the most extreme symptoms and conditions and who require the protection of mental health legislation.

The policy document paves the way for legislation that will replace the Mental Health (Scotland) Act 1984. In so doing, the document accepts the main recommendations of the Millan committee's report, which was published in January. The Millan committee's remit was broad: to review the 1984 act, the definition of mental disorder, the criteria and procedures for detention and discharge from hospital and the role of the Mental Welfare Commission. Like other members, I pay tribute to the committee's work.

The Mental Welfare Commission described the proposals as an up-to-date and ethically sound basis for mental health law. We are pleased that the proposed mental health bill will be based on key principles of non-discrimination, equality, respect for diversity, reciprocity, informal care, participation, respect for carers, least restrictive alternative, benefit for the service user and child welfare. We expect those principles to be enshrined in the bill in due course.

I want to pick up on a few of those principles. Members have commented on the principle of reciprocity. The meaning of that principle is that where a society imposes on an individual an obligation to comply with a treatment of care, it imposes on itself—and on health and social care authorities in particular—a parallel obligation to provide safe and appropriate services, including on-going care following discharge from compulsion. That is why we are keen to embrace Nicola Sturgeon's amendment. It is essential that we see the policy as a framework that will allow a balance of care. When an individual is compelled to accept treatment, they have the right to expect that that treatment will be of the highest possible quality.

I return to the issue of compulsion. The proposed mental health bill will be based on the view that wherever possible, care and treatment should be provided without recourse to compulsion and should take the form of informal care, which should be given in the least restrictive manner and in an environment that is compatible with the delivery of safe and effective care. Where appropriate, treatment should take into account the safety of service users—mentally ill people—and others.

Provision for compulsion in the community is in keeping with the general trend of care in the community—people should live close to their homes and families. At all times, the compulsion debate should seek to balance the rights and needs of the service user with their safety and the safety of others in the wider community. Interventions under the proposed legislation must be likely to produce a benefit for the service user that cannot be achieved by other means.

The minister said that interventions or compulsions should be on the grounds of impaired decision-making ability. Why is that term preferred to impaired judgment, which is the term used in the Millan report, or incapacity, which is the term used in the Adults with Incapacity (Scotland) Act 2000? Service users should be as fully involved in decision making about their treatment as their capacities allow. They should be given support through advocacy or other means to allow them to participate fully. SAMH raised concerns that the Executive has dropped the right to advocacy that was recommended in the Millan report and replaced it with a duty to provide a range of advocacy services. I welcome the minister's comments, but I seek clarification on her intentions on the matter.

In the wake of the strategy for carers and the Scottish carers legislation working group, carers are recognised as deliverers of services and key partners in the provision of care in the area that will be covered by the bill. I welcome the important new right for service users and carers to request an assessment at the outset of mental health problems and at points of deterioration in their condition.

The policy statement makes it clear that the Executive accepts that, in many ways, the existing framework of emergency detention, short-term detention and long-term compulsion will be retained. However, the new approach will introduce more flexibility into the system with detention orders that are based much more on the needs of the individual and their care plans, rather than being, as the minister said, one size fits all.

Crucially, it will be made possible for the patient to remain in a community setting while subject to a community-based order. In the coming months, more detail will emerge on how we will do that. I echo Mary Scanlon's point about how that initiative will be monitored in the community, which is an important issue.

Key groups such as SAMH oppose the extension of compulsion into the community, question the evidence base for it and suggest that community-based compulsion could lead to service users being denied choice in the treatment that they receive. I hope that the principles that underpin the bill, the assurances that the minister has given and the support of the Parliament will ensure that that does not happen, but I look forward to investigating those issues with SAMH and others in due course.

We welcome the establishment of a new mental health tribunal system to consider the case for and against compulsion and to take into account the patient's care plan and individual needs. We welcome the fact that the tribunal will be a much more informal system than the present sheriff court system and will take away the sense of criminalisation that the minister referred to earlier.

The new system will involve people from a range of disciplines and patients and named persons will have access to free legal representation. Bearing in mind earlier comments about advocacy, it is important that within the tribunal framework people are given the opportunity to have a real voice in the judgments being made about their care. Where patients are able to make judgments on treatment or where their representatives can be consulted, it is essential that that takes place and that whatever advocacy services are required are available.

We believe that there is a need to pursue a discussion on the use of advance statements and we associate ourselves with comments made by others on that matter. I am sure that many organisations will have a great deal to say about the proposals in the coming months and that safeguards for particular treatments will be on their agenda.

We are pleased that independent second opinions will be required before treatment such as ECT and forcible feeding can be pursued without consent. However, I would like the minister to assure us that that—and other aspects of the legislation—will comply with article 3 and other elements of the European convention on human rights. I also ask the minister to outline how the proposals on treatment sit alongside the Adults with Incapacity (Scotland) Act 2000.

I pay tribute to the on-going work of the Mental Welfare Commission and its robust defence of individuals suffering from mental ill health. I welcome the review of its functions. I also note that the commission is concerned that the tribunal alone will be given the power to discharge patients from compulsion, although both the sheriff and the commission can do so under the present system. I will be interested to hear further comments from the minister on that point.

Today, we have begun the investigation of this serious matter. We will return to the planned legislation on a number of occasions in the committee and in the chamber. We all look forward to listening to and taking on board the concerns of interested parties to build on the policy statement, the work of Bruce Millan and his colleagues and the work that is being done throughout Scotland within the mental health services framework.

We believe that this is a welcome move in the right direction to deliver a mental health framework that is based on the principles of fairness, access to clinical service, and partnership between agencies, patients and carers, and which is within a wider human rights framework. We welcome the policy document and the support given to it throughout the chamber.

15:36

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Many members will be aware that, over many years in my previous employment, I gained much experience of mental health services in Scotland, particularly in the west of Scotland. That included experience of the many Victorian institutions that are now closed. I have seen at first hand the failure of the current legislation to meet the needs and aspirations of service users. I agree that there is a crying need for effective new mental health legislation that will address the needs of today’s service users, their families and society.

The response of the public to mental illness is dramatically different from their response to physical illness. That has been shown by the many sick jokes about mentally ill people that have often disfigured conversations and even comedians’ performances over many years.

Presiding Officer, I am sure that if you walked down the Mound with a large stookie on your leg, you would attract a great deal of sympathy from passers by. However, if, God forbid, you had a car accident that led to head trauma and left you exhibiting what is often called challenging behaviour, the reaction would be very different.

The response of previous generations has been to drive mental illness into the shade. We in the chamber all accept that that response is no longer acceptable. It is difficult for anyone to admit to having or having had mental illness, which can come in many forms. It is even difficult for families to admit that a family member is a sufferer.

As a society, we must address our response to mental health. We must begin to treat it as we would treat a physical illness. We must care for and acknowledge those who suffer from this illness and ensure that their many skills are not lost to our society by shutting them away from their communities. That is easy to say and if our society was one unit we could deal with the matter easily and quickly. However, Scotland is made up of more than 5 million individuals, who all have their own experiences, links and attitudes. We have come together as a society, but we need to give individuals information that will reform their attitudes and make our society more caring towards mental illness.

This is a society issue. On mental illness, we are still faced with the battle for the hearts and minds of the Scottish people. We can legislate as much as we want on the structures of caring for the mentally ill, but if we do not accompany that with a massive education process to change people’s attitudes to such illnesses we will have failed those who will suffer in silence and in the background. Such education campaigns work. We need only remember the attitudes towards drinking and driving before the introduction of campaigns on that issue to recognise the value of such campaigns.

Therefore I look forward to hearing the minister's comments about the Executive proposals on that issue when he responds to the debate. Now as never before, we have an opportunity to change the Scottish perception of mental health. We must grasp that opportunity with both hands and take the next major step towards making the new Scotland an even more caring society for all those sufferers of mental health problems.

15:40

Mr Kenneth Gibson (Glasgow) (SNP): I am pleased that the minister has now decided to join my campaign to reverse Scotland's declining birth rate. I wish her all the very best over the coming months and years.

This afternoon, I will speak very much as the vice-convener of the cross-party group on survivors of childhood sexual abuse. Sexual abuse is obviously an horrific experience for any child. However, not only might the psychological and emotional consequences of sexual abuse in childhood have a profound impact on the victim at the time, they might significantly damage his or her ability to function successfully in society throughout adulthood, seriously impair personal relationships and in many cases result in serious mental health problems.

Sexual abuse that is perpetrated during the formative years of childhood undoubtedly has the most traumatic impact of all mental health difficulties in terms of severity and duration. Alongside struggling to achieve and maintain meaningful relationships, victims can frequently demonstrate individual emotional and psychological conflicts through repeated self-harm and other detrimental behaviour such as drug and alcohol abuse. Other victims present themselves to the psychiatric services with less dramatic but still prolonged mental illness. It is well documented that a high proportion of people committing suicide suffered sexual abuse in childhood.

Such factors combine to pose major problems for mental health services, most obviously in relation to admission rates to hospitals. A recent study conducted on behalf of Fife Health Board, "A Safe Place to Talk", identified that 10 to 20 per cent of all admissions of both sexes to psychiatric units involved a history of serious sexual abuse.

The same study showed a disturbing fourfold increase in the referral of victims of sexual abuse to psychological services in Fife over a three-year period. Furthermore, it provided an assessment of the views of service providers and users that highlighted the many limitations of existing psychiatric services, especially in the prevention of repeat admissions by sufferers. Statutory and non-statutory systematic evaluation of the services on offer highlighted patchy distribution, lack of co-ordinated resource planning and absence of shared best practice. In addition, given the identified inconsistencies in service provision, all participants agreed on the need for increased awareness and well-constructed training programmes for service providers.

The study's conclusions highlighted the need to develop a variety of services to address individual needs ranging, for example, from specialist psychotherapy to respite in crisis. The greatest emphasis was placed on the need to recognise the essential role played by non-statutory organisations within a properly co-ordinated national strategy.

Two recent studies conducted in Glasgow and Lothian produced broadly similar findings. Given the shortcomings that the Fife study referred to, if replicated throughout the country, such a scenario would imply that many thousands of sufferers are being denied the treatment and support that they justly deserve. Also, by interpretation, statutory services are already heavily involved with the problem, but in a way that does not resolve the deep-seated trauma endured by victims.

Evidence from across Scotland indicates that the level of funding of non-statutory services varies considerably from area to area and might be short term. That may impede the continued development of such services or, at worst, threaten their very survival.

In changing mental health law, we must fully recognise the extent of the problem of childhood sexual abuse within a national framework for mental health, given the victims' reliance on psychiatric services. That recognition should be reflected centrally in the requirement of psychiatric and social services in each locality to incorporate within their mental health strategies the development of services that are specifically designed to tackle the mental health problems of people who have suffered childhood sexual abuse. Each area should also clearly identify the level of funding that will be apportioned to develop non-statutory services on a continuing basis.

