MEETING OF THE PARLIAMENT

Thursday 20 March 2003

Session 1

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Scottish Parliament

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[THE PRESIDING OFFICER *opened the meeting at 09:30*]

Business Motion

The Presiding Officer (Sir David Steel): This morning we resume stage 3 consideration of the Mental Health (Care and Treatment) (Scotland) Bill, and the first item of business is motion S1M-4047, on a revised timetable.

09:30

The Deputy Minister for Parliamentary Business (Euan Robson): I wish simply to point out that the motion reflects the progress that was made on the bill yesterday.

I move,

That the Parliament agrees that, during today's proceedings at Stage 3 of the Mental Health (Care and Treatment) (Scotland) Bill, debate on each part of the proceedings shall be brought to a conclusion by the time-limits indicated (each time-limit being calculated from when today's proceedings at Stage 3 begin and excluding any periods when other business is under consideration or when the meeting of the Parliament is suspended or otherwise not in progress)—

Groups 58 to 67 - no later than 1 hour and 30 minutes

Groups 68 and 69 - no later than 3 hours

Groups 70 to 81 - no later than 4 hours

Motion to pass the bill – no later than 4 hours and 30 minutes.

Motion agreed to.

Mental Health (Care and Treatment) (Scotland) Bill: Stage 3

09:31

Resumed debate.

The Presiding Officer (Sir David Steel): Before we start, I remind members that they should have before them the revised marshalled list of amendments, which was published this morning, and not yesterday's list.

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

The Presiding Officer: The first group of amendments for consideration today is group 58. Amendment 655 is grouped with amendments 216, 217, 656, 657, 664 and 665.

The Minister for Health and Community Care (Malcolm Chisholm): This group of amendments deals with the issue of electroconvulsive therapy, which is something that the Executive and the Health and Community Care Committee have thought very carefully about. Understandably, the treatment raises strong concerns, and even fears, but some people will testify that it has helped to alleviate their terrible and crippling illness. Our concern has always been to reassure people that the necessary safeguards are in place, while not imposing restrictions that could prevent some patients from receiving treatment that they desperately need. Those safeguards have already been strengthened under the bill. Today, I propose to strengthen them further in two significant ways.

The bill already provides that a patient who is liable to be treated compulsorily can be given ECT only if a second doctor authorised by the Mental Welfare Commission for Scotland certifies that that is in the best interests of the patient. The only exception is where treatment is required as a matter of urgency. If a patient is capable of making a treatment choice and refuses ECT, the second doctor may not overrule that decision. That is already a major and significant advance on the current situation. Amendments 664 and 665 strengthen that provision further.

Concern was expressed at stage 2 that the refusal of a competent patient could still be overruled in an emergency situation. We accepted that, as long as a patient is able to understand the implications of their decisions and to make a competent choice, that choice must be respected, and we undertook to lodge appropriate amendments at stage 3. Amendments 664 and 665 give effect to that undertaking by disapplying the emergency provisions of section 171 where

the patient is capable of consenting but does not so consent.

Some of the patients for whom ECT might be considered will be incapacitated by illness, such as severe clinical depression, and will not be in a position to make an informed treatment choice. At stage 2, it was suggested that ECT should not be given to incapable patients. The committee considered the issue carefully, and concluded that that would be wrong.

Amendments 216 and 217, in the name of Shona Robison, are a refinement of that approach. They provide that ECT could not be given to an incapable patient who resisted or objected to the treatment, except in an emergency. That may appear to be an attractive option, but ECT is the only treatment for some severely depressed patients, according to clinical advice. I am advised that, as a consequence of their illness, such patients may be agitated, disturbed or even delusional and may object to the treatment when they are not well enough to know what the treatment is. Amendments 216 and 217 would deny people in that desperate situation access to the very treatment that might help them to recover their capacity. It is true that the treatment could still be given if the responsible medical officer—RMO—decided that it was a matter of urgency. However, that could mean patients having to endure prolonged suffering and physical deterioration before their condition became so acute that they could be treated.

We appreciate the concern that this issue causes among many service users. In its stage 1 report, the Health and Community Care Committee asked the Executive to consider ways in which it could strengthen the safeguards for incapable patients. Amendments 655, 656, and 657 respond to that request. Their effect is to tighten up the criteria for giving ECT where an incapable patient objects to or resists the treatment. Instead of it being necessary for the second doctor to certify that the treatment is in the best interests of the patient, one of the stricter tests in paragraphs (a) to (c) of section 171(3) must be met. In other words, the independent doctor must certify that the treatment is necessary for

"(a) saving the patient's life;

(b) preventing serious deterioration in the patient's condition";

or

"(c) alleviating serious suffering on the part of the patient".

Those are the same grounds that would entitle a doctor to treat a patient who objected to ECT on the basis of Shona Robison's amendments, but without requiring the RMO to allow the patient to deteriorate until the situation became an emergency. I hope that members will agree that our way forward is reasonable.

I move amendment 655, and I hope that Shona Robison will agree not to move amendments 216 and 217.

Shona Robison (North-East Scotland) (SNP): I appreciate what the minister has said about the complexity of this issue. By no means is it a simple matter to resolve. The purpose of my amendments 216 and 217 is to prevent ECT from being given to patients who are incapable of consenting to treatment, or who resist or object to its being administered. The only exception would arise in urgent situations, where the treatment could be given under the urgent treatment provisions in section 171.

The reason why I lodged my two amendments and why I am persuaded that there is a debate to be had on the issues involved is based on the written and oral evidence that the Health and Community Care Committee received on ECT.

One of my constituents had ECT when he was 16 years old. He underwent the treatment as a voluntary patient, although it might perhaps be difficult to make an important choice about that and to agree to the treatment at 16. He now regrets the treatment very much, because it completely wiped out all his primary school learning. He was unfortunate that that was the effect that the treatment had on him and, on reflection, he feels that he did not make an informed choice, as he was in no position to do so.

The National Institute for Clinical Excellence—NICE—produced an appraisal consultation document on ECT, from which I quote:

"The evidence submitted to the Committee, both written and verbal, demonstrated that, on balance, current opinion is that ECT is an effective treatment for certain subgroups of individuals with mental disorders. However opinion varies from those who consider that its adverse effects are tolerable to those who consider that it is associated with significant side effects including brain damage, severe confusion and considerable cognitive impairment in both the short and longer terms. Whilst some patients consider ECT to be a beneficial and lifesaving treatment, others report feelings of terror, shame and distress, and find it positively harmful and an abusive invasion of personal autonomy."

There is clearly huge division over whether ECT is effective or ineffective and over the lasting effects of ECT on patients. Service users expressed mixed views about ECT to the Scottish Association for Mental Health.

In its stage 1 report, the Health and Community Care Committee recommended that the Executive introduce

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

That is what my amendments seek to achieve.

Preventing ECT from being given to patients who are incapable of consenting would make the safeguards for ECT for incapable patients closer to those that apply to neurosurgery for mental disorder and incapable patients, without going as far as those NMD safeguards.

I accept that the Executive amendments represent a tightening up of safeguards for incapable patients who resist or object to ECT. As the minister outlined, a patient would not be given ECT under section 167 unless the circumstances that are stated in section 171 apply. I could be persuaded to compromise on the matter if certain safeguards are put in place.

The primary concern about amendment 656 is the wording of the phrases used in section 171. The treatment can be given if its purpose is

"(b) preventing serious deterioration in the patient's condition"

and

"(c) alleviating serious suffering on the part of the patient".

Those terms already appear in the urgent treatment provisions in the Mental Health (Scotland) Act 1984 and in section 171 of the bill. However, those urgent treatment provisions include the phrases "immediately necessary" and

"necessary as a matter of urgency".

Amendment 656 would effectively incorporate the terms of the urgent treatment provisions, but without the use of the phrases "immediately necessary" or "urgent". I am concerned that that could mean there is a lack of clarity about how the terms could be interpreted in practice. There is a danger that they could be interpreted too widely when treatment is given under section 167.

If the minister can give an assurance that the terms will be clarified outwith the bill so that they can be clearly interpreted in practice, that clear guidance will be given in a code of practice or good practice guidelines—whichever is most appropriate—and, importantly, that there would be wide consultation, involving user groups in particular, on the preparation of such guidance, we could reach a compromise this morning on ECT.

Mary Scanlon (Highlands and Islands) (Con): I support Shona Robison's amendments 216 and 217. I also ask for further clarification from the minister. I am very much at one with Shona Robison's comments.

When opinion is so divided on the benefits and the side effects of ECT—the potential side effects are inestimable for each individual—how can anyone recommend that the treatment is beneficial? This controversial issue is probably the one that patients with mental illness who spoke to us feared the most. They feared that their lives would get out of control and that they would be given ECT, although it is difficult to predict whether it would be beneficial or, as Shona Robison said, whether it would wipe out all long-term memory. Those are serious concerns.

I am minded to support the Executive's amendment 656, because I think that it is a good compromise, but I have difficulties in respect of the points made in the 1984 act, which provide the basis for urgent treatment under section 171(3). That section states that ECT can be given to save a patient's life, alleviate serious suffering or prevent deterioration. I am not a clinician, but I would have thought that, in any circumstances, any treatment surely has to be intended to save a patient's life, alleviate suffering or prevent deterioration. My fear is that the use of those three phrases could open the door for any patient who has mental illness to be given ECT, as it would only have to be stated that its use would prevent deterioration of the condition.

I struggle with this issue because although we have heard that ECT is beneficial for many people, it has serious, detrimental and long-lasting side effects for many others. The minister must clarify exactly what the phrases mean, as they could be interpreted widely. The bottom line is that I would like patients to have faith and trust in the advance statements that they write. If, when they are well, they write that they do not want ECT, I hope that at the point at which they need help someone does not overrule their advance statement on the basis that the purpose of the treatment is to save the patient's life, alleviate serious suffering or prevent deterioration. Those phrases could be used to justify the use of ECT treatment in any case. I seek the minister's assurances on those three phrases, but I am minded to support amendment 656.

09:45

Mrs Margaret Smith (Edinburgh West) (LD): Colleagues in the chamber who have not been part of the discussions at the Health and Community Care Committee are probably getting a flavour of the difficulties that the issue has thrown up for committee. It is one of those issues for which there does not seem to us to be a black-and-white solution. We are trying to find a suitable shade of grey in order to cover many of the concerns that have been raised on both sides of the debate. SAMH is concerned about anybody being given ECT treatment who has not consented fully to it. That concern took us to the point at which it was necessary to consider people who, because of their condition, are incapable of giving consent. That is the point at which the committee found real problems, and I welcome the

compromise position that the Executive has proposed.

The NICE document, from which Shona Robison quoted, shows that there is evidence on both sides of the argument. If ever a situation called for the decision to be in the hands of the individual and their clinical team, this is such a situation.

I have complete faith in the fact that Shona Robison believes that the route that she proposes is a good one. She has argued for it consistently throughout our discussions, without, I think, being able to sure that it is the right position—none of us can be sure that we are advocating the right position on the issue. On the other side of the argument, we must take on board the comments that the Mental Welfare Commission for Scotland made to the committee. It said that if we go down the route that SAMH advocates, we might prevent people from getting treatment that, in some cases, might help them. I do not think that any of us wanted to close an option down. That is why the committee recommended, at stage 1, that the Executive should

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

The Executive's amendments give a clear indication that extra safeguards would be put in place, as an independent doctor would have to certify that ECT treatment would be given to save life, prevent serious deterioration or alleviate serious suffering. I am content to go along with those safeguards. However, time and again we are left with the feeling that we must ensure that the implications of the bill are carefully monitored when it is enacted. I call upon the minister to give us assurances on that matter. If he gives us those assurances, I will be content to support the Executive's amendments.

Malcolm Chisholm: I think that we have reached a degree of consensus because there is no great difference between the original position stated by Shona Robison and my proposal. There is also an underlying agreement about the direction in which we want to travel and the intention of our policy.

We have listened—I certainly have—to the serious concerns of some service users about the matter. We must concede that other service users testify to the benefits that they have received from ECT, but there is no doubt that some service users have concerns—often based on their own experience—about ECT. A significant advance in the bill is that we are saying clearly that anyone who is capable, even if they are subject to compulsory treatment in general, will not receive ECT against their wishes—not even in an emergency. That is a significant step forward in terms of the history of ECT and the rights of service users more generally. We should acknowledge that point, because some recent reports about the matter in the media have suggested that we are turning the clock back. We have already made significant progress in the bill as drafted and in the bill as amended at stage 2. Today, we seek to push that progress further.

The exemption of those who are capable from the emergency provisions is proposed in amendments 664 and 665, with which no one disagrees. That matter was discussed in general terms at committee and today we are trying to engage with the position of people who are incapable and how their objections should be dealt with. We take on board what the Health and Community Care Committee said in its stage 1 report about additional protections for patients in that particular situation.

Shona Robison's comments were helpful, and I acknowledge the potential danger that the conditions we are applying could be interpreted too widely. I make it absolutely clear that the code of practice will give clear guidance on the effect of the provisions and that it will take on board the spirit of the debate in which we have agreed that, unless there are overriding reasons, if someone says no to ECT, that means no. I also assure her that there will be consultation on that guidance, and it is particularly important that we listen to service users on the subject.

Mary Scanlon: Will the code of practice and the guidance go further than having regard to or listening to service users? What role will the advance statement play in the code or guidance? How much weight will be given to the advance statement in the judgments that are made on whether to use ECT?

Malcolm Chisholm: Wider issues concerning advance statements, which we will revisit soon, have been partly debated. The bill says that advance statements that object to ECT have to be taken into account by both the RMO and any doctor who gives a second opinion. That is the position. I know that Mary Scanlon wants to argue another point—she will have a further opportunity to do that.

Any decision not to comply with an advance statement would need to be reported to the Mental Welfare Commission. There are more complex issues surrounding advance statements, as the Health and Community Care Committee acknowledged in its stage 1 report. However, we are building so much into the matter that perhaps the question of advance statements is not quite so critical. Basically, we are saying, "If you are capable, ECT will not happen under any circumstances." We are saying today that there is also a presumption that someone who is incapable will not receive ECT, unless the clear conditions

that are stated in section 171 are met. Those conditions will be further described in the code of practice on which there will be consultation.

The position reflects the clear consensus of the Parliament on the matter today, and that is the spirit in which we should advance. Most of us, including Margaret Smith, who was explicit in her comments, and me—and I am following clinical advice—do not want to go as far as Shona Robison proposes, although in many ways it is my instinct to do so. However, as a responsible health minister, I must pay heed to clinical advice and to the situations in which a difficulty would be caused by the more absolutist position proposed by Shona Robison. I admitted in my opening speech that her proposal was an attractive option, but we have to be responsible, as Margaret Smith said, and ensure that we pass a law that covers all eventualities.

I understand people's concerns about the Executive's position. That is why I make it clear that a code of practice will give guidance on the effect of the provisions and that there will be consultation on that guidance. ECT is an area about which some service users feel strongly, and SAMH has reflected the concerns that are expressed to that organisation by service users.

Mary Scanlon: I am sorry if this sounds like a daft lassie question, but I have struggled to understand the bill. At what point does a capable patient with mental illness become an incapable patient?

Malcolm Chisholm: That is a very good question, which I have also asked. There are definitions in the Adults with Incapacity (Scotland) Act 2000, with which we are all familiar. Whichever amendments we agree to today, including the Executive's amendments, we will have to examine what is said in the 2000 act because we are extending the rights of incapable people in relation to ECT beyond what is stated in that act.

I hope that there can be agreement on Executive amendment 655 and that members will accept the undertakings I have given about further work on the code of practice. I also accept what Margaret Smith said about the need to monitor the situation—along with the bill's other provisions—closely.

Amendment 655 agreed to.

Shona Robison: In the light of what the minister said about the guidance and the consultation on it, and in the interests of compromise and agreement, I will not move amendments 216 and 217.

Amendments 216 and 217 not moved.

Amendments 656 to 658 moved—[Malcolm Chisholm]—and agreed to.

Section 168—Treatments given over period of time etc

The Presiding Officer: Amendment 659 is grouped with amendment 660.

The Deputy Minister for Health and Community Care (Mrs Mary Mulligan): Amendments 659 and 660 are drafting amendments that are intended to make clearer the effect of section 168. They respond to points made by Shona Robison at stage 2, and I am grateful to her for drawing attention to the matter.

I move amendment 659.

Amendment 659 agreed to.

Amendment 660 moved—[Mrs Mary Mulligan]—and agreed to.

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

Amendment 661 moved—[Mrs Mary Mulligan]—and agreed to.

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

The Presiding Officer: Amendment 662 is grouped with amendment 663.

Mrs Mulligan: Amendments 662 and 663 fulfil a commitment that we gave at stage 2 to lodge amendments at stage 3 to provide a further safeguard with respect to the authorisation of medical treatment for persons who are subject to an assessment order.

Essentially, the amendments ensure that, where treatment is to be given under part 13 to a patient who is subject to an assessment order, the responsible medical officer must get a second opinion before proceeding with the treatment.

I move amendment 662.

Amendment 662 agreed to.

Amendment 663 moved—[Mrs Mary Mulligan]—and agreed to.

Section 171—Urgent medical treatment

Amendments 664 and 665 moved—[Mrs Mary Mulligan]—and agreed to.

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

The Presiding Officer: Amendment 666 is in a group on its own.

Mrs Mulligan: Amendment 666 fulfils an undertaking given at stage 2 in response to an amendment lodged by Shona Robison. It

broadens the provision that the commission may revoke a certificate that authorises treatment, so that it applies to all certificates in part 13. That reflects concern expressed in the commission's annual reports that some certificates stated that the patient had consented to the treatment, when the patient's ability to give such consent was doubtful.

I move amendment 666.

Amendment 666 agreed to.

Section 175A—Named person: mental health officer's duties etc

The Presiding Officer: Amendment 667 is grouped with amendments 77, 78, 99 and 103.

Mrs Mulligan: Amendment 667 adds a reference to the Criminal Procedure (Scotland) Act 1995 to section 175A. That is necessary because named persons also have a role where a person is subject to a mental health disposal made by a criminal court under the 1995 act.

Amendment 77 is a technical amendment that moves section 175A to a more appropriate place in the bill.

Amendments 78 and 103 move the definition of "named person" from part 14 to section 228, which is the general interpretation section. Amendment 99 removes a cross-reference to the deleted section 176 from section 181C.

I move amendment 667.

Amendment 667 agreed to.

Amendment 77 moved—[Mrs Mary Mulligan]—and agreed to.

Section 176—Meaning of "named person"

Amendment 78 moved—[Mrs Mary Mulligan]—and agreed to.

Section 177—Nomination of named person

10:00

The Presiding Officer: Amendment 79 is grouped with amendments 80 to 87 and 95 to 98.

Mrs Mulligan: At stage 2, Shona Robison lodged an amendment that sought to provide that any named person should be aged at least 16. Our initial view was that that was unnecessary, as the tribunal could take steps to appoint a new named person if a child was nominated by the patient or was the primary carer. On reflection, we agree that it would be helpful to put the matter beyond doubt. As a result, amendments 79 to 87 and 95 to 98 seek to provide that the named person can in no circumstances be aged under 16.

I move amendment 79.

Amendment 79 agreed to.

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

Amendments 80 to 82 moved—[Mrs Mary Mulligan]—and agreed to.

Section 179—Named person in relation to child

Amendments 83 to 87 moved—[Mrs Mary Mulligan]—and agreed to.

Section 181—Meaning of "nearest relative"

The Presiding Officer: Amendment 88 is grouped with amendments 89 to 94.

Mrs Mulligan: Amendments 88 to 93 respond to an amendment lodged at stage 2 that sought to shorten the list in section 181 of "nearest relatives" who could become the named person in certain circumstances if no specific appointment is made. We undertook to consult the mental health legislation reference group on the matter. As there was general agreement that the list was too long, we have lodged amendments that delete in-laws and other more distant relationships through marriage.

Amendment 94 deletes an unnecessary reference to "welfare" in relation to a patient's guardian. Section 228 makes it clear that the word "guardian" in the bill means a welfare guardian.

I move amendment 88.

Amendment 88 agreed to.

Amendments 89 to 93 moved—[Mrs Mary Mulligan]—and agreed to.