In developing services, we must pay attention to the need for a range of services and, given the particular difficulties of sexual abuse victims, the ability to respond with flexibility and sensitivity at a local level.

The policy statement rightly comments on protection of mentally disordered adults, although it does not mention victims of childhood sexual abuse. I hope that in future discussions about mental health—and, indeed, when the bill comes before Parliament—that matter will be addressed. I also hope that the deputy minister will respond to that in his summing-up speech.

15:45

Janis Hughes (Glasgow Rutherglen) (Lab): I want first to echo the sentiments that the minister expressed in her speech and to add my support to the motion that is before us.

One in four people in Scotland will suffer from some kind of mental illness during his or her life—a statistic that has been mentioned in the chamber on numerous occasions in the past two years. Many more people are affected indirectly through watching family members and friends suffering the trauma of mental illness. It is therefore important that we offer every support that we can.

The review of mental health law must be welcomed but, as the Millan report says, changing the law is but part of dealing with mental illness. It is an important part, but attitudes must also change. For as long as there remains a stigma attached to mental illness, equality can never be achieved. That is why the principle of care in the community is so important. Allowing those who suffer from mental illness to participate in society is a crucial step, not only towards improving sufferers' care and treatment, but towards removing the unhelpful stigma that is often attached to mental illness. It helps to break down the barriers between those who suffer from mental health problems and those who do not.

The issue of compulsory treatment in the community is—as the minister stated—controversial, but I agree with the Millan report's conclusion that where possible and, obviously, where it is safe do so, we should seek to provide treatment in the community. As Nicola Sturgeon said, compulsory care must be provided for the right reasons and it must not be abused.

I was a nurse in my previous life so I am at least partly aware of the problems that are suffered by people who have mental illnesses. However, I believe—this has been mentioned by many other members and I make no apology for mentioning it again—that there is a real need to educate the public about what mental illness is and about what sufferers require.

In my constituency, the Eastvale resource centre in Rutherglen provides a vital service in helping to break down those barriers. That centre provides a valuable seven-days-a-week psychiatric service to the people in south-east Glasgow who require it. I am sure that the Deputy Minister for Health and Community Care is well aware of the work that is being done at that resource centre, because he recently attended a mental health forum in Rutherglen that was organised by the centre. I know that the organisers were very grateful for his interest.

I am pleased to see that the proposed legislation will also recognise the crucial role that is played by carers in supporting people who suffer from mental illness. As has also been said in the chamber on numerous occasions, the work of carers often goes unrecognised, but for people who suffer from mental illness, carers are crucial; they are the most important people in sufferers' lives.

During the past year, I have visited in my constituency both Rutherglen Community Carers and Cambuslang Community Carers Ltd. Both those organisations demonstrate the vital role that is played by people who care for sufferers of mental illness. The newly recognised right of carers to request assessment is an important step forward.

I have been keen to encourage the Executive to increase support for carers and I am very pleased that that is happening. I hope, however, that the Executive will continue to provide funding for local authorities to offer respite for carers. As I have said previously, the working time directive does not apply to those who must care for loved ones, often for 24 hours a day, seven days a week, 365 days a year. I hope sincerely that the Executive takes that on board and continues to give carers the support that they truly deserve.

In conclusion, I am delighted to support the motion and I congratulate the Executive on taking positive steps to improve mental health law in Scotland.

15:49

Lord James Douglas-Hamilton (Lothians) (Con): I wish the Minister for Health and Community Care continuing good health.

We can welcome the Executive's policy statement with commitment and enthusiasm, because mental health problems should always be given top priority. I know from experience of visiting patients who have mental health problems that those problems can give rise to great anguish for the patient and family members.

It is not always easy to strike the best balance between the interests of the patient and the protection of the wider community, which may include members of the patient's family. Finding the right balance involves enormous patience, hard work, understanding and good will. Just as the interests of the community have to be taken into account, so do the interests of the patient. It is all too easy for a doctor exercising authority and powers over a compulsorily detained patient to overdose that patient, which may have long-term ill effects.

I remember one patient saying to me that there is no stigma attached to having a sprained ankle but that there is to having a sprained mind. I applaud the minister's admirable aim to remove any such stigma. I believe that the Administration is right to set out a statement of basic principles for the proposed bill.

Compulsory care and treatment should be used only as a last resort and should be linked to a plan of care for the patient. We would like to know a good deal more about how patients can be compulsorily treated in the community, rather than in hospital. That is a worthy aim in cases where a patient needs such treatment, but we need to know in detail how the situation would be dealt with in the event of non-co-operation.

I welcome the proposal for a new independent tribunal to consider compulsory measures. The great advantage of a tribunal is that it can consider each case impartially and on its merits, having weighed up the evidence from the doctor, the patient, family members and others who are directly affected. We have a serious reservation, however, in that the tribunal is entitled to release a patient even if that is contrary to the medical evidence and the advice of the doctor. The tribunal's jurisdiction has no check on that. In other words, the minister has no say if a potentially dangerous patient is about to be released into the community. I believe that such a safeguard operated in the past as a protection to the public and I would be glad if the minister could reassure us in that respect.

Janis Hughes was right to welcome the strengthening and clarification of the rights of carers. I note that reforms are proposed for dealing with mentally disordered offenders. Those proposals will provide for a more thorough assessment before the court makes a disposal. It is important to remember that some offenders with serious mental disorders and a history of violence can be dangerous. There is a risk that the proposed bill could focus too much on the interests of an offender who is a patient rather than on those of the community. That is a question of getting the balance right. It is important, for example, that a person who takes another's life should not be released without some provision for supervision. We will be pressing that point with the minister.

It goes without saying that the proposed bill must be supported by a sufficiency of resources. Some years ago, I had to deal with the aftermath of a tragic case in which a mental patient stabbed a police officer to death. I put in place a package of reforms, which was welcomed by George Foulkes. The reforms included provision for contact with the doctor of a known patient who is acting in a wholly unacceptable or dangerous way.

I recognise the proposed bill for what it is: a sincere and genuine attempt by the Administration to deal appropriately with the subject of mental health. However, I fear that it may not give sufficient weight to the protection of the public. We will seek to address that matter in committee.

15:54

Mrs Margaret Ewing (Moray) (SNP): I feel as though I am participating in a discussion rather than in a debate; I am pleased about the consensual approach that the Parliament is adopting on this subject.

I noted with some surprise the comments of the Minister for Health and Community Care on Bruce Millan's report, and I applauded. That may seem strange to others, but I genuinely meant it, because I believe that credit should be given where it is due. I worked for many years in the House of Commons when Bruce Millan was there. Despite all his responsibilities and all our political differences—and there were quite a few—I knew him as a man who was genuinely interested in this sphere of legislation. Future generations will owe him a huge debt of gratitude for his work. His report is a massive tome, full of great information. I place on record my thanks to Bruce Millan and all his colleagues for their work. As we progress through stage 2 of the proposed bill, we may not agree with every dot and comma of the recommendations but, my goodness, has not Bruce Millan given us a good basis from which to start?

I will not touch on many of the issues that colleagues have raised, as I am sure that the minister has taken on board the points that have been made—she has nodded sensibly when colleagues have raised various issues. However, I would like to ask about the implementation and monitoring group that is referred to on the final page of the Millan report. Although it is clear that the code of practice will be reviewed every five years, there is no indication of how the implementation and monitoring group will function and report back to the Parliament. I am sure that members will want the group to report back to us.

I would also like to raise the issue of training and support. It seems to me that the training of those involved in providing services to individuals affected by mental illness and their families should be a priority. For a long time, I worked as an administrator of the now-defunct certificate in social services, which included a mental health option. We always had difficulty in attracting people to work in the area of mental health.

People found working with children, the elderly or the handicapped more attractive. One reason for our difficulty was the strain that is placed on those who work in mental health services. Perhaps we do not provide enough training or support to the nurses, teachers, social workers, volunteers and voluntary organisations that work in those services.

I have two final brief messages. First, I reiterate a point that Margaret Jamieson made. The SAMH report, which I am sure all members will have read in preparation for today's discussion, contains a section headed "Fighting stigma". It mentions the insensitive slang terms that are used in the popular media to refer to people with the disabilities that we are discussing. Those terms include "psycho", "mental", "crazed" and "schizo". I know that the scribblers in our Parliament are always accurate in their use of language and in their reporting. Perhaps they could pass on that message to some of their colleagues. Use of insensitive language creates difficulties when we try to build community projects, because it leads people to say that they do not want people with mental health problems in their area. The media should be restrained in the language that they use.

Secondly, I ask the minister to ensure that we build on best practice. I am sure that she has read the report by the Moray Association for Mental Health. We have had a great deal of success in tackling this problem in our area. We are not saying that we are perfect, but all those who were involved in developing the projects that have been introduced in Moray are to be congratulated on their tenacity and on having taken such a cohesive approach.

I welcome this debate and have a message for those members of the public who are watching it. Although the traumas that happen in political life always seem to grab the headlines, people should realise that the issue that we are now discussing is precisely the kind of issue that we wanted a Scottish Parliament to be established to deal with. I cannot remember—I am sure that Malcolm Chisholm, John McAllion and others who have served as MPs also cannot remember—having an opportunity at Westminster to discuss such a vital issue at length and being able to look forward to a legislative process that will make life better in our communities for so many people. This debate is a shining example of what this Parliament is about.

15:59

Des McNulty (Clydebank and Milngavie) (Lab): Like others, particularly Margaret Ewing, I very much welcome today's debate on what is an important subject. The Parliament's second bill on mental health will result from a process that contrasts markedly with the way in which we dealt with the first bill. At that time, our process did not include consideration and development of the arguments in debate. As Margaret Ewing pointed out, the Parliament now facilitates a process of constructive debate, which involves all the different agencies putting forward their ideas and clarifying the concepts that they want to apply. At the end of the process and as a result of our work, I expect Scotland to have a leading framework for the handling of mental health.

If I may introduce a cautionary note, however, I do not think that today's debate can entirely be seen as a box ticked. We have not dealt with all mental health issues. For example, we have not talked about the promotion of sound mental health, which is an important subject that needs to be addressed. Perhaps that can be developed in another debate; today's debate has addressed other important issues.

I will concentrate my attention on compulsory orders, which have raised concerns among some who work in mental health. I share some of SAMH's reservations about the lack of a firm evidence base to justify some of the claims that are made about the benefits of community-based compulsion.