Section 181A—Named person: application by patient etc

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

Section 181B—Named person: Tribunal's powers

Amendments 95 to 98 moved—[Mrs Mary Mulligan]—and agreed to.

Section 181C—Interpretation of Chapter

Amendment 99 moved—[Mrs Mary Mulligan]—and agreed to.

Section 182—Advocacy

The Presiding Officer: Amendment 14 is grouped with amendments 15 to 17.

Malcolm Chisholm: This important group of amendments follows extensive discussion at committee on the right to advocacy. Indeed, amendments were lodged on the provisions on

that. In response to other points that were made during the committee's consideration of the bill and amendments that were lodged by John McAllion, we have discussed the issue further with the Advocacy Safeguards Agency and the mental health legislation reference group, and I am pleased to say that we have reached agreement on the way forward.

Amendment 14 deletes section 182(4)(b), which defines the term "advocacy services". As I have said, that change was proposed by John McAllion at stage 2 because of concern that the wording of the subsection gave undue emphasis to the notion that the mentally disordered person is unable to state an opinion. It is fundamental that the advocate represents their advocacy partner's views, not their own.

Amendment 16 tightens up the definition of "independent advocacy" to ensure that voluntary or other organisations that provide care services to a person under arrangements with the national health service or a local authority cannot also provide that person with advocacy services. However, Enable and other members of the reference group pointed out that excluding "employees" of the NHS and local authorities from being advocates under the bill went too far. Such a provision could have excluded people who happened to work in public services but not in a way that would create a conflict of interest with an advocacy role. As a result, amendments 15 and 17 delete the provision.

I move amendment 14.

Amendment 14 agreed to.

Amendments 15 to 17 moved—[Malcolm Chisholm]—and agreed to.

The Presiding Officer: Amendment 756 is grouped with amendment 757.

Malcolm Chisholm: Amendment 756 seeks to remove a reference to section 145 from section 182(11). Because section 145 was deleted at stage 2, that reference is incorrect. Amendment 757 seeks to tidy up the drafting of section 215(1), which should now refer only to one further subsection.

I move amendment 756.

Amendment 756 agreed to.

Section 185—Provision of information to patient

The Presiding Officer: Amendment 668 is grouped with amendments 669 to 676.

Malcolm Chisholm: Amendments 668 and 669 are technical amendments that seek to clarify that the duties in section 185 continue to apply, even if the detention of a patient has been temporarily suspended. Amendment 670 is a drafting amendment that seeks to make it clear that the permanent copy of the information given to the patient under section 185 must be in a form that is appropriate to the patient's needs. Amendment 672 seeks to do likewise for the information that is to be provided to the named person.

Amendment 671 seeks to make it clear that information on advocacy relates to the duties to secure independent advocacy services under section 182. At the moment, duties to provide information to the patient in section 185 are imposed on hospital managers for detained patients and on the mental health officer for patients in the community. After reviewing that provision, we feel that it is not the correct approach. Whether a patient is in hospital or in the community, the primary purpose of a compulsory treatment order is likely to be to ensure that the patient can receive medical treatment under the supervision of a responsible medical officer. The RMO will have a continuing involvement with the patient. That may not be the case for the mental health officer. As a result, we have concluded that it makes more sense for hospital managers to have the duty to ensure that the patient is given appropriate information—for example, where a CTO is renewed. That is the intention behind amendment 673.

Amendments 674 and 675 are technical amendments that seek to make it clear that the duties in section 186 continue to apply, even if the detention of a patient has been temporarily suspended. Amendment 676 seeks to clarify that the duties also apply where the patient is subject to a review of a mental health order imposed by a criminal court.

I move amendment 668.

Amendment 668 agreed to.

Amendments 669 to 673 moved—[Malcolm Chisholm]—and agreed to.

Section 186—Provision of assistance to patient with communication difficulties

Amendments 674 to 676 moved—[Malcolm Chisholm]—and agreed to.

Section 183—Access to medical practitioner for purposes of medical examination

The Presiding Officer: Amendment 677 is grouped with amendments 678 to 680.

Malcolm Chisholm: Sections 183 and 183A provide that a medical practitioner may examine a patient or the patient's medical records for the purposes of advising the patient or named person in connection with an application to the tribunal, or

of providing information to the patient or named person in connection with a tribunal hearing.

The mental health legislation reference group expressed concerns that such a provision might mean that a named person could have access to private medical information concerning the patient, even if the patient did not agree to that. In order to ensure that that does not happen, amendments 677 to 680 provide that a competent patient can rescind any authorisation given by a named person for a doctor to carry out an examination or to examine medical records.

I move amendment 677.

Amendment 677 agreed to.

Amendment 678 moved—[Malcolm Chisholm]—and agreed to.

Section 183A—Inspection of records by medical practitioner

Amendments 679 and 680 moved—[Malcolm Chisholm]—and agreed to.

After section 183A

The Presiding Officer: Amendment 681 is grouped with amendments 682 to 690, 719, 720, 726 to 728, 755, 732, 740 and 741.

Mrs Mulligan: We have faced many difficult issues during the bill's passage, but one of the most difficult concerns patients who are detained at an excessive level of security, in particular those in the state hospital who are ready to move on but have not been found places in local services. That issue is, rightly, of great concern. Through discussions with the Health and Community Care Committee, we have been able to make considerable progress. I believe that our amendments meet the aspirations of both Millan and the committee.

Before I explain the details of the amendments, I will set out the context. We have always recognised that it was wholly wrong that some patients should spend prolonged periods at the state hospital after their condition had improved to the extent that they could be safely treated in a less secure and more local environment. However, when we first considered the Millan recommendations, it seemed to us that the real problem was the lack of appropriate local services. An appeal right is of little use if there is genuinely no bed available that can meet the patient's needs.

We now accept that an appeal provision is not only an important protection for the individual patient, but should act as a spur for the development of the local forensic services, which are a key component of our strategy for mentally disordered offenders.

We recognise that if the amendments are to achieve their objective, they have to be backed up by the Executive intensifying the pressure on boards and local authorities to agree and implement plans that will address any remaining shortcomings against the assessed need. We need to build on the progress made with the development of the Orchard clinic here in Edinburgh and with the new facility at Stobhill in Glasgow by ensuring that the west, north and north-east of Scotland produce proposals that will secure local services for those areas.

We believe that key to that is the development of a managed network for mentally disordered offenders, the requirement for which was highlighted in the consultation document on the review of the state hospital, "The Right Place, The Right Time". Having considered the response to the document, the Executive has asked Andreana Adamson, the chief executive of the State Hospitals Board for Scotland, to lead the development of such a network. The objective is to bring a pan-Scotland dimension to the planning process for services for this patient group, to support the development of local services where such development is required, and to secure protocols that will ease the management of patients through the system.

I turn to the amendments, an early draft of which we shared with the Health and Community Care Committee. The committee identified a number of concerns about the drafting and we have addressed those concerns in the amendments that are before members today. Amendment 681 sets out the right of patients who are detained in the state hospital to apply to the tribunal for an order declaring that the patient is held in conditions of excessive security. The application may be made by the patient, the patient's named person, guardian or welfare attorney, or by the Mental Welfare Commission. An application may be made on an annual basis, after the patient has been detained for a period of six months.

The basis for deciding that the patient is held in conditions of excessive security is that the statutory criteria for detention in the state hospital are no longer met. If the tribunal decides that the patient is being held in conditions of excessive security, it may make an order giving the appropriate health board up to three months to find a suitable hospital place. At the suggestion of the committee, we have reduced the maximum time period from six months to three and made it clear that the place found must be available for the patient. Where the patient is a "restricted" patient, the board must ensure that the place that it identifies is one that the Scottish ministers agree is suitable.

Amendment 682 provides that if at the end of the specified period the patient has not been transferred from the state hospital, the tribunal must hold a further hearing. That addresses a concern of the committee that the patient should not have to take formal steps to raise the case again. At the review, the tribunal can give the board another chance, by allowing it another period of up to three months to find a suitable place, or the tribunal can move straight to a final order. Amendment 683 provides that if the tribunal allows the board more time, there can be a final tribunal hearing at the end of that period if the patient has still not been transferred. At that stage, the tribunal again may make a final order. The effect of the final order is that the board has 28 days to find a suitable place for the patient.

We are confident that boards will comply with the new statutory duty imposed by the amendments. As with any such duty, failure to comply would leave the board open to proceedings in the Court of Session for breach of statutory duty. Amendment 689 provides that such proceedings cannot be taken at the earlier stages, where the matter still falls to be considered by the tribunal, but the failure to comply with the final order would render the board liable to legal proceedings.

10:15

The committee felt that it might be unreasonable to expect a patient in the state hospital to raise an action in the Court of Session. One suggested way round that was that the Mental Welfare Commission should, if necessary, be able to raise an action on a patient's behalf. We have discussed that option with the commission, which has confirmed that it is prepared to take on that role where necessary, and subsection (2) of the new section inserted by amendment 689 provides for that.

Of course it is possible that circumstances might change, so that an order made by the tribunal is no longer appropriate. Amendment 684 allows the board and the RMO or the Scottish ministers to seek a recall of an order. That might be justified if, for example, the patient's condition deteriorated so that the level of security at the state hospital was still necessary.

At the moment, the problem of entrapped patients particularly concerns the state hospital, but it is possible that similar problems might arise in other secure facilities in future. Amendments 685 to 688 allow for regulations to grant similar rights in future to patients detained in hospitals other than the state hospital. Amendment 732 provides that those will be dealt with by affirmative procedure. Amendment 690 sets out the definitions for the purposes of those provisions.

Amendments 719, 720 and 726 to 728 deal with appeals against decisions of the tribunal concerning excessive security. Essentially, the appeal regime is the same as it is for other tribunal decisions concerning non-restricted patients.

We are happy to accept amendments 740 and 741, which Mary Scanlon lodged—she should not get used to that—subject to a small technical manuscript amendment to 741. That will provide a guarantee that the new rights will be brought into force no later than May 2006. The committee pressed the issue and I believe that the Executive has responded appropriately to what is a serious concern.

I move amendment 681.

Mary Scanlon: On this great historic occasion, I think that a cheer is appropriate. I am delighted that the Executive has accepted amendments 740 and 741. The thread that ran through all the proceedings—this came up in what Margaret Jamieson and Bill Butler said yesterday—is that, despite the fact that mental health is unquestionably a priority of the Parliament and the Executive, it is not always a priority at health board and local authority level.

There is almost a domino effect with Carstairs. People cannot get out of Carstairs and up to 29 people have been blocking beds through no fault of their own. When they get into the only medium-secure unit—we all visited Carstairs and the Orchard clinic—they cannot get out, because there are not sufficient day centres or places in supported accommodation.

MSPs might like to jump on a bandwagon and say that we do not want medium-secure units in our backyard. All of us who agree to pass the bill must be more tolerant and understanding of, and more sensitive to, this unique client group. It might be all right to get a few petitions to the Public Petitions Committee and a few votes locally before an election—

Paul Martin (Glasgow Springburn) (Lab): Does Mary Scanlon agree that it is important that the local health boards consult communities prior to making proposals for a medium-secure unit? Does she agree that it is important that we do not have the negative attitude of consulting communities and then saying that they will get a medium-secure unit whether they like it or not, because the local quango board has taken that decision?

Mary Scanlon: We have certainly received petitions from Father Stephen Dunn in Glasgow, which Paul Martin has talked about. Greater Glasgow NHS Board and other health boards have a lot to learn in the consultation process, which should not be about the presentation of a fait accompli. However, notwithstanding all the

arguments for consultation, we still must be much more sensitive, tolerant and understanding. Let us have less of the nimby culture for medium-secure units. Frankly, if it is all right to have the Orchard clinic in Morningside in Edinburgh, I expect the people of Glasgow to be equally tolerant of that client group.

Mrs Smith: I do not know that I can follow that contribution, Presiding Officer. I am delighted that the Executive has accepted Mary Scanlon's amendments, which have the support of the Mental Welfare Commission, the Law Society of Scotland and, I guess, all the members of the Health and Community Care Committee. We have now had several discussions with the minister and the bill team about the issue. You will hear a few of us moan and groan and say that parliamentary procedure has not covered itself in glory over the bill. On the other hand, its success rate lies with several of these amendments and with the discussions that we have had with the Executive and the bill team; we have arrived at an end point that is better than where we began. We have all worked in partnership during those discussions. Indeed, the question of detention in conditions of excessive security has proved a classic example of the partnership approach.

The committee shared the concerns expressed by the Millan committee about patients who were detained under levels of security in excess of those required. People have focused on those who are entrapped at the state hospital, because there are up to 30 patients in that situation at any time. Some patients are entrapped there for up to three years—we should imagine ourselves in their shoes. We heard evidence from a mother whose young son had been in Carstairs for that length of time. We are dealing not only with inappropriate services in inappropriate conditions, but with an issue that could well be challenged under human rights legislation.

At paragraph 199 of our stage 1 report on the bill, we described the entrapment of patients in the state hospital as scandalous and noted that every witness who commented on it wished to see the addition of a right to appeal. For that reason, we welcome the work advanced by the Executive and the amendments before us today. I am very pleased that the Executive has picked up my suggestion that patients should not have to take their appeals all the way to the High Court, but that the Mental Welfare Commission should have a part to play in the process.

We were very impressed by our visit to the Orchard clinic in Morningside. It stands in stark contrast to the unfortunate situation at Stobhill, of which we heard so much in our committee deliberations. However, to agree to these amendments today is to recognise that when people are taken out of the state hospital because they should not be there, they must nevertheless be placed somewhere else. We must invest in medium-secure units. Indeed, we must also be able to move people out of medium-secure units and place them elsewhere when appropriate.

I cannot express it any better than my colleague Mary Scanlon has. This is not an easy matter for us to tackle and it is perhaps even more difficult to bring it to our constituents. We must say that these people require our assistance and support; that is the logical end point of the amendments that we will agree to today, and it is right that we do so. I support the amendments in the name of the Executive and Mary Scanlon. If it is to be done, let us make sure that it is done quickly.

Shona Robison: It is worth putting on the record that the Health and Community Care Committee stuck doggedly to the principle behind what it wanted to achieve with these amendments. At one stage, the minister was sent away to think again and come back to us, which, to give her her due, she did. The amendments were only going to mean anything if they forced health boards to do what they were required to do. They will now do that.

I am also pleased that, if a patient has ultimately to go to the Court of Session for assistance, they will be given help to do that by the Mental Welfare Commission as a matter of last resort. That is to be welcomed.

Margaret Smith referred to the Crichton family, who will be pleased to know that in future there should be no one who ends up in the position in which their son found himself. He spent three years that he did not have to spend in Carstairs, waiting to leave. I hope that the bill will have the practical effect of ensuring that no one else is ever in that position again. That is why it is important that Mary Scanlon's amendments have been supported. That will ensure that there is no undue delay in getting to that position, so that the people who are currently in that situation in Carstairs will not have to be there for very much longer. My personal view is that that is one of the most welcome parts of the bill and many people throughout Scotland will welcome it.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I welcome the Executive's view of Mary Scanlon's amendments. Throughout the whole process, members of the Health and Community Care Committee were united in their wish to ensure that, whatever happened in relation to entrapped patients, there would be a compromise that would enshrine in the bill our views about the least restrictive detention of patients.

Mary Scanlon's point about regional secure units is clearly one that the minister has already taken on board, given the many petitions on consultation that the committee has considered. All the local NHS systems should take on board our commitment to full consultation. We indicated long ago, prior to what happened at Stobhill, that communities should be involved in designing services to meet the needs of patients. The difficulty with regional secure units is that people do not understand why we need them. The committee certainly understands why we need them. At Carstairs, we spoke to staff and patients alike, and we then went to the Orchard clinic here in Edinburgh to see the many benefits that can be achieved in the step-down process as patients return to full health. I certainly support the amendments.

Dr Richard Simpson (Ochil) (Lab): The history of medium-secure units, as they are now called, goes back to the late 1970s, when the programme planning group for mental health, which I sat on, was discussing whether we should have such units, in parallel with what was being developed in England and Wales. Regrettably, the minister at that time was of the view that the difficulties that would arise in terms of staffing costs from the development of such units would be too great. As a result, Scotland has been left with a legacy of insufficient medium-secure units. Individuals have been kept in the state hospital for far longer than they should have been, and it is therefore important that we move forward on the issue. I commend the work that the Executive and the Health and Community Care Committee have done in achieving the compromises that are being discussed today.

The original report that I wrote for the Health and Community Care Committee on the medium-secure unit at Stobhill illustrates the difficulties that there can be if health boards do not pre-emptively and openly discuss the situation with their communities. It is an absolute prerequisite that communities have adequate information and that it is explained to them that those units are indeed secure—that word is there not just by chance, but because those units are secure. Our society owes it to our communities to ensure that they are secure. Equally, however, it is a mark of a mature and humane society that we do not retain people in the state hospital unnecessarily. I very much commend the Health and Community Care Committee, the Executive and Mary Scanlon for the amendments.

10:30

Mrs Mulligan: I support what members have said about regional secure units. We recognise that there is a need to move speedily on the matter, but that does not absolve health boards from the necessary consultation that will bring about successful conclusions within local communities.

On what Margaret Smith said about the Mental Welfare Commission taking on the final appeal stage, we discussed with the committee the issue of the individual not losing their ability to proceed if they wished to do so. The amendment that we have lodged allows that to happen.

Amendment 681 agreed to.

Amendments 682 to 690 moved—[Mrs Mary Mulligan]—and agreed to.

Section 186A—Replacement of responsible medical officer etc

Amendment 691 moved—[Mrs Mary Mulligan]—and agreed to.

Section 187—Advance statements: making and withdrawal

The Presiding Officer: Amendment 18 is grouped with amendments 19 to 25.

Mrs Mulligan: Amendments 18 to 20 are minor and technical drafting amendments to section 187. Amendments 20, 21, 22 and 24 are also drafting amendments, as is amendment 23, which clarifies the cross-reference in section 188(3).

Amendment 25 clarifies the drafting of section 188(6). It makes it clear that the decision of the tribunal concerning whether an advance statement is validly made should be treated by a commission-appointed second-opinion doctor as conclusive, just as it would be for the treating doctor.

I move amendment 18.

Amendment 18 agreed to.

Amendments 19 and 20 moved—[Mrs Mary Mulligan]—and agreed to.

Section 188—Advance statements: effect

Amendments 21 to 25 moved—[Mrs Mary Mulligan]—and agreed to.

The Presiding Officer: Group 70 is on treatment that conflicts with advance statements. The amendments in the group are 100, 26 to 30 and 101. I call Mr Chisholm—I beg your pardon; I call Mary Mulligan.

Mrs Mulligan: Amendments 26, 27, 28, 29 and 30 are technical amendments that will clarify the duties to record the fact that steps have been taken that are in conflict with the wishes that are recorded in an advance statement. Those duties will now apply also to commission-appointed second-opinion doctors.

Amendments 100 and 101, which were lodged by Adam Ingram, seek to give additional legal force to advance statements and are similar to amendments that were considered, but not agreed to, at stage 2. I am afraid that we still do not believe that such amendments would be desirable.

The bill will, for the first time, give legal status to advance statements that are made by patients who are subject to compulsory treatment, which is a significant development. We think that advance statements have a real role to play in helping to increase the extent to which patients can participate in negotiation and decisions about their treatment. The provisions in the bill concerning advance statements follow the recommendations of the Millan report. The Millan committee considered advance statements carefully and devoted a chapter of its report to considering carefully the extent to which advance statements should have legal force.

The Health and Community Care Committee also heard a considerable amount of evidence at stage 1 about the potential difficulties of advance statements. Some witnesses had profound reservations about the idea of including advance statements in legislation at all. There is good reason to believe that the benefits of advance statements will be maximised when they are used as tools to improve dialogue and negotiation between service users and doctors, rather than being seen primarily as legally enforceable documents.

It might be helpful if I quote from the Health and Community Care Committee's stage 1 report, which said:

"The Committee considers that the provisions on advance statements appear to strike an appropriate balance between increasing patients' autonomy, avoiding practical difficulties, and ensuring that doctors are not inhibited from protecting patients' welfare."

We still believe that Millan and the Health and Community Care Committee were correct in that conclusion.

Concern has been expressed that without a requirement to go to tribunal, an advance statement would be worthless; that is not the case. The bill requires doctors and tribunals to take advance statements seriously. We strengthened the provisions at stage 2 by ensuring that the commission can oversee the actions of doctors who decide not to comply with advance statements and by providing that second-opinion doctors must also take account of such statements. However, there would be serious problems in principle and practice if we were to go further than that.

It is not an appropriate function of the tribunal to decide between one form of medical treatment and another. The tribunal does not have the responsible medical officer's expert knowledge of the patient and will not have examined the patient. If the tribunal is satisfied that a patient requires to be treated compulsorily, it is right that the responsible medical officer—subject to the oversight of an independent second-opinion doctor where appropriate—should be responsible for choosing the best treatment for the patient.

The bill will not allow a doctor to make such a decision regardless of the wishes of the patient. An advance statement must be properly considered and any decision not to follow it must be set out in a report to the Mental Welfare Commission for Scotland. That is on top of the other safeguards that are already in the bill, which include the provisions for an independent second opinion in part 13 and the legal duties in part 1 for doctors to consider the full range of options and to act in a way that involves minimum restriction of the patient's freedom in the circumstances. Therefore, the bill already goes considerably further than does the current law in protecting patients from treatment that they oppose. Its effect will be that there must be truly compelling reasons to treat a patient in a way that contradicts an advance statement.

Adam Ingram's amendments would require any doctor who thought that it was necessary to treat a patient in a way that is inconsistent with an advance statement to seek the approval of the tribunal. The tribunal would have to allow the interested parties the opportunity to give evidence before deciding whether to authorise the treatment. We think that that would be impractical, partly because it could create burdens on doctors and the tribunal, but mainly because it could cause harm to patients. It appears that the amendments would allow treatment to be given without a tribunal hearing if the RMO were to decide that such treatment was a matter of urgency. However, there could be cases in which the matter is not an emergency, but in which treatment's being delayed could nevertheless prolong a patient's distress and cause long-term harm.

At stage 1, the committee expressed concern that the situation might arise in which a patient who had previously made an advance statement subsequently indicated willingness to accept treatment. It was suggested that it should be possible for the doctor to go to the tribunal and seek its approval for the treatment. We do not think that that is necessary, but it highlights one of the many practical and ethical difficulties that are raised by advance statements. Given such difficulties, we think that it is right to proceed cautiously and in line with what Millan recommended. We will certainly emphasise in the code of practice the importance that we attach to advance statements and the need to take them

extremely seriously. We hope that the bill will allow advance statements to take root and influence the culture of decision making in mental health services in a way that emphasises partnership between service users and professionals, rather than conflict.

I hope that Adam Ingram will not press amendments 100 and 101.

The Presiding Officer: I apologise to Adam Ingram—I should have called him to move amendment 100 before I called the minister. I must advise members that if amendment 100 is agreed to, I will not be able to call amendments 26 to 30 because they will have been pre-empted. I invite Adam Ingram to speak to and to move amendment 100.

Mr Adam Ingram (South of Scotland) (SNP): Amendments 100 and 101 are restatements of an amendment that Mary Scanlon lodged at stage 2. The committee was split on the issue and her amendment fell only after the use of a casting vote; therefore, it is right that we revisit the issue today.

The Presiding Officer: That is why I selected the amendment.

Mr Ingram: I will go over what an advance statement does. An advance statement offers an individual an opportunity, when he or she is well enough to do so, to set out their wishes regarding future care and treatment, should they lose their capacity to make decisions about such matters. As the bill stands, in making any decisions about a patient who has made a valid advance statement, a tribunal must "have regard to"—that phrase is used again—the terms of that statement. Patients who are treated under the eventual act might be given treatment that conflicts with their advance statement, provided that the person who gives the treatment has regard to the wishes that are expressed in that statement and complies with certain recording and notification requirements.

Amendment 100 will not make advance statements legally binding; neither will it prevent clinicians from providing treatment in an emergency, which could be dealt with under section 171. If the patient's RMO wished to give, or direct others to give, treatment that conflicted with the advance statement, the RMO would have to apply to the tribunal for authority to do so. The patient or named person would have the opportunity to have their views heard before the decision was made. That would strike the right balance between giving advance statements significant weight and allowing that they can be overridden by the tribunal in appropriate circumstances.

Professionals have written to several MSPs. Professor David Owens, for example, was concerned that advance statements could inhibit psychiatrists' duty of care. However, the availability of an appeal to the tribunal allows expression of clinical judgments and would protect psychiatrists in their judgments about care for, and treatment of, patients.

The point of my amendments is to reassure service users that their voices will be heard when treatment choices are being made, and that they will not be overridden as a matter of course.

I move amendment 100.

Mary Scanlon: As my colleagues on the Health and Community Care Committee have witnessed, this is undoubtedly the issue with which I have struggled more than any other during the passage of the bill—the issue is crucial. I support Adam Ingram's amendments. A patient's rights, as stated in an advance statement, will form the basis of controversy for years to come. To be honest, I agree with both sides, and I find the matter to be enormously complex.

Once again, the issue is the balance between patients' rights and allowing clinicians to make good clinical judgments. I do not wish to deny patients respect and dignity, as has been done in the past, because when they are fit and well, many patients wish to have a say in the type of treatment—for example ECT and other treatments—that they want when they fall ill. I do not wish to deny any patient in Scotland that right, but neither do I wish to deny a psychiatrist the duty of care or to inhibit his or her right to make a clinical judgment. Although I support Adam Ingram's amendments, we also want service users to be encouraged to go through the formality of making an advance statement in accordance with the requirements of section 187. We do not want them to wonder what the point is of making an advance statement when that statement can be overridden at the discretion of professionals, with no means being available to service users to challenge such decisions. We want to empower service users and to treat them with the respect and dignity that they have gained through their experience of the service.

10:45

However, to do so is undoubtedly difficult when one receives a letter such as that from Professor Owens. I would like to share one or two comments from that letter—I make no apologies for the time that I will take because this is such a difficult and complex issue. Professor Owens states:

"I am concerned about the potential conflict for doctors with regard to their duty of care. I wonder what will be the expectations of someone such as myself when a clearly stated advance directive represents in my clinical judgement an inappropriate plan for management.

I strongly believe that the whole principle of advance directives is based on a false assumption—namely, that the circumstances in which psychiatric disorder presents remain static and predictable. This is totally contrary to my clinical experience. What may be an appropriate treatment plan in one set of social and clinical circumstances may be totally inappropriate in another.

There are a series of further practical difficulties—e.g. over 90% of my work is concerned with emergency cases. The idea of a 'cold' psychiatric case is rapidly becoming a thing of the past. In these circumstances, it may be impossible to confirm the details of any extant advance directives—or, worse, establishing their presence in volumes of past clinical records, may unduly delay the implementation of an optimal treatment plan.

The proposal, contained in this amendment"—

which I support—

"to refer dispute in these matters to a Tribunal for, in effect, arbitration, fills me with horror. This is in effect, the act of handing over professional—and CLINICAL—judgement to the legal process, something which I ... abhor ... Should Parliament accept that advance directives must be, in matters of dispute, arbitrated by Tribunals, I MOST FIRMLY believe they must also give psychiatrists the LEGAL right to refuse to accept on-going management responsibility for cases in which their clinical plan is over-ridden by a review Tribunal. To fail to do so, would in my view place psychiatrists in the invidious situation of being forced to supervise treatment they believe to be sub-optimal or worse, positively harmful, something that is contrary to every principle of medicine in which they have been professionally raised and nurtured—and something I do not believe Parliament has the right or authority to impose our profession."

I cite Professor Owens's letter because I want MSPs who are not, or have not been, members of the Health and Community Care Committee to understand the difficulties that the committee has had in trying to give patients more rights and a say in their medication or treatment; in trying to reduce the stigma that we all know is associated with mental health; and in trying to treat patients as worthwhile partners in the partnership of care. I find it very difficult to give patients the authority that I want to give them while respecting the clinical judgment of people such as Professor Owens.

Mrs Smith: The member has argued against herself.

Mary Scanlon: As a true Gemini, I see both sides of the argument clearly. I want to show members how difficult it is not to inhibit clinical judgment while giving patients rights.

Mrs Smith: How do I follow that? Mary Scanlon has provided classic examples of the difficulties to which I alluded earlier and of questions arising from the bill with which the Health and Community Care Committee has wrestled. We have had to make judgment calls at the narrow edges of a border.

I agree whole-heartedly and sympathise with the views that lie behind amendment 100. It is important that we afford people who have mental health difficulties true dignity and respect and that we listen to what they say because they probably know much more about their conditions than do most of the people who will be involved in treating them. Anyone who does not listen to the patients is not doing their clinical job properly.

How do we afford people with mental health difficulties proper dignity and give proper weight to their judgments about the treatment that they should receive, while taking on board the clinician's duty of care? Mary Scanlon has wrestled with the issue and has cited from the letter that many of us received from Professor Owens about the problems that amendment 100 would present from a clinical point of view. In a sense, I am on the other side of the argument, because I voted against the amendment that Adam Ingram lodged on the issue at stage 2, even though I agree whole-heartedly with his view.

Despite the fact that I am an Aquarian, I am in exactly the same situation as Mary Scanlon. Adam Ingram's argument about the right of appeal is seductive and persuasive, but the problem is that if the answer to an appeal is that the clinician is not correct, the legal tribunal would compel the clinician to do something that he or she thinks is wrong and to go against his or her judgment and the terms of their duty of care.

At stage 1, the Health and Community Care Committee said that we do not want advance statements to be legally binding—as far as I am aware, nobody wants that—because we understand the complexities of the issue, as do the Scottish Association for Mental Health and other bodies. We felt that if greater weight were to be given to advance statements, we would have to resolve the issue of what to do about clinicians who are compelled to do something against their best clinical judgment. If I recall rightly, we said at stage 1 that it should be possible for clinicians who have to act contrary to their judgment to be absolved of responsibility for what happens.

I turn to the compelling arguments that were made by the likes of Professor Owens. People can make advance statements about conditions that they might experience, but time and conditions do not stand still. We always hope that people will get better, but often they deteriorate. Given that conditions do not remain static, it is difficult to say that a clinician should at some point in the future be compelled to act on a person's advance statement.

An example that I have used previously—although not entirely seriously—is the suggestion that I gave to my clinicians when I was expecting a baby. I had a wonderful notion about the care that I wanted and I said that I did not want pain relief. I gave the issue some thought and discussed it with

clinicians and my husband, but when it came down to it, I would happily have had my head taken off if the baby could have been brought out that way. I was in so much pain that I would have taken anything, and I tried to do so. [MEMBERS: "Hear, hear."] That hit a raw nerve.

I do not mean to be flippant, but that example is the only occasion on which I have been asked what I wanted in advance of treatment, but the reality of what I experienced was different from what I thought it would be. My example illustrates one of the complexities of the issue. A difficult judgment call is involved, but I do not support Adam Ingram's point of view. I ask the Executive to monitor the system closely because we can learn from experience. I will go with the Executive on this one.

Maureen Macmillan (Highlands and Islands) (Lab): I was not paying too much attention to the debate until I heard Mary Scanlon's speech, which reminded me of arguments that we had in relation to the Adults with Incapacity (Scotland) Act 2000. On the one hand, the family of somebody who is incapax might think that they know best how that person should be treated, but on the other hand, the doctor might think that that treatment would be inappropriate. Initially, we decided that the clinician should have the last word, about which the families were up in arms, but when we reversed that decision at stage 2, the families were happy but the medical profession was extremely unhappy.

If my memory serves me well, we decided that there should be a tribunal that, in extremis, would make a decision about what was best for the patient. My memory is vague, but I do not think that the tribunal was necessarily a medical one—lawyers and other people were to be involved. Perhaps the Executive should consider that system as a model for what might happen with advance statements. We are at a late stage, but perhaps the Executive could find out how the advance statement system works and consider introducing a tribunal.

Dr Simpson: As the back bencher who was instrumental in working closely with the Executive on the provisions of the Adults with Incapacity (Scotland) Act 2000, to which Maureen Macmillan referred, I think that what happened in that act's passage is a good example. The outcome was that the Mental Welfare Commission would appoint a second specialist independent doctor who was an expert in the field and who would listen to the views of the carer and the doctor who proposed the treatment over which there was disagreement. The concept was based on partnership.

The proposed advance statement system will allow a patient who might become incapacitated to make an advance statement, which will ensure as far as possible that the patient's wishes are followed. However, as Mary Scanlon said, there are significant difficulties with the proposal. Psychiatrists often have to move quickly to establish treatment that, although it might not be life saving, is close to it. We are not dealing with absolutes, but with many relative positions. We should consider and take on board the model in the Adults with Incapacity (Scotland) Act 2000, although it has been introduced only recently, so I am not sure whether there is any case history on it.

One great advantage of the parliamentary system is that the Executive, having given an undertaking to monitor advance statements carefully, will be able to return to the Parliament rapidly if the case history in relation to the Adults with Incapacity (Scotland) Act 2000 or the working of the new advance statements prove that additional measures are required. The Executive is right to move cautiously and to try to take the medical professions and the users with us. I support the Executive, but I strongly urge it to monitor the system extremely carefully. The Executive should have an open mind about returning quickly to the issue if users' wishes are not being followed through reasonably.

It is regrettable that some patients who have mental illness are unreasonable—just as some members are unreasonable from time to time. Advance statements are not always in patients' best interests; indeed, they might have serious consequences. A degree of openness about the issue is important.

The Presiding Officer: Does the minister want to add anything before I ask Adam Ingram to wind up?

Mrs Mulligan: Thank you, Presiding Officer. I am sorry that I jumped the gun earlier.

The Presiding Officer: That was my fault.

Mrs Mulligan: I feel strongly that the bill has moved substantially towards giving service users control over their treatment, which is the message that we received loud and clear. The Mental Welfare Commission, the general practitioners committee of the British Medical Association and the Royal College of Psychiatrists welcomed the bill's provisions on advance statements, although I accept that it was a cautious welcome. Even Professor Owens, who had profound reservations about advance statements, indicated that the policy that is enshrined in the bill—which stops short of giving full legal effect to advance statements—might be workable. We get the feeling that people have serious concerns about how to arrive at a correct balance on the issue, but the Executive's amendments should give us that balance.

Maureen Macmillan mentioned tribunals. In reality, if a patient's need for treatment is such that the responsible medical officer and—where appropriate—the independent second-opinion doctor are satisfied that it would be wrong to comply with the advance statement, it would be absolutely exceptional for a tribunal to seek otherwise. Therefore, a tribunal system might be overbureaucratic and lead to practical difficulties, which is why we have not gone down that route.

I agree totally with members who said that it is essential that we keep the issue under review. We are aware of the range of views—some conflicting—that people hold on the issue.

John Scott (Ayr) (Con): The minister will be aware of the shortcomings of section 5 of the Adults with Incapacity (Scotland) Act 2000 and the extra work load that it has brought about, which I have pointed out to Minister Chisholm. Will she ensure that the bill will not introduce another unexpected work load for practitioners? When will she proceed with the review of the Adults with Incapacity (Scotland) Act 2000 that Minister Chisholm promised?

Mrs Mulligan: Section 5 of the Adults with Incapacity (Scotland) Act 2000 is under review and the minister will shortly produce proposals to try to address the work-force issues that have arisen. However, in the majority of cases, the 2000 act is working well.

Advance statements will need to be monitored. We want service users to feel that their views are being taken into account and that they hold great sway over decisions regarding their treatment. We want to encourage service users to make advance statements and to feel that those statements are worth while. We will ensure that they will be overridden only in rare cases, and we will continue to review that option.

11:00

Mr Ingram: This has been a good and interesting debate. Mary Mulligan has shown her passionate side again, as has Margaret Smith. They both made very good speeches.

This is a question of balance and it is clear that we are all struggling to decide where that balance should lie. I believe that we need to move the balance towards the rights of individual users of the service and away from the historical dominance of the professional point of view. On that basis, I will press amendment 100.

The Presiding Officer: The question is, that amendment 100 be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

FOR

Adam, Brian (North-East Scotland) (SNP)
Canavan, Dennis (Falkirk West)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Ewing, Mrs Margaret (Moray) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Grahame, Christine (South of Scotland) (SNP)
Hamilton, Mr Duncan (Highlands and Islands) (SNP)
Harper, Robin (Lothians) (Grn)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Mr Adam (South of Scotland) (SNP)
Johnstone, Alex (North-East Scotland) (Con)
Lochhead, Richard (North-East Scotland) (SNP)
MacAskill, Mr Kenny (Lothians) (SNP)
Marwick, Tricia (Mid Scotland and Fife) (SNP)
McLeod, Fiona (West of Scotland) (SNP)
Morgan, Alasdair (Galloway and Upper Nithsdale) (SNP)
Mundell, David (South of Scotland) (Con)
Neil, Alex (Central Scotland) (SNP)
Paterson, Mr Gil (Central Scotland) (SNP)
Reid, Mr George (Mid Scotland and Fife) (SNP)
Robison, Shona (North-East Scotland) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Sheridan, Tommy (Glasgow) (SSP)
Sturgeon, Nicola (Glasgow) (SNP)
Tosh, Mr Murray (South of Scotland) (Con)
Wallace, Ben (North-East Scotland) (Con)
Welsh, Mr Andrew (Angus) (SNP)

AGAINST

Alexander, Ms Wendy (Paisley North) (Lab)
Baillie, Jackie (Dumbarton) (Lab)
Barrie, Scott (Dunfermline West) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Butler, Bill (Glasgow Anniesland) (Lab)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Eadie, Helen (Dunfermline East) (Lab)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Finnie, Ross (West of Scotland) (LD)
Fitzpatrick, Brian (Strathkelvin and Bearsden) (Lab)
Gillon, Karen (Clydesdale) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Gorrie, Donald (Central Scotland) (LD)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (Edinburgh Pentlands) (Lab)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, Mr John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Jackson, Dr Sylvia (Stirling) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Lyon, George (Argyll and Bute) (LD)
Macdonald, Lewis (Aberdeen Central) (Lab)
MacKay, Angus (Edinburgh South) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
McAllion, Mr John (Dundee East) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McLeish, Henry (Central Fife) (Lab)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)

McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Peacock, Peter (Highlands and Islands) (Lab)
Raffan, Mr Keith (Mid Scotland and Fife) (LD)
Robson, Euan (Roxburgh and Berwickshire) (LD)
Scott, Tavish (Shetland) (LD)
Simpson, Dr Richard (Ochil) (Lab)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North-East Fife) (LD)
Smith, Mrs Margaret (Edinburgh West) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Thomson, Elaine (Aberdeen North) (Lab)
Watson, Mike (Glasgow Cathcart) (Lab)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)

The Presiding Officer: The result of the division is: For 30, Against 56, Abstentions 0.

Amendment 100 disagreed to.

Amendments 26 to 30 moved—[Mrs Mary Mulligan]—and agreed to.

After section 188

Amendment 101 not moved.

Section 189—Education of persons who have mental disorder

Amendments 218 and 219 moved—[Mrs Mary Mulligan]—and agreed to.

Section 193—Correspondence of certain persons detained in hospital

The Presiding Officer: Amendment 56 is grouped with amendments 57 to 66.

Malcolm Chisholm: Amendments 56 and 65 are technical amendments that provide that section 193, which regulates interference with patients' correspondence, may apply both to correspondence that is delivered by the normal postal service and to any other arrangements for the collection of post.

Currently, important aspects of the procedures on interference with correspondence apply only when the patient is detained in the state hospital. We indicated at stage 2 that we wished to review that and we have concluded that it might be necessary for the powers to apply to some patients in other settings. That particularly reflects the fact that some patients who might in the past have been in the state hospital will, in future, be accommodated in regional secure facilities.

Amendments 57 and 62 therefore remove the restriction to the state hospital but leave provisions that allow regulations to specify the kind of patient or the kind of situation that may justify interference with correspondence—for example, to protect other patients or members of the public. Those regulations will be subject to the affirmative procedure, so the Parliament will have a proper opportunity to consider them before they are brought into effect.