The present arrangements for dealing with people who have long-term mental illnesses are wholly inadequate. Some of the more tragic constituency cases that I have had to deal with have arisen out of the distress that mentally ill people—and their families—have suffered because of the lack of care that they receive under the current scheme. I believe that the least restrictive alternative test will provide appropriate safeguards. However, I urge the minister to develop some worked examples of how we might expect that test to be applied in practice. We need further details so that we can develop the principle and let people understand how the test will work in particular cases.

I welcome the principle of reciprocity, which others have mentioned. However, the minister needs to look again at the definition that she gave at the start of her speech. She stated:

> "mental illness is different from other forms of ill health. A person who is mentally ill … may not appreciate the nature of their illness or the need for treatment. Sometimes treatment must be imposed, rather than agreed. That is why we need effective legislation—legislation that balances the needs of patients with their rights as citizens."

I agree with that. However, to take that forward we also need to take into account the rights and needs of families and communities. The emphasis needs to be rebalanced so that we shift from focusing exclusively on the treatment of mental illness to considering how the care of mentally ill people can be developed in a community context.

I have attended a number of case conferences at which I have been astonished and appalled at how the arrangements for dealing with the needs of a mentally ill person have been fragmented among different professionals. Often, the mental framework that doctors use in dealing with their work is more suited to a hospital than to a community context. Doctors' specialisms often dominate their obligations to the patient to such an extent that their specialist concerns take precedence over all other considerations, with the result that the mental health of the person is not brought into proper configuration with their physical health needs. Arrangements for providing appropriate forms of social care and a regular pattern of interaction for the individual are seen as entirely secondary to the method of treatment of the mental illness.

To deal with mental illness in the community, we must provide a constructive and integrated pattern of social support. That is what mentally ill people require. Changing the legal framework is one aspect of taking that forward, but it must be accompanied by a systematic and co-ordinated attempt—involving the minister and her ministerial colleagues with relevant responsibilities—to identify how a whole new framework can be constructed. Medicine must be brought into a proper configuration with social work, housing and other forms of support that mentally ill people and their families require.

We are making a major contribution to renewing the framework for dealing with mental illness in Scotland. However, this must not be the only step. We must make progress in a balanced and structured way. The minister is establishing an appropriate framework, but we must add to it.

16:05

Robin Harper (Lothians) (Green): I add my congratulations to the minister on her impending good news. My business manager gave birth to a fine bouncing baby last month; I am sure that she would be happy to recommend the Simpson memorial maternity pavilion for the happy event.

I will start by taking up Margaret Smith's point on education. I have an optimistic and, I hope, generally sunny disposition, so it may surprise members to know that, while at university, I was treated briefly—effectively and chemically—for depression. I therefore have a small knowledge of the condition. I feel that the Executive must do all that it can to promote the teaching of mental health issues in schools, colleges and universities through social education.

I pay personal tribute to many organisations in Scotland. I cannot list all of them, but I pay particular tribute to SAMH, Mencap, Penumbra, mindscape and other organisations in Edinburgh and the Lothians. They are doing their best to highlight mental health issues and to get us to a point at which we can openly discuss them. People have mentioned broken legs and sprained ankles. I feel that, even now, it is easier to discuss cancer than it is to discuss mental health. As I think I have said before in the chamber, mental health is one of the last great taboos in general conversation round the dinner table.

When we started to move towards care in the community about 10 years ago and caring moved from the hospitals and places of secure care into the community, people could see little holes appearing in the net. Is the minister satisfied that all those holes have been closed or are being closed, especially in relation to the mental health of homeless people?

There is a need for some form of publicly available and accessible advocacy service for people who suffer from high levels of stress, anxiety, depression or—even more seriously—mental illness but who, at the same time, are engaged for personal, business or family reasons in litigation. It is extremely difficult for someone who is suffering from any kind of stress, depression or mental illness to engage in litigation. I know that I am not sticking to the subject—as it seems Des McNulty would like us to do—and that I am widening the debate still further. However, I wanted to mention the point about an advocacy service in this context.

Nicola Sturgeon said that there was no proposal for a title for the bill, but SAMH has said:

> "We argued against the title 'Mental Health Act' on a variety of grounds, including that this was inaccurate as the scope of the Act is wider than mental health. As the purpose of the Act is to regulate psychiatric care practice we think a more suitable title would be the 'Regulation of Psychiatric Care Act'. This describes what the act does."

16:10

Dr Richard Simpson (Ochil) (Lab): I declare that I am still a fellow of the Royal College of Psychiatry and I am a member of SAMH.

The Millan report is a patient, thorough and comprehensive review of our mental health law. The process surrounding it, which has involved at every stage all those who have a legitimate interest, has been excellent. In that respect, it builds on the report "The same as you?", which was highly praised for its involvement of users and carers.

One of the most difficult aspects of legislation in this area is the need to promote the most effective treatment while allowing the individual as much freedom of choice in treatment as possible and, as Lord James Douglas-Hamilton said, protecting the public from the rare event of violence.

Down the centuries, we have steadily progressed from the manacles and shackles of the 18th century—which I was presented with as a student, as they were still being used in Australia in the late 1960s—to the acts of the 1950s, 1960s and 1980s, which moderated and regulated the infringement of liberty. Recently, I was involved in a study tour for Dutch health workers and politicians, who were astonished that we never use restraints, unlike in the Netherlands. Already, society in Scotland has moved significantly ahead of other countries in terms of the treatment of the most disturbed individuals. Through the legislation that we are about to introduce, we can embrace proposals that will be fit for the 21st century and will promote what Des McNulty referred to: a genuine partnership between the patient, their family or carer and the health professionals.

The principles in the Adults with Incapacity (Scotland) Act 2000, which stated that the treatment chosen should be the least invasive and should follow the perceived wishes of the patient, presage the new legislation. The notion that the treatment and the setting should be the least restrictive will be a central part of the new bill.

Nicola Sturgeon and others referred to advocacy, so I will not dwell on it. Forth Valley Health Board developed one of the earliest advocacy services, which has been crucial to some people with mental health problems. Advance directives, particularly on special treatments such as ECT, are absolutely vital. The management of those advance directives, combined with the nomination of an individual to act for the patient, provides a sensitive and important way of dealing with a difficult situation.

This has been one of the most consensual debates that we have had in the chamber. It feels almost like a members' business debate, so little difference is there between the parties.

The most exciting proposal is the principle of reciprocity, which will ensure that, if the state has to curtail aspects of liberty, the patient will receive the services and treatment that they need. That guarantee is crucial to every citizen. If it is enshrined in law, we will have moved forward care in Scotland in a big way. I would like the roles of the Clinical Standards Board for Scotland and the Mental Welfare Commission in protecting and guaranteeing that right to be spelled out and I welcome the fact that the Executive will review the Mental Welfare Commission.

The CSBS must define the clinical standards that are acceptable and it must inspect the mental health services, while the Mental Welfare Commission must have powers to require health boards to meet those standards. To ensure that we achieve the standards that we want, the mental health framework needs to be driven forward with real urgency and the health boards and community plans need to be subjected to rigorous local accountability and defined outcomes through the national assessment framework.

I say to Robin Harper that community care began in 1956, following the report of the Dunlop commission. It has been part of my life as a psychiatrist for all my working years, although, for the most part, it has not been a reality. Some 80 per cent of our expenditure on mental health services is still on institutional care. We must work to change that situation.

I cannot finish without commenting on one contentious part of the proposals—the new community orders. A recent review in the *Psychiatric Bulletin*, to which Des McNulty obliquely referred, could be summarised as indicating that, on the basis of the evidence across the world where such orders, in different forms, have been tried, there is as yet no proven advantage to compulsory community orders over high-quality services on their own. Before we proceed with the bill, we should use this brief period to produce research to assist in determining whether those orders are likely to help in fulfilling the Executive's stated aim of introducing greater flexibility and preventing hospitalisation

As the Minister for Health and Community Care said, there is a danger that compulsion, even with guaranteed high standards of care, may be abused. We should commend the Millan commission for its report. I commend the Executive for the exemplary consultation process that it has gone through and for its ambition for the people of Scotland in this policy area. I await the new bill with eager anticipation. I commend the motion and the SNP's amendment.

The Deputy Presiding Officer (Mr George Reid): From now, speeches are down to four minutes.

16:16

Stewart Stevenson (Banff and Buchan) (SNP): Presiding Officer, thank you for chopping off the last page of my speech.

I join the prevailing consensus in the chamber and welcome the Millan report and the Executive's response to it. I cannot bring the kind of experience that Margaret Jamieson brought as a psychiatric nurse when she made her speech, but I have a bit of family history. My mother chaired the local mental health committee in Cupar in Fife for between 15 and 18 years. My father was a general practitioner and a physician in the local psychiatric hospital. According to my father's express wishes, the very house in which I was brought up was sold to the health board in Fife and is now a psychiatric day unit. My best pal's father was the medical superintendent at the local psychiatric hospital, and by some strange coincidence, when I met my future wife at university, her father was a psychiatric nurse at Craig Dunain, as was her sister.

For my part, as a bored school student at the age of 17, I left school early to work in the local psychiatric hospital as a nurse in one of the last locked wards. We had in that ward schizophrenics; people suffering from manic depression, general paralysis of the insane from alcohol abuse, and tertiary syphilis with GPI; an accident victim who was unable to communicate with anyone; and Willie. I will protect his identity by describing him simply as Willie. I will come back to him in a minute.

My experience of that ward underpinned many of my attitudes to social issues subsequently. We had 32 beds. We were working 108 hours each fortnight, and we were paid £6 10/- a week, less stoppages. On one particular occasion, I remember working the double shifts that we worked on Saturday and Sunday—a full weekend—with just two nurses, one of whom was me with the barest of bare experience; the other had 18 months' experience. We were the medical ward in the psychiatric hospital, and that weekend we had three deaths. It was not an unusual occurrence.

The key point that struck me about being in a psychiatric hospital in the 1960s was the social isolation of the people in the ward. During the period of just under a year when I worked there, we had one single visit, from relatives of a patient who was seriously ill and expected to die. It is on that basis that I return to Willie. Willie was what in some ways we could only describe as our trusty. He went for our cigarettes. He helped us to clean the ward. He sometimes made our tea. He did not have a mental illness, nor a personality disorder. He certainly had a learning difficulty, and perhaps a learning disability.

The continued inclusion of learning disability in the proposed legislation causes me the most concern. I recognise the difficulty in taking that term out but, in her consideration of the proposed bill, I urge the minister to consider that issue. It is a social issue at least as much as a psychiatric issue.

Along with Robin Harper, I feel that the role of advocacy is of great importance, particularly in the area of learning disability. As Richard Simpson mentioned in his well-informed and thoughtful contribution, reciprocity is one of the jewels in the crown of the proposed legislation.