The bill puts in place safeguards, including a list of people whose correspondence cannot be intercepted and powers for the Mental Welfare Commission for Scotland to monitor any such action and, if necessary, to overrule the hospital managers.

Amendment 58 is purely a drafting amendment. I shall not move amendment 59, as the latest advice suggests that the reference to the Scottish ministers should be retained as a fallback in cases in which letters are being received and the identity of the hospital is not known.

Amendments 60 and 61 reflect commitments that were made at stage 2. A member's amendment sought to provide that correspondence between a patient and an advocate could not be interfered with. We agreed in principle, but were concerned to ensure that the drafting was tightly drawn so that the provision applied to properly authorised independent advocates and was not open to abuse. Amendment 61 provides for that. For completeness, we have also added to the list members of the National Assembly for Wales, members of the European Parliament, special health boards and NHS trusts.

Amendment 63 is purely a drafting amendment. Amendment 64 makes it clear that the risk that might justify intercepting a letter that is sent by a patient may relate to the health of that patient as well as to the patient's safety.

Section 197(4) provides that telephone calls by the patient to any one of a list of persons or bodies cannot be intercepted, except in limited circumstances. Amendment 66 adds to the list health boards and the bodies that are listed in amendments 60 and 61, including independent advocacy services.

I move amendment 56.

Amendment 56 agreed to.

Amendments 57 and 58 moved—[Malcolm Chisholm]—and agreed to.

Amendment 59 not moved.

Amendments 60 to 65 moved—[Malcolm Chisholm]—and agreed to.

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

Amendment 66 moved—[Malcolm Chisholm]—and agreed to.

Section 197—Safety and security in hospitals

The Deputy Presiding Officer (Mr George Reid): Amendment 10 is grouped with amendment 67.

Malcolm Chisholm: Amendment 10 is a technical amendment that makes it clear that the regulations that may be made under section 197, concerning safety and security in hospital, apply to patients who are detained under the bill or the related mental health disposals in the Criminal Procedure (Scotland) Act 1995.

Amendment 67 is also a technical amendment. It broadens the consultation requirements in section 197(6) to any regulations that are made under section 197.

I move amendment 10.

Amendment 10 agreed to.

Amendment 67 moved—[Malcolm Chisholm]—and agreed to.

After section 197

Amendment 692 moved—[Malcolm Chisholm]—and agreed to.

After section 200A

The Deputy Presiding Officer: Amendment 693 is grouped with amendments 694 to 700.

Malcolm Chisholm: Amendment 693 introduces a new section that makes provision for the transfer of patients subject to community-based compulsory treatment orders. The new section provides a regulation-making power in which a detailed framework for the transfer of such patients to destinations outside Scotland can be set out.

It is important to emphasise that a patient subject to a community-based compulsory treatment order can be transferred outside Scotland only when that is in accordance with the patient's wishes or, if the patient is unable to express an opinion, when the named person considers it to be in the patient's best interests. It is envisaged that the powers provided for in the new section will be used primarily where the patient wishes to settle in another part of the United Kingdom.

Amendments 694 and 695 adjust section 201(1)(c) to make it clear that, in relation to the removal of a patient from another jurisdiction to Scotland, the bill can make provision only for the reception of the patient in Scotland. The removal of the patient from foreign territory is a matter for that jurisdiction.

Amendment 696 requires that regulations concerning the cross-border transfer of patients under section 201 must require the Scottish ministers to have regard to certain factors before a patient can be transferred. Those factors are the patient's best interests, the existence of suitable arrangements at the receiving end, any preference that the patient has expressed to the Scottish ministers and any risk to the safety of any person.

Amendment 697 expands the list of persons to whom notice must be given of any decision that the patient be removed from Scotland under section 201. Those persons are the patient, the patient's named person, the mental health officer and the Mental Welfare Commission.

Amendment 698 improves the drafting of section 201(3) by making it clearer that exceptions can be made to the requirements under paragraphs (b), (c), (d) or (f) of section 201(2). Exceptions cannot be made to paragraphs (a) and (e), which provide, respectively, that a patient's removal from Scotland must be authorised by a warrant issued by the Scottish ministers and that a patient may appeal against any decision to remove him.

Amendment 699 adjusts section 201(4) to make it clear that the Scottish ministers can veto the reception in Scotland of any patient removed from another jurisdiction. However, the removal itself is a matter for that jurisdiction. Amendment 700 makes it clear that a patient whose detention is suspended by virtue of a certificate issued under the relevant part of the bill is nonetheless included within the scope of section 201, which deals primarily with detained patients.

I move amendment 693.

Amendment 693 agreed to.

Section 201—Cross-border transfer of patients

Amendments 694 to 700 moved—[Malcolm Chisholm]—and agreed to.

Section 198—Removal from public place

The Deputy Presiding Officer: Amendment 102 is grouped with amendments 701 to 703, 220, 704 to 708, 221 to 241, 711, 713 to 717 and 733.

Malcolm Chisholm: Amendment 708 makes provision in section 204 for patients on suspension of detention from emergency or short-term detention where that suspension of detention is subject to conditions that the patient be accompanied or return to hospital and the patient fails to comply with those conditions.

Amendment 220 extends the absconding provisions contained in section 204 to cover patients who are detained in hospital as a result of section 85(5A). Amendment 223 modifies section 205(8) so that a patient who is absent without leave and in breach of his compulsory treatment order is no longer considered to be absent without

leave once taken in under section 85 for breach of the order.

Amendment 225 adds a new provision to section 206 to make it clear that a patient who is subject to a compulsory treatment order and whose period of unauthorised absence has continued for longer than three months is not only no longer liable to be retaken, under section 205(4), but is no longer subject to the order. Without that provision, although the patient could not be retaken, the order would still be alive.

Amendment 226 corrects the drafting of section 207(1)(b) by removing the superfluous reference to a period of two months. Section 207 applies to any patient subject to a compulsory treatment order whose period of unauthorised absence is longer than 28 days and whose unauthorised absence ceases at least 14 days before the expiry of the order.

Amendments 228 and 235 prevent unnecessary duplication of section 60(3) reviews in sections 207 and 209 respectively. If it is necessary to carry out a section 60(3) review for the purposes of part 16 and the 14-day period within which the review is carried out overlaps with the two-month period within which a first or further review must be carried out, for the purposes of renewing the order it is not necessary to repeat those steps. Amendments 229, 231 and 232 are consequential on amendment 228 and improve the drafting of section 207.

11:15

Amendments 230 and 233 remove section 207(6), which was incorrect. That subsection provided that, if the patient absconded after the mandatory review procedures in part 7, chapter 2 had begun, those review procedures did not need to be repeated. That is not correct in the case of patients who have been absent without leave for a period exceeding 28 days. That is such a significant event that any such review must be started again from scratch. Amendments 236 and 239 remove the reference to section 207(6) from sections 209(2) and 210(2) respectively.

Amendments 237 and 240 clarify the application of subsections (3) to (5) of section 207 to sections 209 and 210 respectively. Those subsections provide the interface with part 7, chapter 2, which deals with the renewal of compulsory treatment orders. Amendments 238 and 241 provide that a period of unauthorised absence lasting for 28 days or less does not invalidate any of the review procedures carried out for the purposes of part 7, chapter 2 prior to the absence of the patient.

Amendment 711 introduces a new section providing a regulation-making power to enable provisions equivalent to those for absconding civil patients to be drawn up for patients subject to criminal orders. Amendments 701 to 707, 221, 222, 224, 227 and 234 are technical amendments to part 16 that improve the drafting and tidy things up after amendment at stage 2.

I move amendment 102.

Amendment 102 agreed to.

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

Amendments 701 to 703 moved—[Malcolm Chisholm]—and agreed to.

Section 204—Absconding etc by other patients

Amendments 220, 704 to 708 and 221 moved—[Malcolm Chisholm]—and agreed to.

Section 205—Taking into custody and return of absconding patients

Amendments 222, 709, 710 and 223 moved—[Malcolm Chisholm]—and agreed to.

Section 206—Effect of unauthorised absence

Amendments 224 and 225 moved—[Malcolm Chisholm]—and agreed to.

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

Amendments 226 to 233 moved—[Malcolm Chisholm]—and agreed to.

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

Amendments 234 to 238 moved—[Malcolm Chisholm]—and agreed to.

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

Amendments 239 to 241 moved—[Malcolm Chisholm]—and agreed to.

After section 212

Amendment 711 moved—[Malcolm Chisholm]—and agreed to.

Section 214—Offences under section 213: extended sentences

Amendment 242 moved—[Malcolm Chisholm]—and agreed to.

Section 215—Persons providing care services: sexual offences

Amendment 757 moved—[Malcolm Chisholm]—and agreed to.

The Deputy Presiding Officer: Amendment 712 is grouped with amendments 731, 739, 11 and 12.

Mrs Mulligan: Amendment 712 is a technical amendment that removes unnecessary text, because the definition of "regulations" in section 228(1) already produces the result that all regulations under the bill fall to be made by the Scottish ministers.

Amendment 731 corrects an incorrect cross-reference to the regulation-making powers in section 168, which concerns safeguards for certain treatments for mental disorder. Amendment 731 also provides that regulations under section 168(5), which amend the length of time that medication may be given before attracting safeguards—currently two months—shall be made under the affirmative procedure. That implements a Subordinate Legislation Committee suggestion.

Amendments 11 and 12 are technical amendments. They provide that the powers of the Scottish ministers to prescribe forms and to make supplementary provisions by order will come into force immediately when the act receives royal assent and do not have to be brought into force by order.

Section 228A allows the Scottish ministers to make supplementary, incidental or consequential provisions by order. Those orders may modify other acts and, where that happens, the affirmative procedure applies. Amendment 739 provides that an order under section 228A may modify the terms of the act that the bill will become. The reason for doing that is simply that the bill will be an extremely detailed and intricate piece of legislation. There are complex interrelationships between the different parts. Once they are examined, it might become apparent that consequential amendments are needed to particular provisions to give full effect to the bill's provisions.

I move amendment 712.

Amendment 712 agreed to.

Section 216—Notification requirements for offenders under sections 213 and 215

Amendment 243 moved—[Mrs Mary Mulligan]—and agreed to.

Section 217A—Inducing and assisting absconding etc

Amendments 713 to 717 moved—[Mrs Mary Mulligan]—and agreed to.

Section 219—Appeal to sheriff principal against certain decisions of the Tribunal

The Deputy Presiding Officer: Amendment 718 is grouped with amendments 244 to 247, 721 to 725, 249, 729 and 730.

Mrs Mulligan: The amendments relate to the provisions on appeals against decisions of the tribunal. They adjust the set of decisions that can be appealed and the group of people who have a right of appeal.

A right of appeal exists against a decision to make or refuse to make an order under section 160A(5) or section 160B(5) to prevent a transfer or require that a transferred prisoner be returned. However, by necessity, that relates to a restricted patient, so it belongs in section 221 rather than in section 219. Amendment 718 combined with amendment 725 will give effect to that. Amendment 725 will also add rights of appeal against some decisions made by the tribunal under section 154A, which was added at stage 2.

Amendments 721 to 724 perform two functions: they reflect the consequences of earlier amendments to section 133 and make it clear that the relevant persons—who include the patient, their named person and the Scottish ministers—have a right of appeal against any decision of the tribunal under section 133, including a decision to make no order.

Should the Scottish ministers raise an appeal under section 221, section 222 gives the Court of Session the power to order, should it wish to do so, that the patient should remain detained in hospital subject to the original compulsion order and restriction order until the appeal process has been concluded. Amendments 729 and 730 will ensure that that power also applies to decisions under subsections (3) and (4) of section 154A when a patient is subject to a hospital direction or transfer for treatment direction.

Amendments 244 to 246 and 249 add any guardian or welfare attorney of the person concerned to the people who are considered relevant parties for the purposes of an appeal. Amendment 247 is directly consequential to amendment 246.

I move amendment 718.

Amendment 718 agreed to.

Amendments 719, 244, 245, 720, 246 and 247 moved—[Mrs Mary Mulligan]—and agreed to.

Section 221—Appeals to Court of Session against decisions made under section 133

Amendments 721 to 723, 248, 724 to 727, 249 and 728 moved—[Mrs Mary Mulligan]—and agreed to.

Section 222—Appeal by Scottish Ministers under section 221: suspension of Tribunal's decision

Amendments 729 and 730 moved—[Mrs Mary Mulligan]—and agreed to.

Section 225—Orders, regulations and rules

Amendments 755 and 731 to 733 moved—[Mrs Mary Mulligan]—and agreed to.

Section 228—Interpretation

Amendments 734 and 735 moved—[Mrs Mary Mulligan]—and agreed to.

The Deputy Presiding Officer: Amendment 736 is in a group on its own.

Shona Robison: Like many members, I have received several letters from clinical psychologists who are concerned that the bill omits psychological intervention and treatment. I have some sympathy with the view that the bill does not acknowledge the psychology input to the mental health care system as it should, but the amendments that the clinical psychologists suggested were not the way forward.

To address some of their concerns, I lodged amendment 736, which would include psychological intervention in the definition of medical treatment. The Executive feels that the definition is in case law, but I see no reason not to provide clarity in the bill by specifying psychological intervention in the definition of medical treatment. I await with interest the minister's response.

I move amendment 736.

Mrs Smith: I support what Shona Robison has said. All members have probably received letters about the issue from the British Psychological Society and from clinical psychologists. The Health and Community Care Committee said in its stage 1 report that the Executive should look into the matter, because clinical psychologists raised their concerns with us then.

It would be unfortunate to proceed with enshrining the bill's current definition of medical treatment. Even if the Executive's intention is that the definition should be broader than just medical treatment in its purest sense, the current wording conjures up ideas simply of doctors and medication, and there is an awful lot more to the picture of what is needed to treat and care for people with mental disorder. The letters that we have received have given examples, such as the treatments that sex offenders receive and anger management classes not only in our prisons but elsewhere. All that is valuable work. In building a statutory mental health system for the future, we do not want to look like we are rooted in the past. We should acknowledge that such treatment is the way forward. There are more ways to assist people in dealing with the conditions from which they suffer.

Mr Keith Raffan (Mid Scotland and Fife) (LD): I agree with the direction in which the member is going. Does she agree that one main problem that we face with other treatments, in particular therapeutic treatments, is the shortage of child psychologists and psychotherapists in Scotland?

Mrs Smith: I agree. If Mr Raffan cares to ensure that he is present for the winding-up speeches, he will probably find that all members of the Health and Community Care Committee will return to the lack of psychologists, of which we are well aware. I back up the member's comments.

Dr Simpson: Of course, the situation is not new. Clinical psychologists have been in short supply for the past 10 or 15 years. A proposal has been made to extend the time for their training to about seven years. Does the member feel that that is appropriate when the length of medical degrees has been shortened to five years? In England, faster medical degrees of three years are being introduced for people with associated scientific specialties. A university is being set up to provide such degrees.

In psychology, a person must obtain a first degree with a first or a 2:1, become an assistant psychologist and undertake some practice, then take a course to obtain a clinical psychology qualification. The proposal to extend the length of time for training will make the situation worse. If we are to address the matter properly, we must consider who provides alternative therapies best and which staff can provide them.

The Deputy Presiding Officer: Please be brief. You are making an intervention.

11:30

Dr Simpson: I apologise. Does Margaret Smith agree that that area needs to be considered further?

Mrs Smith: If I could remember what I was saying when Richard Simpson intervened on me, I probably would. I think that I agree with what he says. It links in with another work-force point that the Health and Community Care Committee raised: the shortage of mental health officers. The Executive must examine that.

The bill is laudable. Despite concerns about certain points, I hope that it will command the Parliament's overwhelming support. However, the Executive must examine the resources that are needed to implement it. That includes the work-force resources that are needed.

On MHOs, we have suggested to the Executive that it should consider a form of fast tracking and how it will make MHOs available. Therefore, I am happy to take on board Richard Simpson's point about whether there is any way in which the same thing can be done for psychologists. Over the past week or so, the members of the Health and Community Care Committee have been in discussions with the Executive and the bill team on that issue. We have considered two different proposals. One of them is before members today in the form of amendment 736, in Shona Robison's name, which would insert "psychological intervention" into the list of treatments. That seems to be the easier option in terms of its impact on the rest of the bill.

The bill team tells us that another way might have been to change "medical treatment" to "treatment", with medical treatment and psychological intervention being part of the definition. That would have so many consequential impacts on the rest of the bill that it would not be a good thing to do at this stage, given the time constraints. Those time constraints do not affect Shona Robison's amendment 736. Therefore, we should go ahead with it, so that the bill reflects better the kind of services that are provided to individuals who have mental health disorders now and, I hope, even more so in future.

Mary Scanlon: I, too, support amendment 736. There may be a shortage of clinical psychologists in Scotland, but—my goodness—they got their act together in the final week. They are certainly all talking to one another.

To confirm that point, I have with me today letters that I have received from psychologists in Lanarkshire, Ayrshire and Arran, the Lothians, Argyll and Clyde, Grampian, the Borders, the state hospital at Carstairs, greater Glasgow, the University of Dundee, Gartnavel hospital and the Orchard clinic and from the British Psychological Society. There may be few clinical psychologists, but they have come to the debate. I am sorry that we received their letters late, because we could have done much to acknowledge psychology and to integrate it into the bill at previous stages.

I will make the point that Margaret Smith has just made. I quote from a letter from a psychologist in the Lothians:

"The major difficulty is that 'medical treatment' is used to cover all care for mental disorder. Within the area of mental health, medical treatments clearly differ from psychological therapies … In many areas of mental health, evidence-based research suggests psychological therapies to be as effective or more effective than medical treatment".

Too often, people came to the Health and Community Care Committee and said, "Nobody talks to me. All I get is some pills—more pills—and I just want to talk to someone." As a result, I have a lot of sympathy with the points that the psychologists make. The letter from which I just quoted goes on to talk about treatment for moderate depression, anxiety, personality disorder, and obsessive-compulsive disorder.

Another clinical psychologist from Argyll and Clyde talks about

"the applicability of psychological interventions like anger management, substance abuse therapy, sex offender treatment, cognitive behaviour therapy for psychosis, dialectical behaviour for borderline personality disorder".

A psychologist from the state hospital at Carstairs—which we have debated in the past—says:

"treatment plans now regularly include … 'Anger Management', 'Sex Offender Treatment', 'Cognitive Behaviour Therapy …' and 'Substance Abuse Therapy'."

My final point comes from the a clinical psychologist at the University of Dundee, who says:

"As the Bill stands now, I think that it will be unworkable and could lead to an ineffective and poor quality of service provision for patients"—

unless, of course, psychology and psychologists are given their rightful place in the treatment of patients.

Margaret Jamieson: I welcome amendment 736. It emphasises the changes that are taking place in treatment throughout Scotland. Treatment of mental disorder was once within the purview of one professional organisation, but the world of mental disorder and its treatment has changed significantly. It is right and proper that a group of professionals who provide a significant service in dealing with people who have many challenges, in particular behavioural challenges, should be recognised. Those with challenges need individuals with a clinical psychology qualification to work with them to ensure that they return to better health.

The point that Richard Simpson made about work-force issues was raised time and again during stage 1 and stage 2. We need to plan better for the national health service work force. That has never been done before. We must look to the future rather than just consider where we are now.

Richard Simpson made a point about the length of time that the training of clinical psychologists takes. We must address that. We should have limited facilities for individuals to practise while they undertake such training. The fact that the training takes seven years is an issue. That is not appropriate. It should be shortened, as medical training has been. We should allow qualified doctors who will go on to get a subsequent qualification in a particular field to practise and undertake the training. We should consider new ways to ensure that people get the appropriate

qualification to assist those who require their assistance.

Paul Martin: Not only should secure units be located in the correct areas, but the treatment that is provided in them should be effective. I support amendment 736 because psychological intervention is important. Last week, I met Dr Ramm of the Orchard clinic, to which Mary Scanlon referred, and discussed with him his concerns. It is important that we get the facilities right and ensure that the local communities embrace them, but it is also important that the treatment is correct and proper.

The case for psychological intervention has been well made. I commend the Health and Community Care Committee for allowing that to be developed. Although the psychologists have come to the debate late in the day, it is important that we consider their points. I ask the Executive to consider the amendment, which is serious, in that light.

Malcolm Chisholm: Amendment 736 would add "psychological intervention" to the definition of medical treatment in the bill. The amendment is not strictly necessary, because there is no real doubt that psychological therapies are included in the current definition, but we are happy to take the opportunity to put the matter beyond doubt by accepting the amendment.

I will say a couple of things on the subjects that have been raised. First, I stress that we fully expect that psychologists will play an important role in assessment, care planning and the delivery of care to people with mental disorders under the bill. The role of psychological therapies, such as cognitive behavioural therapy, in the care and treatment of mental illness and learning disability is increasingly recognised.

We have already emphasised the importance of psychological intervention in guidance to the field. More than a year ago, I was pleased to launch circular HDL(2001)75, "Framework for Mental Health Services in Scotland: (A) Psychological Interventions (B) Eating Disorders". Psychological therapy is an important new area—or rather, an increasingly important area—for mental health services. Members might wish to read the core service elements that are referred to in the document, which highlight some of the key themes of mental health policy. The document refers to the views of

"users of services (including advocates), carers of people with mental health problems, and partner agencies",

and emphasises strongly the importance of

"collaborative working with social work departments and voluntary organisations".

Members who are interested in the subject may wish to read another document, "Psychological Interventions Pilot Implementation Projects", which came out in April 2002. It is interesting to read some of the key issues in relation to mental health services that are highlighted in that report, such as the need to take a "whole systems" approach and to identify

"the different interfaces of the system (eg between Primary and Secondary Care … and Voluntary Sector providers) and improve communication and the person's journey across them."

That links up with some of the key themes of the recent white paper.

Dr Simpson: The minister is correct to draw attention to those papers, which are very important.

The minister has stated repeatedly his recognition of the fact that general practitioners undertake the vast preponderance of treatment of mental health conditions. The treatment of those conditions rarely proceeds to psychiatrists or clinical psychologists. I wonder whether the minister agrees that that situation gives rise to a number of problems that need to be addressed and that, although those problems go beyond the scope of the bill, they are fundamental to its implementation.

One of the problems is that there is no compulsory requirement on general practitioners to undertake psychiatric training as part of their postgraduate training. That means that a significant number of GPs undertake treatment on the basis of their undergraduate course alone. That is unsatisfactory.

A second problem is that, given the time constraints in general practice—the current consultation time is roughly seven or eight minutes per consultation—there are profound difficulties in undertaking treatments such as cognitive behavioural therapy. Adequate training for GPs will be vital to the implementation of the bill and to ensuring that psychological treatments play an appropriate part for the user. I also know that the minister is working on the implementation of the new general practitioner contract in Scotland. It will be vital to ensure that it makes it possible to implement in general practice the sort of quality treatment that users are entitled to, and that sufficient time will be allowed.

I hope that those remarks are helpful and that the minister will acknowledge the fact that the issue is broad and that considerable impetus from the Executive is necessary to maintain the work that has been done.

Malcolm Chisholm: I congratulate Richard Simpson on the two longest interventions of recent times. I also acknowledge that he made interesting and important points, to which there are several responses. In summary, I agree entirely with everything he said.

There has been development in a variety of forms. In its report, the primary care modernisation group flagged up mental health as a key area for development in primary care. In our recent work involving stakeholders, which will result in a letter being sent to the stakeholders next week, we have flagged up the increasing role of primary care and local health care co-operatives, in partnership with all the other agencies.

On Dr Simpson's earlier intervention, the other key area is the development of the work force. There are issues about the number of clinical psychologists. Although we have taken action to increase the number of clinical psychologists in training, I agree with Richard Simpson's more general point that the issue does not involve only clinical psychologists. As he said in his last intervention, a wide range of members of the work force—in particular the primary care team—can play an important role in mental health.

The mental health work force is the pathfinder group for our new work-force arrangements, which involve the work-force unit and new structural arrangements for work-force planning and development. The first piece of work on our new work-force planning arrangements will concentrate on the mental health work force. Part of that is about people performing new roles. I agree with Richard Simpson that GPs will want to—and, in many cases, will require to—develop their skills. I recognise that there are time issues. I am sure that Richard Simpson will agree with me about the vital contribution of practitioner nurses, for example, and of many other members of the primary care work force.

It has been useful to respond to the points that have been made. I reassure the psychologists and everyone else who has an interest in amendment 736 that we recognise the increasing importance of their work, not just for the people who are the main centre of attention in the bill, but far more broadly. Part of the new development in mental health policy is to ensure that appropriate services are provided to the thousands of people who suffer from what might be called milder and more moderate forms of mental distress, such as anxiety and depression, which are an enormous issue for the health service and the general population. Psychological interventions are crucial for that area, as well as for the severe and enduring mental illness that was the main focus of the original "Framework for Mental Health Services in Scotland" of six years ago.

In conclusion, I return to the wording of the bill. I ought to give my reasons for saying that amendment 736 is not strictly necessary. Although therapeutic interventions by a psychologist might not always be covered by the day-to-day use of the term "medical treatment", the term has a specialised meaning in the bill, because of section 228—it means "treatment for mental disorder". There is no reason to suppose that any psychological interventions that we would want to be included are not covered by the definition. However, we are aware that strong concerns have been expressed about the issue and it will not cause any problem to have "psychological intervention" stated explicitly in the bill.

Shona Robison: In the interest of brevity, I will say only that I am pleased that the Executive will accept amendment 736, which I press.

Amendment 736 agreed to.

Amendments 103, 737 and 738 moved—[Malcolm Chisholm]—and agreed to.

Section 228A—Supplementary provisions etc

Amendment 739 moved—[Malcolm Chisholm]—and agreed to.

Section 230—Transitional provisions etc

The Deputy Presiding Officer: Amendment 250 is grouped with amendment 272.

Malcolm Chisholm: Amendments 250 and 272 seek to make transitional amendments to the 1984 act in the light of a recent ruling by the European Court of Human Rights. The court found that the 1984 act was incompatible with the European convention on human rights because, in cases in which sheriffs were to decide whether to discharge a patient, the act did not provide that the burden of proof must be on the state rather than on the patient. In practice, that makes no difference in the vast majority of cases. Furthermore, the court's decision relates to a period prior to the commencement of the Human Rights Act 1998, which requires courts to read statutes—so far as it is possible to do so—in a manner that is compatible with the convention.

We are of the view that the flaw in the 1984 act that the Strasbourg court identified has already been remedied by the 1998 act. Nevertheless, in the light of the court's decision, we have lodged amendments that will remove all possible doubt and which will correct the position until such time as the 1984 act is replaced by the bill.

I move amendment 250.

Dr Simpson: My intervention will take the form of a question; it will be briefer than my previous interventions.

My slight concern is about the timetable for the bill's implementation, which is not particularly clear. I am not sure whether details of the Executive's proposed timetable were given to the Health and Community Care Committee, but I certainly have not read anything that states clearly

when it is intended that the various sections of the bill should be implemented. Section 230 allows ministers to make provisions for transitional arrangements. Can the minister give us an idea of how the bill is likely to be implemented? I realise that he may be able to speak only in broad terms at the moment, but can he at least give us a clue as to how long the transitional arrangements might need to apply?

Malcolm Chisholm: As Richard Simpson indicated, the bill does not require to be implemented in one go. However, we intend to start implementing it next year, in 2004.

Amendment 250 agreed to.

Section 231—Short title and commencement

Amendment 740 moved—[Mary Scanlon]—and agreed to.

Amendments 11 and 12 moved—[Malcolm Chisholm]—and agreed to.

Amendment 741 moved—[Mary Scanlon]—and agreed to.

Schedule 2

THE MENTAL HEALTH TRIBUNAL FOR SCOTLAND

The Deputy Presiding Officer: Amendment 104 is grouped with amendment 68.

Malcolm Chisholm: Amendment 104 will amend the criteria for appointing the third member of the tribunal. We intend that the third member should have a background in mental health, but there could be several types of relevant background, including a background as a professional, a carer or a service user. The amendment will add "skills" to the matters that can be taken into account in deciding whether an existing tribunal member is entitled to remain in post on the expiry of his or her term of office. If he or she does not possess the skills that are prescribed for original appointment, any reappointment will be discretionary rather than mandatory.

Amendment 68 is a technical amendment to clarify the position on the make-up of the tribunal when it makes decisions. The basic rule is as set out in paragraphs 6(2A) and 6(2B), which require that the tribunal consist of three members and be chaired by a legal member or the president or, in respect of restricted patients, a sheriff. However, some preliminary or urgent matters might be best dealt with by, for example, a legal member acting alone. Examples might include a decision about appointing a curator ad litem or a decision to authorise an urgent patient transfer pending an appeal. Amendment 68 provides for rules that can make exceptions to the normal composition of the tribunal in such situations.

I move amendment 104.

Amendment 104 agreed to.

Amendment 68 moved—[Malcolm Chisholm]—and agreed to.

After schedule 2

Amendment 251 moved—[Malcolm Chisholm]—and agreed to.

Schedule 3

MINOR AND CONSEQUENTIAL AMENDMENTS

Amendments 252 to 260 moved—[Malcolm Chisholm]—and agreed to.

The Deputy Presiding Officer: Amendment 742 is grouped with amendments 743 to 748, 750, 105, 751, 13, 752 and 753.

Malcolm Chisholm: As the title of the group makes clear, the amendments in this group concern minor and consequential amendments and repeals.

I move amendment 742.

Amendment 742 agreed to.

Amendments 261, 262, 743, 263, 744 to 748 and 264 moved—[Malcolm Chisholm]—and agreed to.

The Deputy Presiding Officer: Amendment 749 stands in a group of its own.

Malcolm Chisholm: Amendment 749 implements policy concerning the making of hospital directions.

A hospital direction is a mental health disposal that allows the sentencing court, in addition to imposing a prison sentence, to direct that a person be detained in hospital to receive treatment for a mental disorder. The patient can then be transferred to prison once their mental disorder no longer requires treatment in a hospital setting. Amendment 749 will bring the provisions on hospital directions in the Criminal Procedure (Scotland) Act 1995 into line with the rest of the bill.

I move amendment 749.

Amendment 749 agreed to.

Amendments 750, 105, 265, 751, 266, 267, 13 and 268 to 271 moved—[Malcolm Chisholm]—and agreed to.

Schedule 4

REPEALS AND REVOCATIONS

Amendments 752 and 753 moved—[Malcolm Chisholm]—and agreed to.

After schedule 4

Amendment 272 moved—[Malcolm Chisholm]—and agreed to.

The Deputy Presiding Officer: That ends consideration of amendments.

Point of Order

11:56

The Deputy Presiding Officer (Mr George Reid): We are ahead of time, so I propose to suspend this meeting of Parliament.

Dennis Canavan (Falkirk West): On a point of order, Presiding Officer. We are more than three hours ahead of the timetable for the bill, which leaves some time spare for our Parliament to debate another matter of an important nature. So far, at least six members of the Parliament have signed a motion that states that the Parliament condemns the commencement of war against Iraq and calls for an immediate cessation of hostilities with a view to recommencing efforts to find a peaceful solution. In view of the fact that we have time to spare, may we have a debate on that important matter?

The Deputy Presiding Officer: The Parliament took a view on the issue yesterday. I stand by that view.

Tommy Sheridan (Glasgow) (SSP): Further to that point of order, Presiding Officer. Yesterday, hostilities had not commenced. There is nothing that is more of an emergency than the commencement of war. Now that war has commenced, and particularly given the time that is left, surely we should have an emergency debate on the whole situation so that the Parliament's views can be heard.

The Deputy Presiding Officer: I hear what you say, Mr Sheridan. The situation is very serious, but I regard the matter as being primarily for the consideration of the Parliamentary Bureau, to which your views will be passed.

Dennis Canavan: Will you pass on our concerns to the Presiding Officer?

The Deputy Presiding Officer: I shall do so.

11:57

Meeting suspended until 14:30.

14:30

On resuming—

Presiding Officer's Ruling

The Presiding Officer (Sir David Steel): Before we begin this afternoon's proceedings, I invite members to give a welcome to Mr Speaker Ssekandi and colleagues from the Parliament of Uganda. [*Applause*.] Also before we begin, I have a short statement to make, following the point of order that Pauline McNeill raised last night.

I remind members of rule 7.3.1 of our standing orders:

"Members shall at all times conduct themselves in a courteous and respectful manner".

Those rules were adopted by the Parliament to protect the orderly working of our democratic Assembly. Similarly, I believe that people who come to our public galleries are entitled to listen to our proceedings in peace, without disruption from other people alongside them. The right to peaceful protest is a basic civil right, but anything that undermines the orderly working of any elected Parliament constitutes a disrespect for that Parliament, and is a threat to civil rights and to democracy itself. [*Applause*.]

Point of Order

14:31

Tommy Sheridan (Glasgow) (SSP): On a point of order, Presiding Officer.

The Presiding Officer (Sir David Steel): I hope that it is a real point of order.

Tommy Sheridan: I have already alerted your office to this point of order, Presiding Officer. A serious and grave statement is being made in Westminster today, which has implications for this Parliament. Have you had notice that there will be an Executive statement on whether it, too, wishes to impose a settlement on the firefighters of this country? Will the Executive undemocratically remove the right of trade unionists to take industrial action?

The Presiding Officer: The answer is no, I have not had a request for such a statement but, with great perspicacity on my part, I selected question 4 to the First Minister, and the member's question will be in order at First Minister's question time.

Tricia Marwick (Mid Scotland and Fife) (SNP): On a point of order.

The Presiding Officer: Is it the same point of order?

Tricia Marwick: It is further to the point of order. I concur with Tommy Sheridan that the matter to which he referred is an extremely important one for the Parliament. I seek your guidance on whether the Executive has given you any indication that a Sewel motion will be lodged and debated in the Parliament next week, or that the Executive intends to make a statement this afternoon on whether legislation will be introduced in Scotland.

The Presiding Officer: With great respect to the member, I have already answered that. Question 4 at First Minister's question time is on that matter, which is a question for the Executive, not for me. Members can ask that question when we reach First Minister's question time.

Question Time

SCOTTISH EXECUTIVE

14:32

Fallen Stock (Disposal)

1. David Mundell (South of Scotland) (Con): To ask the Scottish Executive what progress has been made in developing a national disposal scheme for fallen stock. (S1O-6679)

The Minister for Environment and Rural Development (Ross Finnie): Proposals for a UK-wide fallen stock scheme are under active consideration. We are working closely with the Department for Environment, Food and Rural Affairs and the other devolved Administrations to devise an acceptable national scheme, which must involve producers meeting some of the associated costs. The National Farmers Union of Scotland will be consulted on a draft scheme as soon as possible.

David Mundell: I find that to be an extremely disappointing response, given that the restrictions on burial will be introduced in a few weeks' time. With only weeks to go before the regulations are implemented, is not it wholly unacceptable for farmers across Scotland not to know what the scheme will involve, not to know what the distribution arrangements will be and, most important, not to know how much it will cost them?

Ross Finnie: I have made my frustration clear in a number of other places. I have consistently made it clear that the most sensible arrangement would be to build on the transmissible spongiform encephalopathy uplift scheme. There are two elements to that, one of which is the testing regime. About 33 per cent of the total casualties that we expect are represented by bovines. The sensible way to get value for money is not to have a separate scheme, but to uplift bovines under that scheme. That has been my consistent position.

I regret that it has taken so long for us to get the agreement that I hope to get on a national scheme but, in the long run, that will provide better value for money. Because it embraces the first scheme, it will involve a much reduced level of charge than would otherwise have been the case if we had tried to do it separately.

Mr Jamie Stone (Caithness, Sutherland and Easter Ross) (LD): At a recent joint meeting of Caithness and Sutherland NFUS, this issue was raised with me. It is of enormous concern to our farmers and crofters. Will the minister give me two undertakings? First, will he undertake to allow the maximum input from our crofters and farmers on the draft map that has already been published? Secondly, will he consider the difficulties of geography and remoteness that hugely affect my constituency? If this regulation goes through in its present, untrammelled form, it could be deeply damaging to agriculture in the far north.

Ross Finnie: I am slightly puzzled by the nature of that response, given that, yesterday, we published a document showing the substantial amount of Scotland—including the north, the north-west and the northern part of Argyll—for which the Executive has negotiated a derogation from the requirement to apply the European regulation. I hope that, when he studies that consultation document, the member will understand that the matter is being consulted on and that a substantial derogation is being offered to remote and rural areas for which the imposition of the regulation would be difficult, as he says.

Christine Grahame (South of Scotland) (SNP): This issue has been raised with me by a farmer who has 130 ewes who says that, during the coming months, he anticipates a 10 per cent loss of ewes as well as some lambs. As the minister knows, in April that farmer will be left with no option, as he will not be able to bury them. I support the cross-party calls for as much consultation as possible, as soon as possible, so that the issue can be resolved before the end of April, when that farmer will no longer be allowed to bury dead animals on his land.

Ross Finnie: I appreciate what the member says. I have had several discussions on this matter with the NFUS in the Borders and in the north of Scotland, which is, perhaps, more affected by the measure.

I am cognisant of what the member says. I can only repeat what I said in response to David Mundell: in my opinion, far and away the best way of resolving this matter is through a national scheme that builds on the present TSE uplift regulations. We cannot in any way impose on the integrity of the BSE testing, but we have a separate collection scheme that accounts for a third of present animals. It does not make sense to start a fresh scheme that involves people uplifting bovines on one farm and uplifting sheep on the next door farm.

I hope that the member agrees with me that that is the sensible way in which to proceed. I assure her that I am doing everything that I can to ensure that that will be implemented as quickly as possible.

Dorothy-Grace Elder (Glasgow) (Ind): On a point of order, Presiding Officer. You were obviously calling members who represent rural constituencies and regions to ask questions on this matter, Presiding Officer, but some of us in

Glasgow have an intense interest in fallen stock because that is where fallen stock is being incinerated.

The Presiding Officer (Sir David Steel): That is not a point of order. Whom I call or do not call is a matter on which I exercise my discretion as carefully as I can.

E-health

2. Maureen Macmillan (Highlands and Islands) (Lab): To ask the Scottish Executive whether it will give details of its e-health plan. (S1O-6684)

The Minister for Health and Community Care (Malcolm Chisholm): The main elements of the e-health plan are set out in the "Partnership for Care" report and we have subsequently announced a doubling of funding for e-health over the next three years. The driving force is the urgent need for an e-health culture led by clinicians and one of the key objectives is the development of an integrated care record jointly managed by the patient and NHS staff.

Maureen Macmillan: I am aware that e-health initiatives are already being used in some parts of the Highlands and Islands. How will e-health improve the delivery of health services in remote and rural areas?

Malcolm Chisholm: Over the past year, I have seen several good examples of e-health in action in Maureen Macmillan's far-flung region. For example, in Fort William I saw the communication between general practitioners and hospitals with regard to appointments and discharge levels and in Shetland and the more remote bits of Argyll and Clyde, I have seen the transmission of clinical images, such as X-rays and ultrasound scans, over long distances.

Remote and rural areas are already enjoying advantages because of e-health, but they will also benefit from further, more general, advantages, three of which I flagged up in my previous answer. Those advantages are first, the increase in investment; secondly, the leadership of clinicians, which is a new and emphatic feature; and thirdly, the development of an integrated care effort, which is absolutely fundamental to the more integrated health service that is outlined in the white paper and which we are determined to create.

Mental Health (Elderly People)

3. Mr Adam Ingram (South of Scotland) (SNP): To ask the Scottish Executive what action it is taking to ensure that elderly people with mental health problems receive the care and support that they require. (S1O-6658)

The Deputy Minister for Health and Community Care (Mrs Mary Mulligan): "Partnership for Care" continues our focus on prevention, early detection and prompt access to seamless support for all care groups, including older people. Local progress is monitored through the performance assessment framework and by the visiting mental health and well-being support group.

Mr Ingram: Is the minister aware of reports that people who are suffering from dementia are being disadvantaged in respect of finding care home places and that people are losing care home places in parts of the country such as South Ayrshire. Will she consider introducing supplementary funding to cover the extra costs that care homes incur in caring for people with dementia? I believe that that happens in England and Wales.