In conclusion, let us give the bill any name we like, but let us include the word "care" because that is what the bill is about.

16:20

Mr David Davidson (North-East Scotland) (Con): Members will be well aware of this week's coverage of my daughter Suzy's current problems with an eating disorder. I therefore intend to talk principally about that aspect of mental health.

Problems arise in accessing support in the early stages and long-term support back in the community. I accept that those problems apply to many forms of mental illness in Scotland. I am not attacking the Government, but I am highlighting to the Parliament an area of great concern.

The reason that Suzy and I have gone public is that her colleagues who were in hospital with her asked me, as a member of the Parliament, to do my best to raise awareness of the plight of sufferers and their families. Needless to say, I am very proud of Suzy's bravery.

Eating disorders are not fashionable fads or an outcome of current diet plans. They are a form of mental illness that is fuelled by depression and anxiety, and often triggered by events that have been bottled up for a long time. Eating disorders are life-threatening illnesses and the problem is that they are increasing dramatically in Scotland.

The victims are withdrawn and isolated, and suffer moods of despair and loss of self-esteem, which lead to a risk of self-harm and—too often—to suicide. I do not pretend to be an expert, but the difficulties that my daughter and my family have faced in trying to deal with the matter will perhaps highlight some of the issues and give support to sufferers and their families and—I hope—gain a commitment to future action.

On 8 October 1999, the Minister for Health and Community Care, Susan Deacon, stated:

> "Mental health is as much a part of good health as physical well-being. The Scottish Executive sees mental health as a top priority and is committed to providing high quality support and services and to fostering positive attitudes to those with mental health needs."

My main concern is that the disease is recognised early. One of the problems is that many sufferers deny that the condition exists. The longer the delay in getting access to medical assessment, the greater the risk of dramatic loss of body weight. That leads to physical breakdown and slower thinking processes as the disease takes over.

My daughter's case is fairly typical, but the truth is that there was insufficient support available to her in the short term because of the extended waiting list to gain access to the few experts and their professional teams. Those people's work load is becoming unmanageable. I am afraid that that is one of the causes of the delay in treatment.

Once access to assessment is attained, there is another problem, as there are so few dedicated residential units in Scotland. I accept that some hospitals place patients in general psychiatric wards, but the only dedicated residential unit in Scotland, the Priory hospital, ensures that those with eating disorders are treated with no distraction of staff to other patients with differing and pressing needs.

From the time of my daughter's declaration of the problem, we struggled to get her assessed. Again, demand outstripped supply wherever we looked. She was eventually assessed by an Edinburgh consultant, who told her that if she was not eating by Easter, she would be dead. That is shocking, but it is a fact of life that we have to address in many conditions. That trigger helped her to make a decision to get more help. She went downhill and came home, but luckily our general practitioner managed to get an early appointment with an Aberdeen hospital. The treatment available in a mixed ward in that hospital was helpful, but limited. We are grateful that the consultant was prepared to recommend her for a place, funded by the local health board, in the Priory hospital. That is a model of partnership that I would like to see rolled out throughout the health service. I accept that that admission was based totally on her clinical requirements at that time and that all such decisions must be made on that basis. The priorities are tight because of the difficulty in accessing resource.

When my daughter left hospital and regained her body weight, she required access to day care therapy. Although that was available from the hospital in Glasgow, it could be provided only if she stayed there. We are lucky that we have some access to that in Aberdeen, but that is not the case throughout Scotland. Many people do not live close enough to facilities to obtain that support.

We should pick up the fact that there are problems among more people, not all of whom are girls or young. Accessing early assessment is also a problem. There is a lack of dedicated residential units. Our aspiration should be to establish regional units where access may be dealt with more evenly and fairly. We should also ensure a seamless extension of hospital treatment to the community.

Other members have expressed well the issues of stigma. I praise Margaret Jamieson for her speech.

I thank *The Sunday Times* for its sensitive handling of the issue and I thank the other newspapers and journals for their support. I hope that they will continue to deal with the issue in a non-sensational manner. As others have said, the problem is serious. It needs education, not sensation.

Since Sunday, I have been contacted on all forms of communication from all over Scotland by sufferers, people at universities who are trying to support students with problems and therapists who want to register. I know that other avenues in the media have expressed a desire to continue to raise awareness of the issues. The sufferers, their families and I are grateful for that support. I hope that, in time, that will extend to others who have mental health difficulties.

I hope that the Executive is listening and that mental health is a priority. I hope that we develop early clinical assessment, quicker decision making and access to specialist units. In the first instance, I ask the Executive to assist in developing a database that will highlight the scale of mental health problems and the facilities that are available in Scotland.

I have brought the issue to the chamber as a politician, but I highlight the issue in a non-political way, on behalf of all sufferers and their families.

16:27

Brian Adam (North-East Scotland) (SNP): I will address two matters, one of which is advocacy, to which others have referred. Individual advocacy has been discussed, and I do not doubt that the minister will respond on that today or on publication of the bill. I would like to raise the issue of collective advocacy. The Millan report seems to have been diluted in the Executive's response, and I have some concerns about that. I will highlight that by dealing with the issue as it affects the area that I represent.

In Grampian, a move has been made to establish a patients council in Aberdeen, but resources are an issue. Grampian Primary Care NHS Trust is responsible for the council, which is part of its priorities, but it is an insufficiently high priority for the trust to find funding. If we leave the situation as it is, the Executive's response will mean that patients will continue to have only the right to have a council as a priority and will not have a council established. That should be a duty.

We should support user groups along the lines of those that have been established in the Highland area, perhaps based on local authority boundaries or other suitable boundaries. However, we will have to find resources for them. Unfortunately, when local decision making is left to local health authorities, there is no guarantee that such groups will be created, as long as the decision is discretionary. Advocacy must be clearly established as a priority and not as something that simply ought to happen. That should be in the bill.

I will also talk about reciprocity. If we are to compulsorily treat individuals, greater care must be taken of them. As I understand it, the Millan committee recommended that people who are compelled to take medicine should have the cost of that medicine covered by the state. As far as I can see, that requires an extension of the legislation. In the past, I have raised concerns with the minister about cases involving individuals with on-going mental health problems who choose not to take medication because they cannot afford to do so. The minister is aware that, when people who suffer from manic depression do not take their medication, the risk of suicide is greatly increased. The bill gives an opportunity to rectify that by extending the list of prescription exemptions for those who suffer from enduring and severe mental illness. I ask the minister to give some consideration to that suggestion.

16:31

Mr John McAllion (Dundee East) (Lab): In the spirit of consensus that is prevailing today, I will begin by welcoming all the speeches that have been made during the debate. In particular, I want to mention the very moving contribution that was made by David Davidson.

I also want to mention the warm and kind words that have been said about Bruce Millan and his report. Bruce Millan is probably best remembered as Secretary for State for Scotland and as a member of Parliament representing part of Glasgow, but he is a native of the city of Dundee—one of Dundee's sons who has done well. I am sure that we can look forward to a headline in the *Courier and Advertiser*: "Dundee man reforms Scotland's mental health laws."

That said, I welcome most of what the minister said and proposed in respect of mental health law. The Executive accords a high clinical priority to mental health. It recognises that people with mental illness and with learning disabilities have rights just like any other citizens. I also welcome the underlying principles behind the new legislation. Many members have referred to the principles of non-discrimination, equality, reciprocity and so on. In particular, I welcome the proposal that treatment, whether it be compulsory or voluntary, should be provided in a setting that depends on the assessed needs of the patient rather than on the prejudices of society or of the medical profession.

When the Executive approached the subject, it had nothing but the best of intentions: it wanted to try to do better for patients and for their carers. As other members have said, and as the minister and her deputy know, without the allocation of sufficient money and resources, good intentions remain as intentions.

I was delighted to hear that the Executive will support the SNP amendment, as I was anticipating a summons to Tom McCabe's office yet again. Sometimes I think that I am more often in his office than he is.

I recently attended a seminar, run by the forensic psychiatry service for Tayside, which was held at Murray royal hospital in Perth. The seminar examined the service needs of mentally disordered offenders and was addressed by carers, users, a sheriff, the police, health care staff, housing staff and psychiatrists. All those speakers came to one conclusion about the level of service that is currently available: not enough money is being invested either to sustain the service or to meet the demands of users.

Over time, bed numbers have been reduced continually until we find ourselves in the present situation of having only 26 male beds and one female bed for the whole of Tayside. The beds are occupied 100 per cent. For emergency admissions, somebody has to be discharged inappropriately to make room for them.

Speakers told of patients having to wait for years to find a bed for which their need had been assessed. They spoke about staff having to work double shifts that resulted in up to 80 hours a month of overtime. Speakers also told of patients put inappropriately into prison. All that reflects the fact that, as we debate the issue today, insufficient resources are being allocated to mental health services. It is not a unique circumstance for people who are mentally disordered offenders.

I recently received a letter from a community psychiatric nurse working in Dundee, who complained about proposed cuts to this year's Tayside mental health services budget of more than £0.5 million. When I raised the matter with the health board, it indicated that those were not cuts; in fact, the budget was overspent. That might make bureaucratic sense, but it makes no real sense. There are patients in Dundee who can see reptiles coming through their floor and who severely damage themselves, but are told that there are no beds, and their carers are told that they will just have to put up with it. There are insufficient beds available for the patients who need them. We have to address that, not as the Labour party, the SNP, the Tories or anyone else, but as a Parliament. It is our responsibility to do something about it, and if that means reordering priorities or raising taxes, that is what we should do.

16:36

George Lyon (Argyll and Bute) (LD): I, too, congratulate the minister on the announcement of her pregnancy—there has certainly been consensus on that today.

There has been consensus throughout the debate—few queries or concerns have been raised. As many contributors have said, this is the first fundamental review of mental health law in Scotland for more than 40 years. Reform is much needed to reflect the development and evolution of community-based mental health services, the greater involvement of service users and carers in decisions concerning treatment, and the greater awareness of the need to respect human rights. What the reform will show is that there has been a positive step change in the way in which we deal with mental illness.

On the basic principles, everyone agreed with the minister that the key principles underlying the new mental health bill—equality, diversity, participation, respect for carers and reciprocity—are important. The fundamental aim is to make the law clear on when and why compulsion might be needed. The new system of mental health tribunals to replace the use of sheriff courts has been widely welcomed. Many members highlighted the stigma that is currently associated with having to go to the sheriff court for orders. The new mental health tribunals should take away some of that stigma.

The minister highlighted the fact that this piece of legislation will be complemented by the criminal justice bill that is to be introduced. The SNP expressed support for the bill and the motion before us. The view was expressed by almost all members that the new legal framework alone will not deliver better services; proper services need to be put in place to ensure that service provision is there to meet the requirements of the bill. Nicola Sturgeon highlighted the question of advocacy. I would appreciate some clarification from the minister on whether the right to advocacy will be part of the proposed legislation.

Mary Scanlon highlighted reciprocity as the key issue, and the need for compulsion to take treatment to be matched by the proper resources to meet the needs of the patient. She highlighted an important issue that was mentioned by one or two other members: the need for clarification on how the Executive intends to set up proper monitoring of whether patients actually receive the treatment and services that they require after the compulsory treatment orders are put in place. I hope that the minister can explain how that monitoring will take place, what the sanctions might be and what recourse to action the patient would have if their needs were not being met and the proper service provision was not being put in place.

Margaret Smith highlighted the fact that 30 per cent of consultations are about mental health problems. That reflects the underlying problems throughout the population. However, as Robin Harper said, it is not a subject that is discussed around the dinner table. It is one of the few taboo subjects still left in society.

Margaret Jamieson raised some excellent points about the stigma attached to mental illness and about the need for better education and better understanding of the problems. Again, that is related to what Robin Harper said about our inability to discuss mental illness openly. It is still seen as a stigma for any member of one’s family to have such an illness.

Margaret Ewing paid tribute to Bruce Millan, an ex-colleague at Westminster. We would all agree with the sentiments that she expressed. Bruce Millan’s report is a good basis from which to start.

Finally, I pay tribute to David Davidson, who gave a heart-rending contribution. On behalf of the Liberal Democrats, I extend our sympathies and sorrows to him. I hope that he and his family manage to see their way through the problems that his daughter has faced.

16:41

Ben Wallace (North-East Scotland) (Con): The Scottish Conservatives welcome the opportunity to debate the proposals for new legislation on mental health. Mary Scanlon underlined our commitment to the new legislation. We recognise its importance. The Conservatives will certainly support the Executive’s motion today.

There are many new initiatives and the onus is increasingly on care in the community, so it is only right that we re-examine the definition of such things as mental disorder and the criteria and procedures for the detention of those suffering from certain mental illnesses, but the narrowness of today’s motion is disappointing. It focuses on mental health legislation but does not take the opportunity to use this two-and-a-half-hour debate to examine the concerns of the people who are working in all parts of the mental health sector. Nor does it allow members to discuss progress on the mental health framework initiative that was launched back in October 1997 and was originally initiated by the Conservative Government the year before that.

Building on Mary Scanlon’s remarks, I want to examine in greater depth the delivery side of mental health services. The Government made it clear in its recent strategy, “Our National Health: A plan for action, a plan for change”, that it would make mental health a leading priority in Scotland.

Interestingly enough, it had also pledged to make it a priority in 1997 and 1999, but the positive feedback from those at the coalface has not matched the pace of the Government pledges.

Although we welcome the legislative review as fulfilling part of the Government commitment made more than three years ago, we have to ask why so many of the initiatives clearly laid out in the original framework document have only now started to take shape. For example, the mental health and well-being support group, which was designed to monitor health board action on mental health, was convened only in January last year, four years after the concept was originally proposed in the framework document.

When monitoring lags so far behind implementation, there will inevitably be a fallout. For example, the principle of equality of access for patients suffering from mental disorder still has a long way to go. According to Alzheimer Scotland—Action on Dementia, many Alzheimer sufferers are still experiencing a high level of postcode prescribing. In addition, further concerns voiced in the Millan report by users of mental health services are still being overlooked. Nearly every mental health patient representative group has expressed frustration at the lack of information, drug treatment and the availability of alternative services.

We also recognise that changing the stigma is a long-term goal and one that requires a cultural shift. Margaret Jamieson made those points extremely well in her speech. One of the most common complaints from constituents who care for sufferers is that health boards and local authorities treat such problems at arm’s length. Many of the good intentions fail to get through to the front line. Although we accept that the Government is trying to remedy that with the mental health development fund, we also think that the failure of the joint investment fund has been a lost opportunity. That fund empowered GPs and local health care co-operatives to start some of their own initiatives to solve problems as appropriate.

The Millan report’s consultation with users also highlighted problems with the availability and accessibility of services in rural areas. It also drew attention to the desire to reduce waiting times. We accept that accessibility is a common concern among patients, but we think that the impact of the Arbuthnott formula in regions such as Grampian might not improve it. We should also take warning that waiting times for psychiatric treatment are on the rise again.

Nicola Sturgeon made a clear and articulate argument for the need for a clear right of advocacy. Lord James Douglas-Hamilton rightly sought clarification of how compulsory care in the community can benefit people. I agree with every word of Des McNulty’s speech, which was extremely good. He tried to look beyond the legislative process and towards measures to better mental health.

The Scottish Conservatives support the SNP’s amendment, which recognises that appropriate measures must be behind the initiatives, and the Scottish Executive’s motion, which welcomes legislative changes. Over the coming weeks and months, as the Opposition, we will ensure that the service provision that has been promised to people suffering from Alzheimer’s disease, schizophrenia, anorexia and other mental disorders will be met by the Executive.

16:46

Shona Robison (North-East Scotland) (SNP): The debate has been productive and worth while. There has been much agreement and we are extremely pleased that the SNP’s amendment has been accepted. Long may the trend continue.

The debate is important in many ways, not least because although mental health is one of the Government’s key clinical priorities it is still the poor relation in respect of attention and resources. There is a real stigma associated with mental health—Margaret Jamieson articulated that point extremely well. I support her call for a public education process to tackle that stigma.

Renewing mental health law builds on many of the Millan committee recommendations and will—as has been said often this afternoon—lead to a major improvement in the legislation that underpins how mental health services are delivered in Scotland. We must ensure that adequate resources are provided to back up the principles and intention behind legislation.

The tribunal system has been widely and rightly welcomed as an important change. It will take people away from the sheriff court system, which has stigmatised service users as criminals.

The new right that gives service users and carers a right to request an assessment is an important development. Janis Hughes spoke well of the need for support for carers. I was struck by her comment that the working time directive does not apply to those who care 24 hours a day, 365 days a year—that will stay with me.

Community-based compulsion is a contentious issue. There is continuing concern about the extension of compulsion into the community. Richard Simpson spoke about the reasons for concern. The Millan committee received a range of views on the matter and acknowledged that it would be one of the most controversial elements of the proposals. SAMH is concerned about the new community orders which, if not used appropriately, could reduce the rights of service users. The key is appropriate use. We must explore that issue during the Health and Community Care Committee's evidence-taking sessions.

I am concerned about the impression that has been given of the right to advocacy being watered down to a duty. I hope that the minister will give reassurances that there will be no watering down. Brian Adam outlined the importance of collective advocacy. Patients councils are important. The Executive should consider the Dutch model, in which there is a statutory duty to provide patients councils in every psychiatric hospital. We can learn from that.

Resources are the key to the success or otherwise of the legislative changes. The Millan committee could not consider funding issues, but it highlighted the need for good services. It has already been said that in Scotland, unlike in England, mental health services lost the capital receipts from the sale of psychiatric hospitals. Members know of the difficulties of resource transfer moneys disappearing into the mist and never reappearing to develop the community-based services that are required. We must consider how that happens and try to stop it happening in the future.

SAMH has said that the principle of the least restrictive alternative will not be meaningful in practice unless a full range of services is available, including crisis services and other services based in the community. Many examples have been given of the need for properly resourced services. Kenny Gibson highlighted the need for specialist services for survivors of childhood sexual abuse and expressed concern about the lack of such services. Des McNulty gave the example of a constituent who had experienced a lack of care. I associate myself with the views of John McAllion on the problem in Tayside, where there were cuts in mental health services to the tune of £500,000. Those cuts included the loss of community psychiatric nurses.

One of the few eating disorders services, which is based at the Murray royal hospital, is under threat. It is one of the few day and in-patient services that are operated by the NHS for people with anorexia. We do not need to listen to my views on that issue—David Davidson gave a personal account of how important specialist services are for people with anorexia. I hope that the minister will consider the future of the service at the Murray royal hospital because it is valued by the people who use it and their families.

I look forward to the production of a mental health bill, which will come to the Health and Community Care Committee. A range of evidence will be given. Given that one in four of us is likely to suffer mental health problems at some stage in our lives, the investment of time by the Parliament is absolutely crucial to ensure that mental health receives the recognition and resources that it deserves.

16:52

The Deputy Minister for Health and Community Care (Malcolm Chisholm): The debate has been excellent and, as Margaret Ewing put it, a shining example of what the Parliament is about.

There have been continual references to the wider spectrum of mental health policy and initiatives, but the focus has been on renewing mental health law. At the heart of our approach are the needs and rights of individual mental health service users. We are strengthening the rights of patients to assessment, services and protection and are giving patients a stronger voice in legal proceedings and dealing with professionals.

However, balancing the rights of patients is a wider public interest, particularly when people with mental disorders are involved in offending behaviour. Our reforms in that area will lead to more transparency in decision making, stronger rights for patients and better protection for the public, through more effective assessment and management of risk.

I thank all the members who have expressed their best wishes to Susan Deacon and, since the next member I will deal with is Mary Scanlon, I particularly thank her for her rather interesting reference to the new arrival. I know that Susan Deacon has been working miracles in the development of maternity services, but I am not aware that she has reduced the waiting time for birth to quite such an extent.

Mary Scanlon asked a specific question about the provision of safe and appropriate services and how they would be monitored. I assure her that they will be monitored as part of the care programme approach and that the Mental Welfare Commission will also monitor the delivery of service in individual cases.

Mary Scanlon's main point was perhaps about advocacy, which is also the point that Nicola Sturgeon started with and which many others referred to. I assure members that we are committed to the same aim as Millan—that mental health service users should have access to an advocate when they need one. In "Our National Health", we have already set out a requirement that NHS boards demonstrate their plans for making independent advocacy available to all who need it. That must be done by the end of this calendar year. We are currently examining their plans. The bill will go further and, for the first time, create a duty on both the NHS and local authorities to support independent advocacy in mental health.

Various members, including Brian Adam, expressed concern about collective advocacy. There are different forms of collective advocacy. It is only recently that the importance of collective advocacy has been properly recognised. If we imposed a duty in legislation, it would be necessary to define collective advocacy and how it should be supported. We are concerned that that might restrict flexibility and innovation. We want collective advocacy to develop through local negotiation and discussion, not in response to a statutory imposition from above. However, we recognise that many people feel strongly about this issue. We will continue to discuss with advocacy interests how the duties in the mental health bill should be expressed, to ensure that the aims of Millan are fulfilled.