Mrs Mulligan: I am aware that a number of authorities, including South Ayrshire, are having further discussions about the provision of care home places. We hope that those discussions will come to a successful conclusion fairly soon. In recognising the additional needs of those who suffer from dementia, we take every action possible to ensure that places at care homes are provided locally for those who need them.

Phil Gallie (South of Scotland) (Con): With reference to the Scottish Executive's "The same as you?" document, what thought has the minister given to institutional care and what progress has been made in that regard? What flexibility do ministers have, particularly with respect to withdrawing some of the stated intents for closure? I am thinking of the excellent Arrol Park development in Ayr.

Mrs Mulligan: My understanding is that that place does not seek to offer services for those who suffer from dementia. However, the Executive is taking forward the "The same as you?" document to ensure that individuals are given the adequate provision that they need in the community. I think that the majority of those people want to be part of their communities. With the support that we can offer through the various departments across the Executive, we can ensure that those people get the satisfactory support that they need.

Mr John McAllion (Dundee East) (Lab): Is the minister aware that the recently announced review of adult mental health services in Tayside proposes the closure of acute beds in Angus and Perth and the concentration of services at the Carseview hospital in Dundee, which is a public-private partnership hospital that is run for profit by the private sector on a 25-year lease? Given that Carseview was built to service Dundee, what reassurance can the minister give that the needs

of elderly people and of all other groups with mental health problems in Tayside will come before the need for profit of the PPP that runs Carseview?

Mrs Mulligan: The fact that we have spent the past two days debating mental health provision shows the Executive's commitment to ensuring that all people are offered the service that they need. I have to be honest and say that I am not aware of the case to which Mr McAllion referred. I believe, however, that people accept the provision of modern, up-to-date facilities to provide for their needs. Whether that provision is by PPP is probably not their first concern.

Anti-social Behaviour (Community Wardens)

4. Sarah Boyack (Edinburgh Central) (Lab): To ask the Scottish Executive how initiatives such as community warden schemes can help to tackle anti-social behaviour. (S1O-6687)

The Minister for Social Justice (Ms Margaret Curran): Community warden schemes provide a visible presence on the streets to reassure residents and work with other agencies to tackle anti-social behaviour. Last week, I launched the consultation document "Building Strong, Safe and Attractive Communities", which sets out how warden schemes and other grassroots initiatives can create a "no tolerance" culture for anti-social behaviour in all Scotland's communities.

Sarah Boyack: I have heard that the Tories are against the community warden scheme. However, in my constituency, in areas such as Saughton Mains, residents are desperate for support and action on anti-social behaviour. Will the minister outline how she sees community wardens working in partnership with the police to tackle anti-social behaviour?

Ms Curran: If the Tories are against the scheme, that would prove yet again that they go against the wishes of local communities. I will be kind to them and say that I assume their opposition to be based on a misunderstanding of the scheme. When the warden scheme was introduced in England, there were initial reservations about whether policing should be in place instead of wardens. However, that view is now largely corrected by all involved. People understand that the warden scheme is complementary to police activities—it allows the police to get on with their core duty of dealing with crime while the wardens tackle other issues such as graffiti, act as professional witnesses and so forth. That is why the First Minister had the support of Strathclyde police when he launched the scheme and why I had the support of Lothian and Borders police when I recently visited Broomhouse. I think that I will listen to the police rather than the Tories on this matter.

Lord James Douglas-Hamilton (Lothians) (Con): Does the minister accept that, although we believe that wardens can play a valuable role in an appropriate context, there is still an overwhelming need for far more high-visibility policing in certain areas?

Ms Curran: I absolutely agree that we also need more high-visibility policing. This is not an either/or matter. We need both wardens and policing. I am sure that the member will join me in congratulating this Executive on providing record numbers of police officers on the streets.

Health Funding

5. Mary Scanlon (Highlands and Islands) (Con): To ask the Scottish Executive whether funding under the Arbuthnott formula is being used to address poverty, deprivation and access to national health service care and treatment. (S1O-6664)

The Minister for Health and Community Care (Malcolm Chisholm): The record growth in health funding is distributed through the Arbuthnott formula to ensure that all areas of Scotland benefit, especially areas of deprivation and remote and rural areas.

Mary Scanlon: In recent weeks, it has become apparent that additional moneys received by Highland NHS Board have been used to pay off its end-of-year financial deficit. How will the minister monitor spending that is allocated through the Arbuthnott formula, and what will he do in future when health trusts use the money for purposes other than those intended?

Malcolm Chisholm: Mary Scanlon knows that the way to monitor the situation is through the performance assessment framework, of which targeting money at health inequalities is a key objective. It is also a critical objective of the health improvement challenge, which we launched on Monday. For the first time, we are developing indicators that will allow us to measure health inequalities and ensure that we close those gaps between the richest and poorest communities. Furthermore, health boards are required, for the first time, to implement health and homelessness action plans. As a result, Mary Scanlon can be assured that health boards are doing more than they have in the past about poverty and inequality. That said, I accept that there is more to do. That fundamental intention underlies all the health improvement work that we launched on Monday.

Paul Martin (Glasgow Springburn) (Lab): Does the minister share my concern that funding is not being made available to deal with some of the serious health issues in Glasgow Springburn? For example, statistics show that lung cancer is 93 per cent above the Scottish average and that there

is also a serious problem with heart disease. Will he give a commitment that Glasgow Springburn will receive additional funding to deal with those problems?

Malcolm Chisholm: Although Glasgow has benefited from the Arbuthnott formula, I certainly recognise that city's particular health needs. Indeed, the health board in question will have to deal with such issues in the way that it spends its money.

Paul Martin mentioned both heart disease and cancer. Notwithstanding some difficulties, which I am always prepared to admit, I think that we should all recognise that considerable progress has been made on the cancer strategy over the past year. Indeed, that was acknowledged at question time last Thursday when we discussed the "Scotland against cancer" conference. Furthermore, we have introduced a major new heart disease initiative. Glasgow, among others, will benefit from the extra investment in that respect and from the new way of delivering care through the formation of managed clinical networks for coronary heart disease in every board area.

Richard Lochhead (North-East Scotland) (SNP): The minister is aware that the Arbuthnott formula leaves Grampian at a severe disadvantage, as the area receives the lowest level of funding in Scotland despite having some of the country's longest waiting times. Is he prepared to address that?

I also turn the minister's attention to the views of Grampian general practitioners, who claim that the new GP funding formula will leave them with a 15 per cent pay cut. Will he confirm to the chamber that he will not accept any new funding formula for GPs under the proposed new contracts that will mean that they will receive less funding instead of the expected increase?

Malcolm Chisholm: That question raises two major issues. I realise that I have answered the question about Arbuthnott before; however, perhaps I should put the matter in another way. In the last year before the Arbuthnott formula was implemented, Grampian received an increase of 5.5 per cent. This April, under Arbuthnott, Grampian will receive an increase of 7.4 per cent. I accept that the increase is not quite as large as that in Glasgow. However, Richard Lochhead will have heard Paul Martin's comments about Glasgow's particular needs, with which I entirely agree. We have to keep the matter in perspective. Is Richard Lochhead really saying that he wants Grampian to get exactly the same funding per head as Glasgow? More fundamentally, does the SNP health spokesperson feel the same way?

On the second point, there are still issues to be resolved around the GP contract, but there has been a lot of misinformation about that. Only about 60 per cent of the money is distributed under the formula. It may be that it appears that there are losses there. However, they will be made up for—and in most cases more than made up for—by all the other new parts of the contract, such as the quality payments, which are an important feature of the new contract in relation to the modernisation and the improvement of services.

Joint Future Agenda

6. Mrs Margaret Smith (Edinburgh West) (LD): To ask the Scottish Executive what progress is being made in taking forward the joint future agenda. (S1O-6677)

The Deputy Minister for Health and Community Care (Mr Frank McAveety): We are making good progress on the joint future agenda. Nationally, we have set up a new partnership of the Executive, the Convention of Scottish Local Authorities and NHS Scotland to oversee implementation and development of the policy. We are working towards joint resourcing and joint meetings for older people's services to improve the quality of community care and support services for Scotland's older people.

Mrs Smith: Will the minister tell me what plans the Scottish Executive has to research professional dilemmas and decision-making issues arising from the implementation of the single shared assessment?

Mr McAveety: We have in our implementation group a series of professional interests, such as those representing staff and trade unions, from those who are involved in the delivery of the service to those who plan the service. We believe that through the group there is the capacity to address the concerns that have been highlighted recently by the Royal College of Nursing, for example, to try to ensure that we have a partnership approach. The real target is improving the service for Scotland's older people. As I travel around the country, I find that people are interested in hearing how we can remove the barriers to service delivery to ensure that there is a seamless approach for the individual and maximum opportunity. We are using public resources effectively to deliver a genuine difference for people who need those community care services.

School Buildings

7. Susan Deacon (Edinburgh East and Musselburgh) (Lab): To ask the Scottish Executive what plans it has to further improve school buildings and ensure that pupils have a modern learning environment. (S1O-6688)

The Minister for Education and Young People (Cathy Jamieson): On 19 March, I announced financial support to local authorities for further investment in school buildings through public-private partnerships, with a total capital value of almost £750 million. That is in addition to the £1.2 billion announced in June 2002 and the additional £110 million over three years made available through the schools fund.

Susan Deacon: I warmly welcome the minister's announcement this week. Does she agree that investment in Edinburgh schools' infrastructure is vital to support the capital's economic prosperity, particularly in the light of continued population growth? Does she agree that the £180 million investment announced for Edinburgh this week will provide an unparalleled opportunity to rebuild schools such as Portobello High School, which is the largest secondary school in Edinburgh, so that the learning environment is fit for purpose and fit for the future?

Cathy Jamieson: That was a fairly long question, so I am tempted to give a very short answer: yes, absolutely.

Irene McGugan (North-East Scotland) (SNP): Does the minister agree that children in Roman Catholic schools also deserve to receive their education in new and refurbished premises? If so, why has the Scottish Executive reneged on assurances of additional funding for a new Roman Catholic school in Dundee via the PPP allocation? Is it acceptable that most of the extra £20 million that is needed will now have to be found from Dundee City Council's over-stretched resources?

Cathy Jamieson: My support for the provision of Roman Catholic education has been stated in this chamber on a number of occasions. It is simply not true that the Executive has somehow reneged on a commitment, as Irene McGugan suggests. Dundee City Council has received an allocation under the PPP projects. It has the opportunity within that financial allocation to decide what it does locally. The local member, Kate Maclean, has been active, along with the leader of the council, Julie Sturrock, in coming to a solution to the problem. I have confidence that the council will deliver what is best locally.

Mr Keith Raffan (Mid Scotland and Fife) (LD): Will the minister assure us that in the school improvement programme she will give priority to split-site schools with 1950s classroom huts in their playgrounds, such as Bell Baxter High School in Cupar, and to schools whose rolls are bigger than what they were built for, such as Kinross High School?

Cathy Jamieson: Of course the member knows that I visited Bell Baxter High School at an early stage in my ministerial career. It is for the local authority to prioritise. I am aware of the situation with that school and others that are on split sites. I repeat that it is a matter for the local authority to ensure that they prioritise, dealing first with the worst cases. The circumstances that prevail in some of our schools are simply not acceptable learning environments.

Robin Harper (Lothians) (Green): I hope that the minister will have time to read the environmental statement that is being prepared at Portobello High School. Is she prepared to press the Executive to audit urgently the environmental standards of all public buildings that have been completed to date under private finance initiative and public-private partnership agreements? Will she also urge the Executive to issue updated planning guidance that is designed to ensure maximum environmental standards in the interests of pupils, staff, health, learning and long-term energy savings that could put millions of pounds back into our educational system?

Cathy Jamieson: Again, this matter has been raised on several occasions. During the preparation of a school estate strategy, we made it clear that we want environmental considerations and sustainability to be a key feature. We want schools that have top quality design, that are fit for purpose, and that take these factors into account. Robin Harper and many others in the chamber have made representations on this matter, and local authorities will consider those in preparing their business cases and plans.

Dr Sylvia Jackson (Stirling) (Lab): The £60 million school investment recently announced for the Stirling area was warmly welcomed. Does the minister agree that the funds that have been included for the Raploch campus school and their use within an urban regeneration company for regenerating the whole area will be a model for the rest of Scotland?

Cathy Jamieson: I am aware of the work that is being done in the Stirling area. It is very innovative and gives a good example of joined-up working that other areas will want to take on board.

The Presiding Officer: Question 8 has been withdrawn.

Red Squirrels (Parapox Virus)

9. Alex Johnstone (North-East Scotland) (Con): To ask the Scottish Executive what immediate action it will take to prevent the spread of the parapox virus from the identified outbreak in Sefton, Merseyside, into the Scottish red squirrel population. (S1O-6654)

The Deputy Minister for Environment and Rural Development (Allan Wilson): I am aware of the discovery earlier this month of the outbreak of parapox virus in the Merseyside population of

red squirrels. Initial assessment by the University of Liverpool indicates that that is a local problem. The Scottish Executive, Scottish Natural Heritage and those institutions undertaking research into the virus will monitor the situation and advise me if there is any indication that Scottish squirrels are at risk. For a number of years the Scottish Executive has been funding the Moredun Research Institute to research parapox viruses. One of the aims of this research is to develop a vaccine against squirrel parapox virus.

Alex Johnstone: I thank the minister for his detailed answer and I shall ask two brief follow-up questions. First, I am interested to know what action the minister is likely to take to ensure that all Scottish red squirrels are ultimately vaccinated against the disease. Secondly, and more seriously, will he acknowledge that, if the disease becomes more common in the remaining populations of red squirrels in England, the Scottish population will become significantly more important for the survival of the species in the longer term? Given the Parliament's record on protecting some of the less desirable members of our wildlife community, will he acknowledge that the squirrels deserve our support?

Allan Wilson: I recognise the member's long-standing interest in Scottish squirrels. Current information indicates no serious threat to Scottish red squirrels, as members will be pleased to learn. The early indications are that the Merseyside outbreak appears to be confined to a relatively isolated population of red squirrels in a remote area of the Merseyside coast. I suspect that, as long as Celtic supporters do not bring back any grey squirrels from what I hope will be their successful night at Anfield, Scotland's red squirrel population will be safe for the foreseeable future.

John Young (West of Scotland) (Con): The minister may not be aware that the cross-party animal welfare group was last night discussing the health of hedgehogs, particularly those that are to be transported. Does he think that the convener and members of the cross-party group should put red squirrels on their next agenda?

Allan Wilson: As I said, I do not believe that the Scottish red squirrel population is currently at risk from the parapox virus. However, a serious point should be made. Transporting animals of any species is not a good thing in the hedgehog context. [*Laughter.*] People who move wild animals away from their natural habitat may be well-meaning and motivated, but they do the animals no favours.

Universities (Meetings)

10. Mr Brian Monteith (Mid Scotland and Fife) (Con): To ask the Scottish Executive when it will next meet representatives of universities. (S1O-6686)

The Minister for Enterprise, Transport and Lifelong Learning (Iain Gray): Ministers and officials meet regularly with representatives of higher education institutions to discuss matters of interest. Subject to the outcome of the election, the next scheduled ministerial meeting with key stakeholders is due to take place in June this year.

Mr Monteith: Recently, the Prime Minister said:

"people should go to university based on their merit whatever their class background".—[*Official Report*, *House of Commons*; 26 Feb 2003; Vol 400, c 257.]

Does the minister agree? When he next meets representatives of the universities, will he tell them—if he is the minister at the time—that they should not introduce an admissions policy that subverts that principle?

Iain Gray: HE institutions in Scotland are clear that widening access is a key priority. The approach here is different from that in England. There is 50 per cent participation in higher education in Scotland. Widening access is our key priority. Although admissions policy is a matter for the individual institution and should be transparent and should not compromise academic standards, the universities understand that we believe that there is merit in considering wider issues than simply exam results and in considering factors that have a good correlation with the potential for achieving success and excellence at university.

Andrew Wilson (Central Scotland) (SNP): Is the minister aware of the growing anxiety of university leaders in Scotland about the Executive's ability to respond to their growing funding crisis? Unlike the minister's colleagues, those people do not blame him for the system, but blame the system itself and the constraints that are placed on it by the Scottish Parliament and the Executive's outdated mode of funding. How can it make sense that, if the rest of the United Kingdom becomes more dependent on top-up fees and private funding for higher education, the Parliament and the Executive will lose out financially through the functioning of the arcane Barnett formula? Will the minister open his mind to the reality that if we have independent policy control, we should also have independent control of finances?

Iain Gray: Mr Wilson is never one to let the facts get in the way of a good story. In Scotland, we fund higher education at a level that is 20 per cent higher per head of population than in England. Wales aspires to our level of funding of higher education. Our set-up serves higher education and Scotland's young people well.

Brian Fitzpatrick (Strathkelvin and Bearsden) (Lab): We know that the minister will be part of a ministerial team after the forthcoming elections. [*Interruption.*]

The Presiding Officer: Let us just have a question.

Brian Fitzpatrick: If I could get the opportunity—

The Presiding Officer: Let us just have a question without a prelude.

Brian Fitzpatrick: I would ask a question if I had the opportunity to do so. [*Interruption.*]

The Presiding Officer: The member should proceed with the question. [*Interruption.*] Order.

Brian Fitzpatrick: I am obliged, Presiding Officer. When the minister meets university representatives, will he ensure that representatives of student bodies—and the National Union of Students Scotland in particular—will be included in discussions when decisions are to be made?

Iain Gray: I have had discussions with NUS Scotland in the past couple of hours. I gave it an absolute assurance that when we come to the third phase of our higher education review, which will consider the implications of the changes in funding in England and how we will respond to them in Scotland, it will be included.

Planning Guidelines (Opencast Mines and Landfill)

11. Fiona Hyslop (Lothians) (SNP): To ask the Scottish Executive whether it has any plans to alter planning guidelines for local authorities on opencast mining and landfill. (S1O-6681)

The Deputy Minister for Social Justice (Des McNulty): Research is under way on the operation and effectiveness of current guidance on opencast coal. The researchers are expected to report in the autumn, when a decision will be taken on whether the guidance should be reviewed. Separate planning guidance exists for waste management facilities. There are no immediate plans to amend the waste management guidance.

Fiona Hyslop: I am somewhat disappointed that a decision will not be taken as to whether there should be change. Will the minister give an assurance that the review of national planning policy guideline 16—NPPG 16—will ensure that all the potentially damaging applications in an area and not just other opencast operations will be considered? That will mean that all applications will be assessed—not just the opencast ones—in villages such as Fauldhouse in West Lothian, where there are multiple landfill and opencast applications.

Des McNulty: I am aware of the issues in Fauldhouse, which the constituency MSP, Mary Mulligan, in particular has drawn to my attention.

Even under the present arrangements, when reaching decisions on individual applications, planning authorities should take into account the cumulative effect of a number of developments that can exacerbate the impact on local communities. That is covered in NPPG 16. However, the research that is under way will consider whether that guideline is robust enough to meet the desired objective of adequately protecting communities and the environment from the unacceptable adverse consequences of opencasting.

It is proposed that the full range of guidance that is incorporated in NPPG 16 will be assessed, including the issue of cumulative impacts. The researchers will formulate a view on whether any aspects of the guidance need to be reviewed. We await their recommendations, but I am sure that once we have them we will consider all the issues and act on them.

Karen Whitefield (Airdrie and Shotts) (Lab): Does the minister agree that it is essential that as part of any review of planning legislation we ensure that we create a greater opportunity for communities to influence those planning decisions that affect them?

Des McNulty: Karen Whitefield has made an important point. There are issues in the present planning system to do with a community's capacity to influence the decision-making process. In the near future, we will consider consulting people about how local communities and individuals can involve themselves in the planning process.

Renewable Energy (Zonal Charges)

12. Tavish Scott (Shetland) (LD): To ask the Scottish Executive what discussions it has had with the Office of Gas and Electricity Markets and Her Majesty's Government about the impact of proposed zonal charges for transmission losses on the promotion of renewable energy generation. (S1O-6680)

The Minister for Environment and Rural Development (Ross Finnie): We have worked closely with Ofgem and the Department of Trade and Industry to ensure that the new British electricity trading and transmission arrangements will work for the benefit of Scottish consumers and generators of electricity in Scotland. We are looking very carefully at the Ofgem proposals for transmission and will ensure that the Scottish interest is heard. It is of the utmost importance that the production of renewable energy in the remoter and less-populated areas remains viable.

Tavish Scott: Most of Scotland's renewable energy potential is in coastal and island areas, such as my own constituency of Shetland. Does the minister accept that there is a need to ensure

that the cost of installing or upgrading large capacity grid connections for those areas neither stops such developments nor hits domestic or business consumers disproportionately hard?

Ross Finnie: I accept that. As the member will be aware, an integral part of the BETTA arrangements is that if improvements are made as they were originally consulted on, transmission costs and the cost of grid upgrades will be borne equitably by the whole population. It is important for the Scottish Executive to work hand in hand with the DTI to ensure that Ofgem proposals are implemented in a way that will be highly beneficial to the member's constituency.

The Presiding Officer: I will add three minutes' injury time to question time and First Minister's question time.

A76 (Sanquhar to Kirkconnel)

13. Alasdair Morgan (Galloway and Upper Nithsdale) (SNP): To ask the Scottish Executive what steps it will take to deal with traffic issues on the A76 between Sanquhar and Kirkconnel. (S1O-6698)

The Deputy Minister for Enterprise, Transport and Lifelong Learning (Lewis Macdonald): Earlier today I announced that we will address traffic issues on the A76 by building a climbing lane at Glenairlie, south of Sanquhar. The previous proposal to realign the road at Gateside, north of Sanquhar, will not now proceed.

Alasdair Morgan: The minister will know that improving the road south of Sanquhar does not deal with issues north of Sanquhar, between Sanquhar and Kirkconnel. Given that that is an accident black spot—there have been several accidents there recently—is the minister saying that we must simply put up with the situation? Is he saying that it is beyond the wit of man—or of the Executive—to deal with it? Will he undertake to consider the matter again?

Lewis Macdonald: I am not saying either of the things that Alasdair Morgan suggested. On the contrary, the scheme at Glenairlie that I have announced today is the option that we have chosen to address problems of traffic delays on the A76. I recognise that there are problems on the north side of Sanquhar, to which the member referred. The scheme at Gateside has been abandoned because of a failure to agree with local farmers and landowners on access. That is to be regretted, but we are continuing to consider other options for convoy busting, to reduce the backlog of vehicles behind slow-moving vehicles on the stretch of road between Sanquhar and Kirkconnel.

Alex Fergusson (South of Scotland) (Con): The minister will be aware of correspondence between us on the prioritisation of improvements to the A76, the most recent of which has resulted in what is essentially a long smart new pavement with a green stripe where the A76 enters Dumfries. Does he agree that the considerable amount of money that has been spent on what is an entirely cosmetic improvement would have been far better spent on alterations that would improve safety on what is, as Alasdair Morgan pointed out, an unsafe road? Does the minister agree that he should urgently revisit the prioritisation of such investment, as I have asked him to do before?

Lewis Macdonald: I do not agree that the measures that we have taken to improve visibility on the A76 are in any way cosmetic or beside the point. On the contrary, they are part of a strategy for addressing safety issues on the road—the Glenairlie scheme that we announced today is also part of that strategy. We will continue to use that approach for that route.

Scottish Environment Protection Agency (Meetings)

14. Iain Smith (North-East Fife) (LD): To ask the Scottish Executive when it last met the Scottish Environment Protection Agency and what matters were discussed. (S1O-6694)

The Minister for Environment and Rural Development (Ross Finnie): My last engagement with the Scottish Environment Protection Agency was on 24 February to announce the launch of the national waste plan. My officials are in daily contact with the agency on a range of issues relating to the protection of Scotland's environment.

Iain Smith: Is the minister aware that my constituents in north-east Fife have for many years enjoyed the use of unstaffed civic amenity sites, which are especially welcome in rural villages and which have helped to reduce the environmental damage caused by fly-tipping? Is he also aware that because of licensing conditions being imposed by SEPA, those sites are threatened with closure? Does he accept that that is not in the interests of the environment because it will force residents to drive large distances to staffed sites and will inevitably lead to an increase in fly-tipping? Will the minister raise those concerns with SEPA?

Ross Finnie: I am aware of the problem to which the member refers. He will be aware that the matter is difficult and that it is an operational concern for SEPA, which has evidence that some of the sites to which the member refers are being used illegally by commercial operators. That has given rise to SEPA introducing regulations on the matter. However, I take the member's point that the imposition of those regulations might be counterproductive in that they might result in fly-

tipping and I will be happy to raise that matter with SEPA.

John Scott (Ayr) (Con): During the minister's discussion with SEPA, was any consideration given to the creation of a national flood plan? When will the ad hoc ministerial group on flooding, which was due to report in February, make its report known to Parliament?

Ross Finnie: The outcomes of the group's report have been made public and have been discussed—SEPA is part of those arrangements. The member will find that the results and report of the group, which was chaired by my colleague the Deputy First Minister, have been produced.

Bruce Crawford (Mid Scotland and Fife) (SNP): When the minister last met SEPA, did he discuss the radioactive particles that have been found at Dounreay? Is the minister aware that each particle contains strontium-90, yttrium-90, technetium-99, caesium-137, enriched uranium and plutonium? Will he ensure that, because of that highly dangerous material that exists in the area of Dounreay and Sandside, where there is a beach that is open to the public, a full and comprehensive study be undertaken in the area with immediate effect?

Ross Finnie: The member is obviously aware that radioactive waste has been found at Dounreay because he has correctly articulated the levels and amounts. He will also be aware that the regulatory authorities share his concerns and that the matter is being addressed within the powers that those authorities have. There is nothing further to add.

First Minister's Question Time

15:14

Cabinet (Meetings)

1. Mr John Swinney (North Tayside) (SNP): To ask the First Minister what issues will be discussed at the next meeting of the Scottish Executive's Cabinet. (S1F-2608)

The First Minister (Mr Jack McConnell): At the next meeting of the Cabinet, which is the final meeting before the dissolution of Parliament, a number of important issues will be discussed, including the security and contingency issues resulting from the current international situation. The Cabinet will have provisional arrangements to meet during April, if necessary.

Mr Swinney: I refer to the statement on the international crisis in relation to Iraq that the First Minister made to Parliament. The Scottish National Party opposes the war but, as action has now started, we pray for the safe return of our servicemen and women and that innocent Iraqi civilians will be spared in the conflict. Given that the British Government has gone to war in the absence of a United Nations mandate that would have set out the parameters for the war, will the First Minister tell Parliament what steps are being taken to avoid the humanitarian catastrophe that many of us fear?

The First Minister: I could answer that question in detail from press reports and briefings to which I have been privy. However, I do not think that it is right for us to discuss at question time in this chamber responsibilities that are rightly the responsibilities of ministers elsewhere. I take my responsibilities seriously. I do not expect UK Government ministers to interfere with my responsibilities and I will not interfere with theirs—as I have said consistently in this chamber over a long period.

It is quite clear to anybody who heard with ears that were actually listening to the debate that took place in the House of Commons on Tuesday that the UK Government and the other Governments around the world that will be involved in action over the next few days—I hope that it will not be over too many weeks—are making every possible effort to avoid civilian casualties and the causing of unnecessary destruction or harm. However, we must recognise that there cannot be military conflict in a war without those casualties and that damage.

The Presiding Officer: I remind members that this is not a debate. It is question time, and the First Minister can answer questions only about matters for which he is responsible, not about other matters.

Mr Swinney: Presiding Officer, the First Minister made a statement to Parliament yesterday, to which I listened with great care and which I have in front of me. It went into extensive detail about the international situation, the problems in Iraq, the United Nations and the decisions of the United Kingdom Government. I am seeking to question the First Minister on the responsibilities that he carries as the First Minister of Scotland, by virtue of which office he is a member of the Privy Council of the United Kingdom.

The First Minister will be aware that 60 per cent of the Iraqi population depend on food rations and that 50 per cent are under the age of 14. It is a fragile population. This morning, the President of the United States said that

"this will not be a campaign of half measures".

That rather contradicts what the First Minister has just told me. In the light of those comments, can he give Parliament an assurance that, in his discussions with the United Kingdom Government, he has pressed for the deliberate targeting of sites of significance for humanitarian assistance in Iraq, such as water treatment plants, to be expressly forbidden?

The First Minister: All members—regardless of the views that they have expressed and whether they are members of parties or no longer members of parties—have, over recent weeks, consistently expressed the desire to ensure that, if there has to be military action in Iraq, there is the minimum number of civilian casualties and that the minimum damage is caused, while the clear objective of ensuring that Saddam Hussein no longer has access to weapons of mass destruction is met. It is because the international community agreed unanimously, in UN resolution 1441, that he still had those weapons, had to provide information on them and give them up that we are in this situation. It is because of that situation that we need to support our troops, look after them and ensure that they are not affected by chemical attacks or any other attacks that Saddam Hussein might launch over the next few days or weeks.

Mr Swinney should recognise that this is a serious situation. The time for cheap political points is over. Let us move on and discuss the real issues.

Mr Swinney: The First Minister needs to raise his game and speak for Scotland on these issues. If he cannot recognise the seriousness with which I am raising the concern of many hundreds of thousands of people in Scotland about the humanitarian disaster for which we may be responsible, he misjudges the opinions of the people of Scotland. If he and I cannot agree about how we got here, will he at least agree that, unless we conduct this conflict in the right way, we will be unable to win the peace after having been involved in the war? Does not it matter that we must take the right approach to the protection of humanitarian efforts in Iraq to have any chance of winning the peace in the months to come?

The First Minister: Of course it matters. That is why, yesterday, I was asked three questions—one of which came from Mr George Reid, who has a lot more dignity than do some other members of his party—about what we could do to organise groups in Scotland to assist with humanitarian aid. Questions on that matter were asked by Robin Harper, Dorothy-Grace Elder and George Reid. I said that I would do whatever I could to ensure that we stood ready in Scotland, as we always have done as a nation, to help those elsewhere in the world who need our help.

However, I have to say to John Swinney that we have a democratically elected Government in this country that, for the first time in living memory, put the possibility of going to war to a vote in the House of Commons prior to going to war. The Government did that because we are proud of our democracy. It is precisely because such democracy does not exist in Iraq and because the regime in Iraq slaughtered, 15 years ago last Sunday, thousands of its own civilians that action against Iraq is so important. I do not want the Iraq regime slaughtering British troops in Iraq, Kuwait or anywhere else over the next few weeks. That is why we back our troops. We want to ensure that, having our support, they can bring a quick and effective end to the military conflict.

Margo MacDonald (Lothians) (Ind): After such an exchange, I hope that my question does not seem like we are going from the sublime to the ridiculous. However, we have other responsibilities in the Parliament.

Is the First Minister aware that the efficiency and costs of Scottish Natural Heritage will be detrimentally affected by today's decision to disperse the headquarters, with its 270 jobs, from Edinburgh to Inverness? Will he give me an undertaking that that decision will not be acted on until the new Parliament can review it? I fear that today's decision will be regarded as a poor, politically motivated decision, given that SNH is a model for the policy of dispersing people and departments throughout Scotland.

The First Minister: I have heard, not just since we were elected in 1999 but before then, many members of different parties in the chamber commit themselves to the dispersal of civil service jobs from Edinburgh. I have personally been very committed to that policy. I am committed not only to the policy of dispersing civil service jobs from Edinburgh, but to the dispersal of civil service jobs out of our cities into our towns and other areas. I believe that the decision that was announced this

morning will have a very small impact on the most buoyant, dynamic economy in Scotland, which is the one in Edinburgh, but a big impact in the Highlands. I believe that the decision is absolutely right and I will defend it anywhere.

Prime Minister (Meetings)

2. David McLetchie (Lothians) (Con): To ask the First Minister when he next plans to meet the Prime Minister and what issues he intends to raise. (S1F-2617)

The First Minister (Mr Jack McConnell): I have no immediate plans to meet the Prime Minister, but I have spoken to him regularly and I intend to continue to speak to him regularly over the next few weeks.

David McLetchie: I thank the First Minister for that answer. Now that the military action has started in Iraq, I think that it is important that we give our unanimous support to our armed forces that are serving in the gulf. I am sure, from what he said earlier in the chamber, that he would accept that, whatever political differences and different views we have on the issue, we all have a duty to act responsibly at this time.

Therefore, does the First Minister agree that it is totally irresponsible for elected politicians to encourage young people to truant from our schools? Does he also agree that young people should certainly be encouraged to express opinions on the political issues of the day, but that they should not be encouraged to skive off? Given the disciplinary and truancy problems that, sadly, exist in our schools, does he agree that it is quite wrong to encourage truancy and to turn a blind eye to it?

The First Minister: On that issue, I believe that there is a difference between older teenagers who are still at school and close to voting age and those who are very young. I also believe that two things must be consistent. We have a right to protest and to free speech in this country and I think that that right should be particularly encouraged, rather than discouraged, among teenagers. However, I do not believe that it is right for elected politicians to encourage young people to leave school during the school day. Mr McLetchie is right on that point. I would strongly discourage any member of the Parliament from encouraging any form of truancy. If young people, whatever their views, can be encouraged to protest and make their points outside school time, that would be a far better solution for us all.

David McLetchie: I thank the First Minister for that response. Following on from that, can he give us his opinion of the situation in West Dunbartonshire Council, where the council leader, Mr McCafferty, is apparently giving staff paid time off work to take part in anti-war protests? Although council employees are as entitled as everyone else is to demonstrate in support of their views, does he agree that they should do so in their own time, at their own expense and certainly not at the expense of the local taxpayer or the provision of local services?

The First Minister: I am aware of West Dunbartonshire Council's decision and of the fact that other authorities in Scotland might consider such a decision in the next few days. I make my position clear: staff have a right to protest, but if local councils want their staff to take paid time off to protest, councils should pay for that from their own pockets and should not expect local taxpayers to pay for it from council tax.

Armed Forces (Family Support)

3. Mr John Home Robertson (East Lothian) (Lab): To ask the First Minister what action the Scottish Executive is taking to support families of servicemen and servicewomen based in the gulf area. (S1F-2613)

The First Minister (Mr Jack McConnell): I think—[*Interruption.*] I am surprised that members of the Scottish nationalist party who represent constituencies that have large numbers of families of British servicemen and women cannot accept that John Home Robertson has a right to ask his question about the action that the Executive is taking to support those families. Those members should be ashamed of themselves.

Tommy Sheridan (Glasgow) (SSP): Cheap shot.

The First Minister: It was not a cheap shot. [*Interruption.*] Presiding Officer, it is not right for me to respond to sedentary comments that are made around the chamber.

The Presiding Officer (Sir David Steel): Quite.

The First Minister: The matter is serious. [*Interruption.*]

The Presiding Officer: Order. The question has been asked and I do not understand why interruptions are being made.

The First Minister: The matter is serious. I have a constituent who has four sons in the gulf. We all have constituents who are in such a position and we should take their welfare seriously. Young men and women from throughout Scotland who are serving with the British armed forces in Iraq face a dangerous and life-threatening challenge. We owe them and their families our care and support.

In meetings of the Scottish emergencies co-ordinating committee, we have offered our assistance, in any way that we can provide it, to the forces' welfare services, which provide

excellent support and have developed contacts with local authorities and the statutory support services.

Mr Home Robertson: Will the First Minister convey a message to all the armed services and in particular to regimental associations in branches and clubs of the Royal British Legion Scotland to express the whole-hearted support of members of the Parliament for Scottish servicemen and women as they carry out their dangerous duty to make Iraq safe for the Iraqi people? Will he ensure that every part of the Executive, local authorities and other agencies do everything in their power to support and assist service families, including using all possible means to facilitate telephone or radio contacts between service personnel and their families?

The First Minister: The provision of those services is largely a matter for the Ministry of Defence and I do not want to encroach on its responsibilities. However, we will do all that we can to support it in supporting the families of service personnel throughout Scotland who, although they are proud, are also concerned.

Ben Wallace (North-East Scotland) (Con): I urge the First Minister not to forget those families in the next few weeks as elections loom. I urge him to visit some of the military units and their bases around Scotland and to talk to the families and friends of service personnel to convey our support for their loved ones who are serving in the gulf.

The First Minister: I would be happy to do that and I have approached the Ministry of Defence with a view to making myself available if that would be helpful. However, I am mindful of the position of the services and of families, who might not necessarily want politicians to turn up day after day at barracks or anywhere else. It is important that we take guidance on the matter. When we are invited to talk to the families of service personnel, I will be delighted to take part in that, preferably without publicity.

Firefighters' Dispute

4. Dennis Canavan (Falkirk West): To ask the First Minister what action the Scottish Executive is taking to find a solution to the firefighters' dispute. (S1F-2622)

The First Minister (Mr Jack McConnell): We are in regular contact with the employers in Scotland. Last night, I spoke with the Deputy Prime Minister following news that the Fire Brigades Union conference had rejected the recommendation of the FBU's executive to accept the employers' latest 16 per cent pay offer. I urge the FBU not only to consult its conference again in three weeks' time, but to ballot its members on the latest pay offer and to call off the threat of any further strikes.

Dennis Canavan: Will the First Minister assure us that he will not copy John Prescott's provocative proposal to introduce draconian, anti-trade union legislation to give him dictatorial powers to impose a settlement? Will he also assure us that he will not stand by and allow Westminster to impose such legislation in Scotland? The Scottish Parliament is responsible for legislating on the fire service within Scotland.

The First Minister: The Deputy First Minister and I have made it clear that there will in this Parliament be no legislation on the matter before dissolution. We have had an absolute assurance from our colleagues in London that during dissolution there will in the United Kingdom Parliament be no legislation that covers Scotland. What happens after that will be a matter for the newly elected Parliament in Scotland to decide. That is the right and proper way of carrying through the democratic process. I hope that that clarifies that matter and that we do not spend the next week or so debating hypothetical situations that are not going to occur in Scotland.

The situation is serious; 19,000 troops are currently on standby throughout the United Kingdom because the FBU will not state that it will not call any further strikes in the course of the next two or three weeks. Even while further consultation is taking place, those troops have to remain on standby. We are in a ridiculous position. A 16 per cent pay rise is on offer for commonsense changes in conditions of service. It is time for the FBU to start living in the real world. We have all sympathised with its claim, but it is being treated very generously and it now needs to respond.

Tricia Marwick (Mid Scotland and Fife) (SNP): Can I pin the First Minister down a bit further? He said that there would be no legislation before dissolution. Will he confirm that the Scottish Executive ministers will not use the powers that they have during dissolution to nod through Westminster legislation on a wholly devolved matter?

The First Minister: I answered that question in my previous answer.

Bill Aitken (Glasgow) (Con): In the light of the First Minister's answer to Mr Canavan, does the First Minister agree that it is imperative that early action be taken to stop the strikes? The law on the matter is clear. Will he instruct the Lord Advocate today to seek the appropriate interdict in order that the strikes be stopped for the duration of the Iraq conflict?

The First Minister: No, I will not. The Lord Advocate is independent on that matter. He will make his own decisions should he ever wish to take that course of action. The best way to end the dispute—the best way to bring about there being no more strikes in Scotland or anywhere else in the United Kingdom—is for the FBU to ballot its members on a recommendation to accept the generous offer. I hope that it does so. If it does, we can bring the whole dispute to an end.

Elaine Smith (Coatbridge and Chryston) (Lab): Is the First Minister aware of the apparently unilateral decision that the chief officer of Strathclyde fire service recently took to reduce from five to four the minimum number of permitted riders on first-attendant appliances and to constrain recruitment levels? Does he agree that that action is less than helpful during an industrial dispute?

The First Minister: We cannot have such a dispute going on for months on end, with generous pay offers on the table, and not have managers in the local fire service continuing to manage their service and trying to ensure that it runs as efficiently as possible. Those of us who have been in positions of council responsibility have been in situations in which we had to make difficult decisions at a local level to move services around, change priorities or adapt to changes in society, geography or population in an area. That is exactly what is needed in our fire service. The commonsense changes in conditions of service that are now being proposed would facilitate that work without any threat to the quality of life, quality of conditions, quality of work or pay levels of firefighters in Scotland.