Nicola Sturgeon made many points in her speech. I do not have time to go over all of them. She made an interesting and important reference to advance statements and commented on the suggestion from SAMH that those should have a formal standing and perhaps should be able to be overturned only by a tribunal. We will consider that and the many other helpful suggestions from SAMH. We currently feel that that suggestion might create problems in emergencies or where statements are unclear.

Nicola Sturgeon also referred to the title of the coming bill. Robin Harper suggested that it should be called the regulation of psychiatric care act. I think that that title would be rather narrower than the current scope of the bill.

A lot of what Nicola Sturgeon said, and stated in her amendment, focused on resources. She referred to her fear that compulsory treatment orders might be a sticking plaster. We should remember that a new feature of compulsory treatment in the proposals is that a care plan must go with it. Some members have drawn a false dichotomy between services and compulsion.

As I said, Nicola Sturgeon's main point was about resources. I am pleased to announce that we accept the SNP's amendment. We are in discussions with service providers on the resource implications of the bill. It would be premature to specify a figure for its cost. When the bill is published, the financial memorandum will set out our views on resources, but members should be in no doubt about the Executive's commitment to the proposals that we are putting forward. We will ensure that the necessary resources are in place for effective implementation of the reforms.

Margaret Smith asked why we are using impaired decision making, rather than impaired judgment, as one of the criteria for compulsion. It reflects advice from the mental health legislation reference group. A concern was that the term impaired judgment was too limited and subjective. For example, disagreeing with the psychiatrist might be said to be impaired judgment. The point of the test is that the mental disorder must be adversely affecting the patient's ability to understand and make a real choice about the treatment.

Kenny Gibson raised concerns about psychiatric services in relation to sexual abuse. I am very aware of that issue and was pleased to launch some research recently by Sarah Nelson, which focused on female survivors of sexual abuse. The matter was also raised in the "National Framework for the Prevention of Suicide and Deliberate Self-harm in Scotland", which I was pleased to launch recently. I hope that the addition to the mental health framework, on psychological interventions, which I also announced in October, will help survivors of sexual abuse.

Margaret Jamieson made a passionate speech about stigma. I was pleased to announce, on 8 October, the setting up of a national advisory group to take forward the programme of work funded by the £4 million allocated in "Our National Health: A plan for action, a plan for change" for the promotion of mental health and well-being and the attack on stigma. I intended to say more about that group, but I have one eye on the clock so I will just say that the members of the group will be announced soon. Part of its work will take on board Robin Harper's concerns about doing work in schools and Margaret Ewing's concerns about the use of certain language by the media. I regret the absence of the media at this debate.

Lord James Douglas-Hamilton asked how patients could be compulsorily treated in the community. We will explicitly legislate that forcible treatment can be administered only at designated clinics and hospitals. We accept that such treatment in a patient's home, or other domestic or public setting, would be very traumatic and unhelpful, and it will not be allowed.

Lord James Douglas-Hamilton was concerned about the role of ministers. It is right that ministers should no longer be able to discharge restricted patients. That is a judicial role; however, ministers will still be involved in the oversight of restricted patients and will be able to make representations to the independent tribunal and to appeal to the Court of Session against discharge decisions that they consider to be inappropriate.

Margaret Ewing asked about the implementation and monitoring group. We are continuing to support a mental health legislation reference group throughout the process of implementation. Once the act is in force, we will wish to review how the monitoring will continue and will bear in mind the on-going role of bodies such as the Mental Welfare Commission.

I am sure that we all agree that David Davidson made a most moving speech about eating disorders. I am pleased to remind members that, in October, we announced a further extension to the mental health framework which deals specifically with eating disorders and which states:

> "Much more needs to be done to create treatment protocols, clear referral pathways and a pattern of specialist in-patient provision in the NHS."

I will conclude by referring to two points made by Richard Simpson. He said that the mental health framework must be driven forward with a real sense of urgency. I believe that that is happening now. Ben Wallace may well be right to say that no support group existed in the early years of the framework, before the Parliament was created, but one of Susan Deacon's early acts was to set up such a group. As a result of the group's excellent work and the additions to the framework to which I have referred, there is now a momentum behind the framework's implementation.

Richard Simpson also referred to the fact that institutional care accounts for 80 per cent of mental health expenditure. That issue is being addressed by the performance assessment framework, in which we specifically examine the percentage of mental health spend on services in the community.

My time is up. I hope that members will appreciate the vast range of initiatives that are in store. Although I have not mentioned the resource question that John McAllion and Shona Robison raised, I should point out that spending increased by 9 per cent in the NHS last year. That increase is over and above specific initiatives such as the mental illness specific grant.

As for the law reform proposals that we recently announced, although our changes are radical, they are also principled and practical and amount to the most fundamental reform of mental health legislation for a whole generation. I commend them to the chamber.

Decision Time

17:02

The Presiding Officer (Sir David Steel): I have only two questions to put to the chamber as a result of today's business. The first question is, that amendment S1M-2438.1, in the name of Nicola Sturgeon, which seeks to amend motion S1M-2438, in the name of Susan Deacon, on renewing mental health law, be agreed to. Are we agreed?

Amendment agreed to.

The Presiding Officer: The second question is, that motion S1M-2438, as amended, in the name of Susan Deacon, on renewing mental health law, be agreed to. Are we agreed?

Motion, as amended, agreed to.

Resolved,

That the Parliament welcomes the publication of the Executive's policy statement *Renewing Mental Health Law*; agrees that the statement provides a sound framework for new legislation which responds to the needs, rights and aspirations of people who use mental health services, while having regard to the public interest, and looks forward to the introduction of a Mental Health Bill, thus fulfilling the *Programme for Government* commitment to modernise mental health legislation in the light of the Millan Committee's review of existing law and also supports the view expressed in the Millan Committee's report that the aspirations underlying its recommendations for new mental health law will not be met unless services and facilities are adequate to meet the demands placed on them.

Hypertrophic Cardiomyopathy

The Presiding Officer (Sir David Steel): The final item of business today is a members' business debate on motion S1M-2243, in the name of Johann Lamont, on hypertrophic cardiomyopathy.

Motion debated,

That the Parliament notes the prevalence of the mainly inherited heart disease hypertrophic cardiomyopathy (HCM) which affects one in 500 of the population and is the number one cause of sudden death among under 25-year-olds; congratulates the Cardiomyopathy Association on its role in highlighting the condition and acknowledges the work of those involved in the association who have often suffered the loss of a family member because of HCM; further notes the Cardiomyopathy Association's campaign to secure screening by electrocardiogram and echo ultrasound of all first degree relatives of those who die as a result of this condition, and believes that the Scottish Executive, in partnership with the Health and Community Care Committee, the National Health Service and relevant groups working in this field, should consider how best those suffering from this condition might be identified and given access to the appropriate treatment.

17:04

Johann Lamont (Glasgow Pollok) (Lab): I am proud and privileged to speak during members' business to the motion in my name on hypertrophic cardiomyopathy. I am grateful for all the support that the motion has attracted, which indicates the concern felt across the chamber about the issues that it highlights.

All members will acknowledge that we live in times of hubbub and change in the Parliament. I believe that the time for debating members' business is of real importance and plays a part in establishing the Scottish Parliament's worth. The debate represents business as usual, in particular for back benchers such as me. This is an important opportunity for the citizens of Scotland to see the structures and work of the Parliament being influenced by their priorities.

I must start with a confession. The subject of the debate is not an area in which I have great expertise—indeed, I am conscious of my total ignorance of the condition when I first heard about it. Since then I have been interested to see the often puzzled and bemused reactions of others when I have talked to them about hypertrophic cardiomyopathy. It is not easy to say it, never mind to understand it.

Hypertrophic cardiomyopathy is a mainly inherited disease that affects one in 500 of the population. It is the No 1 cause of sudden heart-related death among under-25s. It is a familial disease and each child of an affected person is exposed to a 50:50 chance of inheriting the condition. It is a condition that, by what seems to be the most cruel of ironies, often affects the youngest, fittest and most athletic people in our communities. Those are the facts and I am grateful to the Cardiomyopathy Association for the briefing with which it provided me to assist me and inform me in the debate. I will be happy to pass on the information to anybody who requests it.

I am also conscious that statistics alone do not speak of the impact of the condition on families, nor of the individual tragedies that they represent. Constituents of mine lost a much-loved son and brother because of cardiomyopathy, which had gone undetected in that lively, enthusiastic, fit and talented young man of 19; a young man who was—it seemed—as far from ill health as one could be. At that devastating time, my constituents had to seek out information about the condition, which was not easy to find. Even now, while they are still dealing with their bereavement, they seek to do something positive to help others and to prevent others from suffering a loss such as the one with which they still live.

I believe that it is important to acknowledge the courage not only of my constituents, but of all those who are coping with loss and who seek to drive, influence and support the work of organisations, such as the Cardiomyopathy Association, which seek to create better knowledge and understanding of illnesses and diseases, be that Marie Curie Cancer Care, the Cancer Research Campaign or whatever. Such organisations are full of people who want to create something better for others from their own experiences. I believe, in the difficult times—at home and internationally—in which we live, that we should take succour in the basic goodness and caring for others that we see all around us in voluntary groups and organisations.

My motion contains a simple demand: that there should be a right to automatic screening for all first-degree relatives of those who are diagnosed as having or who have died as a result of the condition. It seems simple; I am led to believe that general practitioners are encouraged to offer such screening, but my constituents' experience speaks volumes about the inadequacies of that encouragement. My constituents, when dealing with the death of their son, had to seek out information. On learning that the condition is inherited, that it could affect others in the family, that it could be detected through screening and that it can be managed if it is detected, they had to fight to have their potentially affected family members screened using electrocardiogram and echocardiogram tests. It is hard enough at any time in our lives to battle for tests of whatever kind, but in the aftermath of a loss such as my constituents' loss, to have to do so seems unacceptably cruel.

In conclusion—I am aware that others have contributions to make to the debate—I seek reassurance from the minister. I seek a commitment from the Scottish Executive that it will examine closely what can be done to provide speedy access to screening for first-degree relatives and to ensure that GPs' knowledge of the subject is improved. I believe that the Scottish Executive should commit itself to consideration of what might be done to raise awareness of the condition and that it should do so in conjunction with the Health and Community Care Committee, the national health service and, in particular, GPs and health organisations, to offer real hope that deaths that result from the condition can be prevented and that families can be properly supported.

I welcome the support of other members in the chamber and I hope that the debate will provide the opportunity to increase awareness of and action on the condition.

17:09

Shona Robison (North-East Scotland) (SNP): I start by congratulating Johann Lamont on securing the debate. I am pleased that she said that she was not totally aware of the condition before it was brought to her attention by her constituents as a result of the sad loss of their son. I can make a similar confession—until the debate, I was not very aware of the condition, but I have done some research and I am surprised by the extent to which the condition affects people. It affects about one in 500 people.

Given the difficulty in pronouncing the name of the condition, I will talk about HCM. HCM is an incurable but manageable condition, although it can lead to sudden, premature death. Systematic evaluation can identify the majority of patients at particular risk. That provides the opportunity for targeted therapy. Treatment can include drug therapy and, in severe cases, cardiac surgery to remove some of the muscle or to insert a pacemaker or converter defibrillator.

Because of the risk of premature death, the Cardiomyopathy Association is campaigning for the mandatory offering of screening to children and young people up to the age of 21 in cases where a first-degree relative has the condition. Diagnosis would require a physical examination and both an electrocardiogram and an echocardiogram. An argument against screening for the disorder is that it is not foolproof, but I do not think that any screening process is totally foolproof.

The CMA is not advocating the screening of all children, or even of all young athletes, who are a key group affected by the condition. The association would like screening to be offered to all first-degree relatives up to the age of 21 of people in whom the condition has been found. That will often follow the tragic loss of a loved one, and there will obviously be concern for the rest of the family.

I do not think that a request to consider the offering of screening is beyond the capability of the Executive; I think that it is very reasonable. Screening should not depend on who someone's doctor is or where someone lives, which unfortunately is, I think, the case. Screening should be open to everybody in Scotland who falls into the category that I have described. I hope that the minister will respond positively to Johann Lamont's call.

17:12

Mary Scanlon (Highlands and Islands) (Con): I associate myself with Johann Lamont's comments about having expertise on the disease: I find it difficult to pronounce, let alone understand. However, as is the case with many subjects that have been chosen for members' business debates, I have gained an awareness and an understanding of the condition. I hope that the debate allows that to be achieved on a wider scale.

To say that the condition affects one in 500 does not sound much, but when we state that it affects 12,000 people in Scotland, the figure seems more realistic. There seems to be a consensus in support of the Cardiomyopathy Association's campaign to secure screening by electrocardiogram and echo-ultrasound for all first-degree relatives.

I received a letter from a lady in Portknockie, in Morayshire. Her son died of the condition in December 1998. Following the loss of her son, all members of the immediate family were screened, and none had any signs of the condition. Naturally, that lady shares the concern that has been mentioned about familial screening for first-degree relatives. She said in her letter that, had a familial screening programme been available, and had the family been aware of it, she might still have her son today. Having heard that personal point of view, we can understand why people wish to raise awareness of the condition.

Given that the disease is familial, exposing each child of an affected parent to a 50:50 chance of inheriting the condition, the need for first-degree relatives to be offered case testing would seem to be a right, rather than an obligation. The British Medical Association has stated:

> "Many patients with hypertrophic cardiomyopathy do not have symptoms and may be relatives of patients known to have the disease. Unfortunately, the first manifestation of

the disease may be sudden death, frequently occurring in children and young adults, often during or after physical exertion".

The case of Shona Hill, which is clearly outlined in the information that we received from the Cardiomyopathy Association, indicates the risks and the benefits of screening for the condition. I was shocked to discover how it can affect the members of one family. Shona Hill is a member of the Cardiomyopathy Association and a voluntary co-ordinator. She was diagnosed with hypertrophic cardiomyopathy in her early 30s, while pregnant with her second child, and has been fitted with a pacemaker. As the gene responsible for the condition has been identified in her family, her children have been screened and shown not to carry it, but Shona's father, brother, sister and nephew all suffer from the condition. Tragically, as is too often the case, before the family gene was identified, Shona lost four first-degree relatives at a young age because of hypertrophic cardiomyopathy.

I am pleased to speak in today's debate, because I think that the condition is worthy of our consideration. In seeking to outline the problem and to raise awareness of hypertrophic cardiomyopathy, it is important to remember that the condition will not limit the quality or duration of life for the majority of individuals who are affected, provided that it is picked up and treated at an early stage.

A few minutes ago I picked up the paper that the Scottish Parliament information centre has produced on the subject. I note the question that Christine Grahame asked about the number of deaths over the past five years from hypertrophic cardiomyopathy. The answer was that there were 11 deaths in 1995, 11 deaths in 1996, five deaths in 1997, six deaths in 1998 and six deaths in 1999. The information we have received from SPICe indicates that, if male and female deaths from the condition are added together, the figures are 22 deaths in 1995, not 11; 28 deaths in 1996, not 11; 27 deaths in 1997, not five; 17 in 1998, not six; and 36 in 1999, not six. I do not know whether I am interpreting the information wrongly, but the figures for deaths from the condition seem to be much more dramatic than the figures we were given in the written answer to Christine Grahame's question.

17:17

Ian Jenkins (Tweeddale, Ettrick and Lauderdale) (LD): Like others, I congratulate Johann Lamont on raising this issue and on securing today's debate.

This Monday I attended a meeting of the Scottish oral cancer action group. I mention that because my attention was first drawn to the importance and prevalence of oral cancer when the parent of a young man who was a former pupil of mine and who had died of the disease decided to form a group to raise awareness of the condition among the public and professionals. The group that he formed has successfully drawn together many levels of health professionals, including professors and dentists. The group was supposed to meet Mr Chisholm yesterday morning, but at the time he had other things on his mind and the meeting was cancelled.

Some years ago, my attention was drawn in a similar way to hypertrophic cardiomyopathy. Mrs Wilma Gunn, whose son Cameron, a young athlete, died as a result of the condition, decided to put all her efforts into ensuring that Cameron's death would lead to something positive. Johann Lamont's motion mentions that many of the activists in the Cardiomyopathy Association are parents. I hope that we will recognise the value of the work that has come out of their distress, just as we recognise the value of the work that is done by the oral cancer action group. All over Scotland, parents who have experienced such distress have decided to try to turn it into something positive. As Johann Lamont said, our whole society benefits from that.

Wilma Gunn's organisation, Scottish Heart at Risk Testing—Scottish HART—has campaigned for improved screening in Scotland's sports centres and sports clubs, where many of the vulnerable youngsters can be found. She has sought to raise funds for a mobile screening unit and has taken her case to politicians. Indeed, she made a presentation to the cross-party sports group in the Parliament. I will not say too much more about that, as I know that Christine Grahame is particularly interested in Scottish HART.

Today's motion pays tribute to the Cardiomyopathy Association and backs its campaign to secure screening of all first-degree relatives of those who have died from hypertrophic cardiomyopathy. There is a case for widening screening to youngsters who are at risk, in the hope of avoiding the sudden death to which the condition gives rise, with all its traumatic consequences for the families that are affected. There appears to be evidence that similar programmes in other European countries have cut down the number of unexpected deaths among young people. We should not dismiss those claims lightly. I know that the Executive is wary of widespread screening programmes for various reasons, which I can understand to an extent, but I hope that it will consider the proposition carefully.

It must be traumatic to be told the result of a screening test that must change—or is likely to change—one's approach to life. For any screening programme to be valuable, early warning results must be backed up with the appropriate treatment. If necessary, counselling and advice should be offered to those who are found to be at particular risk. As the motion implies, people who are close to the person, who might be worried and affected, also need support.

I support the extension of screening. I hope that the minister will be able to go at least some way towards progress in that area.

17:20

Cathy Jamieson (Carrick, Cumnock and Doon Valley) (Lab): I, too, congratulate Johann Lamont on securing tonight’s debate. For me, the issue is close to home. Unlike others who had never heard of the condition, I can inform members that my husband has had to live with hypertrophic cardiomyopathy for a number of years. He was always involved in sporting activities. Some members, who know the shape that he is currently in, may find that hard to believe, but he is a former runner and was involved in half-marathons, hillwalking and various other things.

My husband discovered through a routine hospital operation that he was suffering from the condition. That was a life-changing situation for him. The discovery has meant that he has had to reconsider the way that he deals with day-to-day issues such as physical exercise. It has also raised some other issues: suddenly, he was not in a position to get life insurance; his travel insurance would not cover him for going abroad; and he had to go for a medical if he wanted to apply for a new job or take up other opportunities.

My son is one of the lucky ones, because he was screened when my husband was found to have the condition. However, the three or four weeks’ wait between the diagnosis of my husband’s condition and my son’s being screened in hospital were some of the most traumatic of our lives. What were we to do with a football-mad boy, who wanted to be outside kicking a ball around? Since an early age, my son had taken up all sorts of sport and was sport-mad. Were we to keep him in the house, or tell him that he could not play sport? Were we to raise all those issues, potentially inappropriately, or were we to wait for the result? Thankfully, the result showed that my son does not suffer from the condition, but it is important that, when we consider the wider picture, we ensure that those who are close to people who have been diagnosed with the condition are given the opportunity to be screened.

Ian Jenkins hit the nail on the head when he talked about the need to put in place the appropriate supports. I do not know how I would have coped if somebody had said to me that my young child would be at risk. I do not know how he would have coped with having to make decisions about what he wanted to do with his life. My family are aware that we are among the lucky ones. We are conscious that there are many people out there who, having suffered traumatic times, have committed their lives to doing something to improve things.

I hope that the Executive takes the issue seriously. The Executive needs to considers how it can ensure that the availability of screening and treatment is not simply dependent—as in our case—on the individual general practitioner. People need to have that kind of opportunity so that situations are dealt with appropriately.

On the statistics, my husband would probably claim that, rather than being one in 500, he is one in a million for having to put up with me and with everything that I have to do. I am sure that he will be pleased to see that on the record.

17:24

Christine Grahame (South of Scotland) (SNP): Presiding Officer, thank you for allowing me to remain seated. I congratulate Johann Lamont on securing tonight’s debate.

I declare an interest: I am a patron of Scottish HART, the Borders-based charity to which Ian Jenkins referred, which is also known as the Cameron Gunn memorial fund. As Ian Jenkins indicated, the organisation was set up by Wilma and Kenny Gunn after their son died from hypertrophic cardiomyopathy some 10 years ago. Since then, Mr and Mrs Gunn have worked tirelessly to promote awareness of cardiomyopathy and to encourage the testing of young athletes.

The Gunns have done that by endeavouring to raise the £0.25 million that is required to provide a mobile echocardiogram that could be used at sports clubs and schools to test young people. The disease is usually more recognisable under the headlines that we unfortunately sometimes read, such as “Sudden Death on Sports Field”, “Heart Condition Kills Youth” and “Teenager in Mystery Death”.

Cameron Gunn was playing five-a-side football with workmates, practising for a charity game, when he suddenly dropped down dead. He was 19.

As has been said, hypertrophic cardiomyopathy is the largest single cause of death among the under-30s. It is thought to affect at least 125,000 people in the UK, which means about 12,000 in Scotland. Without a heart scan, the condition is difficult to diagnose. Often there is no sign that anything is wrong until the sudden fatality of someone who had appeared to be young and fit. However, with screening, the disease is easily treatable.

I refer Mr Chisholm to a series of questions that I have lodged on this disease. I do not expect answers now, but I hope to get them later. Last year, I asked question S1W-8790 in response to an Executive claim that only 1,000 people in Scotland were affected by cardiomyopathy. Does the minister accept that the figure should be 10 times that amount? The higher figure has been indicated by Professor W J McKenna, who is the professor of cardiac medicine at St George's hospital medical school, London.

In her response to my question S1W-6079, the Minister for Health and Community Care indicated that, under advice from the UK national screening committee and on the basis of current knowledge, Scotland should not offer population-wide screening for the condition. Have we made any progress on that?

I also refer the minister to an Executive news release of 10 April last year, which again stressed that the minister would not consider a national screening programme. The news release contained comments from Professor Stewart Hillis, who said:

> "I agree that on the basis of present evidence there is no justification for the introduction of a national screening programme though this should not stop those who feel they are at risk from having access to local screening facilities if they so wish. We are currently piloting work with *Sport Scotland* where we are examining the value of offering a test or screening to young people taking up competitive sports."

What progress has been made with sportscotland? Will the minister at least consider selective screening for young athletes, sportsmen and sportswomen?

Last year, in the answer to question S1W-4653 on research and funding, I was advised that there were 129 UK-wide research projects at that time. Will the minister provide an update on the current state of research, the collation of that research, and the funding of that research?

Would the minister, or ministerial representatives, be prepared to meet the trustees of Scottish HART, as they have repeatedly requested, in order that they can put forward their views?

17:29

Cathie Craigie (Cumbernauld and Kilsyth) (Lab): Like everyone else, I welcome the chance to debate this issue and I congratulate Johann Lamont on the motion. I fully support the points that she made.

Screening is important to families who find themselves faced with the awful news that they have lost a loved one, a young relative, to hypertrophic cardiomyopathy. I remember, when I was a teenager, losing a good friend. Like all of us, he played on the football field at night. At 17, he tragically died—of a heart attack, we thought. We did not know at the time that it was hypertrophic cardiomyopathy. Like most people, I had never heard of it.

I have a very close friend whose family has suffered from HCM and who have had to live with it for many years. Fortunately, the family have had the benefit of screening. Two out of six in the family have been diagnosed with the condition; they are being treated and they have been able to live as normal a life as possible.

I got to know about the condition through my nephew, Edward Blair, who is a clinical genetic consultant in Oxford. He and his team have recently published a paper on HCM with details of an important gene that they have found that will help develop treatments that will benefit the families involved.

Screening is great and it helps us to treat those who need treatment, but what are we doing with the information that we gather when we screen people? Research into that information is the way forward. In England and Wales, the Government is considering funding four new research projects into the genetic field, but what are we doing in Scotland? Are we funding similar research or will we contribute to those research projects? Screening is important if we want families to be able to live as normal a life as possible, but it is also important that we find solutions to the condition so that the young people who are diagnosed with HCM will know that, when they have families, they might be able to take medication that will allow them to have a normal life without the stress and worry that the condition causes, which Cathy Jamieson talked about tonight.

If the minister cannot tell me tonight what Scotland is doing in relation to research, I would appreciate receiving information on that through the Executive.

17:30

Mr Kenneth Gibson (Glasgow) (SNP): I thank Johann Lamont for securing this debate today. I pay tribute to the sterling work of the Cardiomyopathy Association and to Christine Grahame, who has also done excellent work in this area.

Hypertrophic cardiomyopathy is an excessive thickening of the heart muscle without obvious cause. It can strike those who have inherited the dominant gene, even though only minor symptoms have been evident, and lead to tragic and sudden death. As has been said, an investigation such as an ECG might not always detect the condition.

No cure has been found and, of course, further research is needed. It is important that we consider the findings of research that has already been done, not only in the UK, but overseas. The disease is fairly new in that it has been known about only for the past half century. However, a substantial number of families are affected by it. The SPICe briefing says that 16,800 people in Scotland have died of the disease in the past 20 years. Interestingly, 9,500 of those have been women. Perhaps research has to be done into why women are 20 to 25 per cent more likely to suffer from the disease than men are.

It is important that we have screening not only for hypertrophic cardiomyopathy, but for familial hypercholesterolemia, which is another disease of the heart that can strike suddenly with fatal consequences. It has a high prevalence among the south Asian population.

Cathy Jamieson hit the nail on the head when she talked about insurance. The Association of British Insurers does not ask those with a family history to take a genetic test but it requires to be informed if a test has been taken. In that way, the benefits of life insurance might be denied to the families of sufferers. All family members must be screened if those with the condition are to receive treatment. That circle has to be squared if we are to provide justice for families who suffer from the illness.

I pay tribute again to Johann Lamont for securing this important debate and for the way in which she spoke about the McConnachie family in her constituency and others who suffered tragic deaths because of the disease. I hope that the Executive can provide some answers to help to prevent future deaths from this awful condition.

17:34

The Deputy Minister for Health and Community Care (Malcolm Chisholm): I congratulate Johann Lamont on securing a debate on this most important subject, following the tragic death of a young man in her constituency. I thank all the other speakers, especially Cathy Jamieson for sharing her family's experience of the condition. I also congratulate the Cardiomyopathy Association on the work that it does to raise awareness of the condition among the medical profession and the public.

As we have heard, hypertrophic cardiomyopathy is an inherited condition that involves an abnormal thickening of the heart muscle. Because the thickening occurs in an inward direction, the working of the heart is obstructed. At present, there is no cure for the condition. There is a slight possibility that some drugs can decrease the degree of muscle thickening. Treatment aims to improve symptoms, for those who have them, and to prevent complications. There is no standardised therapy. Various drugs that affect the rate and rhythm of the heart have been used with some success, although those drugs do not necessarily affect the long-term outcome. Similarly, surgical treatment has been of benefit in selected cases.

Recent evidence suggests that the prevalence of the condition is higher than had been thought. It is now accepted that about one person in 500 has the condition. Its clinical course varies markedly from person to person. Some patients have no symptoms at any time during their life. Some have symptoms of severe heart failure. Others die suddenly, often in the absence of previous symptoms. As for the number of sudden deaths among young people in Scotland, the main category is in those below the age of one. In the past 10 years, there have been 16 deaths in that age group. The other peaks are among those aged 15 and 16. Over the past 10 years, there have been eight deaths of 15-year-olds and 10 deaths of 16-year-olds.

I note the points that Mary Scanlon made about the possible discrepancy between some of the Executive's figures and figures elsewhere. I shall look into that and write to her about it. Christine Grahame also raised issues to do with figures and other matters, which I shall look into and write to her about. She asked whether I would meet the trustees of Scottish HART. I am happy to do that. I ask Ian Jenkins to pass on my apologies for having to postpone the meeting to which he referred. I shall reschedule it as soon as possible. Cathie Craigie mentioned research, on which I undertake to write my third follow-up letter, although I know that Susan Deacon recently wrote to Scottish HART about the issue, saying that the chief scientist's office would consider any proposals that Scottish HART produced. None has so far been received, but we would be happy to hear from Scottish HART on that subject.

Any sudden death is a tragic event, but all the more so when it happens to a baby or to someone on the threshold of adult life. I can well understand why there have been calls for some form of screening from those who hope that such deaths can be prevented. The rest of my speech will be divided into two parts: first, whole-population screening and, secondly, targeted screening.

Mr Gibson: I have two points. First, the information that we have been given refers to prevalence per 100,000 population, which makes the incidence appear considerably greater than the minister has indicated. Secondly, does the

Executive have any information on why the incidence of hypertrophic cardiomyopathy appears to have increased substantially during the past 20 years? For example, there has been an increase from 17 cases to 228 cases among males. Is that because of improved diagnosis or because the disease is becoming more prevalent? Do we have any data on that?

Malcolm Chisholm: I do not have any data on that, but I can look into the matter and get back to Kenny Gibson.

In taking decisions about screening, the Scottish Executive is advised by the national screening committee, which provides independent expert advice to the UK health ministers on the introduction of new screening programmes. The committee will recommend the introduction of a population screening programme only if the natural history of the disease is well understood, if there is a simple, safe, precise and validated screening test and if there is an effective treatment for the patients who are identified as a result of screening.

Having examined population screening for hypertrophic cardiomyopathy, the committee concluded that it could not recommend the introduction of population screening for that condition. That was because none of the committee's key criteria was satisfied: the natural history of the disease is poorly defined; there is no clear definition of the degree of thickness of the heart muscle, as measured by the ultrasound technique echocardiography; and, as I have mentioned, there is no good evidence that treatment will necessarily improve the outlook for those who have the condition but do not have symptoms. As the Executive announced in April last year, we have accepted the committee's advice.

The motion mentions ECG and ultrasound screening of all first-degree relatives of those who die as a result of the condition. We support that approach. We have made it clear all along that we want clinicians to be alert to those people who are at higher risk of sudden death because they have a significant family history of hypertrophic cardiomyopathy. Those people might benefit from advice and treatment. Everything should be done to ensure that the condition is tackled with care and sensitivity. We have emphasised that GPs are expected to refer such patients to a cardiologist for the appropriate investigations. Those patients, and relevant family members, should also be given counselling, including genetic counselling.

Johann Lamont referred to the inadequate encouragement of GPs and asked us to ensure that GPs' knowledge was improved. I will certainly look into that and write back to her.

Recent scientific publications suggest that the use of implantable defibrillators might help to prevent sudden death in high-risk patients with hypertrophic cardiomyopathy. Those initial findings need to be confirmed, but that could be the first form of therapy to prolong survival in such patients. In the light of that new evidence, the national screening committee has commissioned further work and will be considering a report on it next month.

For those families in which a particularly serious form of the disease occurs, the Scottish molecular genetics consortium has been considering the possibility of including tests for hypertrophic cardiomyopathy in its molecular genetic service. That could help with identification of family members affected by the condition.

I fully agree that we should all be working together to raise awareness of the condition, partly among the public but—perhaps even more fundamental—among the medical profession. Johann Lamont and Shona Robison emphasised that GP awareness is critical and, as I said, I undertake to follow up that issue as a matter of urgency.

I again congratulate Johann Lamont on raising an important subject and on ensuring that renewed impetus is given to addressing a most serious condition.

Meeting closed at 17:42.

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Printed in Scotland by The Stationery Office Limited

ISBN 0 338 000003 ISSN 1467-0178