Points of Order

15:29

Lord James Douglas-Hamilton (Lothians) (Con): On a point of order, Presiding Officer. Is not it the case that, as the Lord Advocate is an Executive minister with collective responsibility, he cannot act independently on matters that involve the whole Executive? The constitutional principle that the First Minister suggested cannot possibly be right.

The Presiding Officer (Sir David Steel): I do not want to comment on that off the cuff, but the First Minister might want to.

The First Minister (Mr Jack McConnell): The Lord Advocate acts as the legal adviser to the Scottish Cabinet. It is quite right that that is the arrangement. He is a member of the Executive and is therefore accountable to the Parliament. He is also accountable to the Parliament for his running of the prosecution service in Scotland. When he makes a decision to go into court and to argue for a particular course of action, he has to make that decision himself. He will certainly not be instructed by me on such a decision.

Dennis Canavan (Falkirk West): On a point of order, Presiding Officer. As you know, I submitted an emergency question this morning, which asked the First Minister to make a statement following the outbreak of war against Iraq. I realise that you are not obliged to give a reason for your refusal to allow the First Minister to answer my question. Bearing it in mind that, by its very nature, war is an emergency that the Parliament cannot and should not ignore, will you give us an assurance that you will not rule out automatically any such future emergency request for a statement?

The Presiding Officer: The member is right that I never give reasons for why I accept or reject an emergency question. It is going a bit far to ask me to rule on hypothetical emergency questions that I might receive in the future. I will consider each such request on its merits—genuinely.

Andrew Wilson (Central Scotland) (SNP): On a point of order, Presiding Order. My point of order relates to that of Lord James Douglas-Hamilton and the First Minister's response to it. At the close of the Parliament's proceedings today, I ask that guidance be given to the chamber. On reflection, the First Minister will be aware that the guidance that he has given is inaccurate and that what Lord James Douglas-Hamilton said was correct.

The Presiding Officer: I will not rule any further on that matter. I will study the *Official Report*. If I need to say anything more about the issue, I will do so at 5 o'clock, but I am not promising anything.

Mental Health (Care and Treatment) (Scotland) Bill: Stage 3

The Deputy Presiding Officer (Mr Murray Tosh): The next item of business is a debate on motion S1M-4024, in the name of Malcolm Chisholm, that the Mental Health (Care and Treatment) (Scotland) Bill be passed.

15:37

The Minister for Health and Community Care (Malcolm Chisholm): Today marks the culmination of an inclusive and extensive process that has shown our new Scottish legislative arrangements working at their best and has delivered a landmark bill that places patients and their welfare at its heart.

That is exemplified by a coherent set of principles to which anyone discharging functions under the bill must have regard. There will be: a new mental health tribunal that will combine professional, legal and practical experience in deciding what is best for patients; a new compulsory treatment order, which will allow care and treatment to be tailored to the personal needs of each patient, whether in hospital or in the community; duties on local authorities to promote the well-being and social development of all persons in their area who have, or who have had, a mental disorder; additional safeguards in the use of certain medical treatments; a strengthened Mental Welfare Commission for Scotland to ensure that the mentally ill are properly protected; novel provisions to ensure that advocacy is available to all persons with mental disorder; and mechanisms for the nomination of a named person with significant rights to represent the patient's interests.

I am grateful to everyone who has contributed to the preparation of the bill and its proceedings. I thank again the Millan committee of four years ago. The mental health legislation reference group played a significant part in the preparatory work, both in the development of the policy statement, "Renewing Mental Health Law", which preceded the bill, and by acting as a sounding board and a source of sensible advice on issues that have arisen as the bill has progressed. One of the amendments that I moved this morning followed late advice from that group.

The Mental Welfare Commission and the Law Society of Scotland have also been particularly helpful in bringing a keen and experienced eye to the bill. A large range of voluntary organisations, such as the Scottish Association for Mental Health and the National Schizophrenia Fellowship, have, by their tenacity and persistence, kept us on our mettle and ensured that the patient's perspective was always clearly recognised. I thank all those bodies, mentioned and unmentioned.

On the Health and Community Care Committee has fallen a huge burden, so I give warm thanks to its members, its clerks and everyone who gave evidence to it over a period of several weeks. The bill is by far the largest to have been considered by the Parliament. With the consideration of some 1,400 amendments at stage 2, the committee's energy and commitment to the task were clearly demonstrated. The committee's efforts have resulted in a number of significant changes to the bill. Indeed, many amendments that we have considered in the past two days were lodged in response to the committee's views at earlier stages of the bill.

Last, but by no means least, I thank the officials in the bill team. Given the complexity and length of the bill, theirs was a particularly difficult and arduous task, so I place on record my thanks to them.

The outcome is a bill of which we can justly be proud. As I said, we will proceed to push forward the implementation process. Work to that end is already in hand. I am pleased to say that the mental health legislation reference group has agreed to continue to make its expertise available in the implementation phase. I am grateful to the group for its continuing commitment.

I can announce today that our preliminary date for the commencement of the bill's main provisions is October 2004. Some free-standing provisions, such as the amendment to the Mental Health (Scotland) Act 1984 to allow for the appointment of a new chief officer to the Mental Welfare Commission and the provision that was added at stage 3 concerning the burden of proof, will be brought into operation as soon as possible. However, we wish to be certain that the infrastructure is in place to ensure that this superb legislation is implemented in a way that does justice to its provisions.

Presiding Officer, how long do I have? Is it five minutes or seven minutes?

The Deputy Presiding Officer: According to my script, you have 10 minutes.

Malcolm Chisholm: Ten minutes. I have already omitted some of my speech on the assumption that I had only five minutes, but there we are. I should have found out before I started.

In implementing the bill, we will work with everyone who has an interest in mental health law in Scotland to ensure that we achieve the benefits for users and carers that the bill makes possible. We will establish a tribunal system that makes good decisions and that promotes the participation

of users and carers. We will develop guidance and a code of practice on the bill to help professionals to deliver quality care. We will put in place arrangements for monitoring and evaluation to ensure that, in the future, we know how the legislation is working and why and how we can make it work as well as possible. We will work with service providers to help them to prepare to meet the responsibilities that the bill places on them.

Our intentions are that, before the end of this year, we will have appointed a president of the tribunal to oversee the latter stages of preparatory work, we will have announced the location of the president's office and we will have issued a draft code of practice for formal consultation. I hope and expect that the Parliament will maintain a close interest in that important process.

The amendment from the Scottish National Party is unnecessary. As it repeats what I have said on many occasions, clearly I have no reason to oppose it. On 14 November 2001, in the debate on the white paper, I made it absolutely clear that adequate resources would be made available for the implementation of the bill. I give that commitment again today. At stage 1, I said that I was

"setting in train a comprehensive assessment of existing mental health service provision. That will enable us better to determine how the current range of facilities, augmented by the substantial additional resources that we are making available, will be able to meet the bill's objectives."—[*Official Report*, 11 December 2002; c 16205.]

On 5 February, I duly announced that Dr Sandra Grant had agreed to carry out that assessment. I have asked her to complete her report, which will be made publicly available, by 31 August. We look forward to receiving Dr Grant's report, which will give an objective and comprehensive perspective of current service provision and will inform the steps that we are taking to ensure that the implementation of the bill is adequately resourced.

The amendment would therefore be more accurate if it said that the Parliament "supports the view expressed by many giving evidence on the Bill, by three committees of the Parliament and by the Minister for Health and Community Care that the aims of the Bill will not be met unless services and facilities are adequate to meet the demands placed on them." However, we shall not quibble at this stage; we shall accept the amendment in spite of the fact that it is unnecessary.

I have great pleasure in commending a bill that revolutionises mental health law in Scotland, that puts the patient at the centre of treatment and care decisions and that ensures that their well-being is and will be paramount.

I move,

That the Parliament agrees that the Mental Health (Care and Treatment) (Scotland) Bill be passed.

The Deputy Presiding Officer: I now call Shona Robison to speak to and move amendment S1M-4024.1. You have up to seven minutes. Quite a lot of members want to take part in the debate, so it would be helpful if time could be saved from the opening speeches.

15:45

Shona Robison (North-East Scotland) (SNP): I will certainly do my best.

I begin by thanking all the Health and Community Care Committee clerks, who have worked so hard on the bill. They were still working on the bill until well after midnight last Friday, which really is beyond the call of duty. I also thank everyone who gave evidence, particularly service users, many of whom shared personal experiences with us. We appreciated that very much.

Suffice it to say that the bill has been a long haul for everyone involved. We have to learn lessons from the way in which the legislation has been handled. The initial delay in introducing the bill due to drafting problems was the start of the difficulties. Then there was the unprecedented number of amendments lodged at stage 2—more than 1,300—again due to drafting problems. Finally, more than 700 additional amendments were lodged at stage 3.

I do not want to dwell on that too much but, as I said yesterday, I fear that there might be problems with the legislation that will come back to haunt us. There might be a need for an amending bill in the near future, although I hope not. We must ensure that our new Parliament reflects on what improvements can be made to our legislative process so that we can avoid such problems happening again.

The amendment to the motion goes to the heart of the concerns that have been expressed at all stages of the bill. I believe that those concerns have to be expressed again. I am pleased that the Executive has, even if a little grudgingly, said that it will accept the amendment. The bill will work and deliver its aims and objectives only if the services and facilities exist to meet demand. I will come back to that issue in more detail.

I broadly welcome the content of the bill, although I still have some reservations about elements of it. On the principles of the bill, it was important to try to keep service users on board with the legislation. It is fair to say that their biggest disappointment was with the failure to include the principle of reciprocity. That remains a concern and it is unfortunate that our suggestions on that point were not accepted.

Some unease remains about community-based CTOs, despite the safeguards that have now been included in the bill. I would have liked more safeguards but, now that we are where we are, it is important that there is effective monitoring of the numbers of community-based CTOs and swift action to investigate any unforeseen rise in the use of such orders. That would go some way towards reassuring the people who are concerned.

There has been a lot of compromise with the bill, which is always a good thing. I was reassured by what was said about electroconvulsive therapy this morning, as I am sure many service users will have been. I was particularly pleased when the amendment on age-appropriate services was passed yesterday. With only 35 in-patient beds for adolescents throughout Scotland when there should be 80 to 100, that measure could not have come at a better time.

For me, the most satisfying aspect of the bill is that is enshrines in statute the right to appeal against excessive security. The Crichton family's evidence about their experiences was powerful. For a young man to spend three years of his life in a maximum-security setting when he did not require to was a failure of the system. Rehabilitation should start at the earliest opportunity, not three years later than it has to.

As a number of members said this morning, we now need to focus on appropriate alternative services, with local medium-secure units where rehabilitation and recovery can begin. We should talk about that more. At the moment, those facilities are inadequate—we need more of them. However, the public have to be given full information on what such units are about, otherwise opposition will develop based on myths and fear. It is imperative that community resources are developed for the next stage in people's rehabilitation into the community. If that does not happen, a bottleneck will develop in medium-secure units.

That brings me back to resources and the reason for my amendment. It has been said throughout the process—by three committees of the Parliament and by nearly all the people who gave evidence—that there is concern in all quarters about resources. There are outstanding issues of resources for staffing and finding the staff to fill posts. I hope that those problems can be overcome.

The proof of the pudding will be whether the services and facilities that are required by service users are sufficient. Only by ensuring that that is the case will the aims and aspirations of the bill be met. At the moment, I am afraid that the jury is out. However, the Parliament has a huge role to play in monitoring the development of those services. I am sure that service users will work with us to ensure that that happens.

I end by talking about the context of the bill. Although most of us will never need compulsory treatment or need to be detained, one in four of us will suffer from a mental health problem at some point in our lives. Therefore, it is in all our interests that appropriate services are available when and where people need them. Too often, that is not the case and by the time a person comes into the system their condition is much worse. Preventive work must be the key to ensuring that we have good mental health in Scotland. Mental health services must cease to be the cinderella services and must reflect the fact that mental health is supposed to be a key clinical priority.

I urge the Parliament to support my amendment to the Executive motion on the bill. I am pleased that the Minister for Health and Community Care has accepted it, as that means that he will not experience the anxiety that he felt last week.

I move amendment S1M-4024.1, to insert at end:

"but, in doing so, supports the view expressed by many giving evidence on the Bill, and by three committees of the Parliament, that the aims of the Bill will not be met unless services and facilities are adequate to meet the demands placed on them."

15:52

Mary Scanlon (Highlands and Islands) (Con): I, too, thank the clerks for their incredible work. Like Shona Robison, I noted the time of midnight on e-mails from last week.

The Scottish Conservatives will support the SNP amendment, even though it states the obvious—it repeats what many people have said at every stage of the bill. However, if nothing else, it puts down a marker that we need continually to monitor what we are trying to achieve through the bill and that we must ensure that services are provided.

I welcome the fact that the Minister for Health and Community Care has put Dr Sandra Grant in charge of the review of service provision. If her review is as good as her Scottish Health Advisory Service reports, it will be an excellent piece of work.

I also thank the witnesses. For me, the most memorable users who came along to the Health and Community Care Committee were Maggie Keppie and Marcia Reid from Elgin. As I have been speaking in the past two days, much of what Marcia said about ECT and so on came back to me.

I am pleased that Health and Community Care Committee members succeeded with their amendments, particularly Margaret Jamieson and Bill Butler, who doggedly stuck with the issues at all points in the bill. They have to be commended for that. Shona Robison is to be commended for

her amendment on the inclusion of psychology as part of medical treatment. Although the issue came to us late, we welcome the success of that amendment. Of course, I commend myself for the amendments on medium-secure units.

The bill was due at the Health and Community Care Committee at the end of January 2002. We received the draft bill of 89 pages in June 2002. The bill as introduced grew to 168 pages; committee members received it in September 2003.

The Deputy Minister for Health and Community Care (Mrs Mary Mulligan): No, 2002.

Mary Scanlon: Sorry, there are so many figures.

After 1,357 amendments at stage 2, the bill grew to 242 pages. A further 756 amendments were lodged at stage 3. If I do nothing else in this speech, I would like to put on record—especially as the convener of the Procedures Committee is in the chair—a plea to have an updated version of the explanatory notes made available when such a great number of amendments are lodged. I would have found that helpful when I was struggling with the more than 2,000 amendments with which we had to deal.

In the week before the dissolution of Parliament, it is almost with a sigh of relief rather than with the pride that I should feel that I contemplate the passing of the bill. Many serious questions about the resources that are available to us when we pass legislation have arisen from our experience of the bill. When I see the ministers at committee meetings with their armies of civil servants and their speaking notes for their amendments and replies to members of the committee, I contrast that sight with the experience of members of Opposition parties on the Health and Community Care Committee, who have no such resources or support yet also carry the burden of the responsibility for scrutinising legislation. I am not putting the case for having a second chamber, but there are arguments for one—indeed, there could be no greater justification for having one than our experience in passing the bill.

Like the minister, I believe that the Parliament owes a debt of gratitude to the Law Society, the Mental Welfare Commission and the Scottish Association for Mental Health. The responsibility for scrutinising the legislation fell to them, because I had to assume that, if they raised no concerns, it was okay to agree to certain points. The problem was that, at stage 3, because the bulk of the 755 amendments were submitted at around 4.30 pm last Friday, those organisations did not see the text of the amendments until the business bulletin was published on Monday, which was far too late to discuss, consult on or measure the full impact of many of the proposals. That cannot be acceptable from a democratic Government.

I want to put on record the fact that the Health and Community Care Committee took a non-party-political stance throughout the consideration of the bill. There has been no political point scoring. Given the complexity of the bill, the process has shown the workings of the Health and Community Care Committee at their best.

However, the legislation will be effective only if health boards and local authorities give it the priority that it deserves. Time and again, concerns about that have been raised in the committee and in the chamber. I share the view that was expressed about the fact that Carstairs has 29 blocked beds. We also heard that the Orchard clinic could not move people on because there were insufficient numbers of supported accommodation places, day centres, certified paediatric nurses and so on. For example, there are currently 29 vacancies for psychiatrists in Scotland and, in order to implement the bill, we will need an additional 28 psychiatrists. That means that we need 57 consultant psychiatrists. Furthermore, we face shortages of psychologists, psychiatric nurses, social workers, care workers, mental health officers and people to support general practitioners, 30 per cent of whose patients have mental health problems.

I struggled more on the subject of advance statements than I did on any other issue. I even fell into the danger of becoming a Liberal by supporting both sides—only for a short time, I must add. It was extremely painful not to be able to make a decision. I am glad that I am a Conservative, as we can usually see things clearly.

The Mental Health (Care and Treatment) (Scotland) Bill is undoubtedly the largest and most complex bill that the Scottish Parliament has dealt with. I have carried out my role in relation to the bill in good faith. I hope that the amendments that I have agreed to on behalf of the Scottish Conservatives will be beneficial to patients and supportive of good clinical practice. Given the size of the bill, the huge number of amendments and the time limitations, I can only hope that we are passing a good bill today. Time will tell.

15:59

Mrs Margaret Smith (Edinburgh West) (LD): If ever I was going to be tempted by a Conservative, it would probably be by Mary Scanlon. I think that she would make not a bad Liberal Democrat.

I would like to thank several people—the fact that they have been thanked already does not make my thanks any less heartfelt. Our clerks

have done a tremendous job on the bill. At some point in the discussions that I had with the Executive on Friday, I said that what was being asked of our clerks was inhuman—I think that I chose my words well.

I thank the committee's stage 1 adviser, Jacqueline Atkinson, the other committees that took stage 1 evidence and the ministers, particularly Mary Mulligan for the way in which she dealt with our concerns. I also thank the bill team, whose members worked tremendously hard on what is a complex but incredibly important piece of legislation.

I have further thanks to give to those who gave oral and written evidence to the committee and who stuck with the task of keeping us up to date with their views and concerns as the great number of amendments were lodged. I thank in particular the Law Society of Scotland, the Mental Welfare Commission for Scotland, the Scottish Association for Mental Health and the other groups who support mental health service users, without whom the committee would not have been able to do the work that was undertaken.

My final thanks go my colleagues on the committee. I echo Mary Scanlon's comments about the fact that there was no party-political point scoring or manoeuvring on the committee—nothing of that kind happened during our scrutiny of the bill. The questions that we wrestled with were questions of conscience, balance and judgment. It made no difference to our deliberations which party we were a member of. That is why I am delighted that the minister is accepting the SNP amendment to the motion, as the amendment makes a statement of fact. It is also important that the motion that we agree on at the end of today's business represents a united front on the bill and that there is no difference between us—we have been together on the bill all the way through.

Although I plan to pass on to the Procedures Committee the concerns that I raised with the Executive on a number of occasions, I will put them on the record this afternoon. The concerns relate to the fact that we had to deal with 1,400 stage 2 amendments and 750 stage 3 amendments. We had loads of time at stage 1 to do our job properly in terms of consultation. However, at the critical point when we needed to consult people to find out whether amendments would make a difference and whether we should support the provisions, there was no time to do that. It is important that we remember the strain that that put on the small non-governmental organisations that attempted to keep up with the legislative process.

The Mental Health (Care and Treatment) (Scotland) Bill is a prime candidate for early review. The bill is complex and, even with the best will in the world, MSPs and bill teams can make mistakes. There were times when we were considering sections of the bill and had to make very close judgment calls. We took decisions this morning and yesterday when in our hearts we did not know whether we had done the right thing. It would be worth while monitoring the legislation in a couple of years' time to see whether it needs to be reviewed. That would allow the Parliament to see whether we had taken the right side of the argument on, for example, advance statements.

That said, I welcome the bill—it contains a lot of good stuff and is long overdue. We are introducing a new flexibility into the system so that people can have the least restrictive alternative made available to them. People should not have to be taken into hospital when it might be better and less disruptive for them and their families if they were to remain at home.

The bill needs monitoring and its implementation needs resources and staff. I welcome the establishment of the independent tribunal, as that will take a difficult role away from sheriffs. The bill will lead to improvements in respect of patient involvement through the right to advocacy, named persons and advance statements.

We have had a constructive debate over the past two days and indeed throughout the bill process. I am pleased that, at stage 2, the Executive took on board a number of points on issues such as ECT safeguards and the inclusion of the Millan principles in the bill. I am also pleased that over the past two days we have seen some significant changes to the bill, as they represent an important move forward.

I enjoyed the way in which the members of the committee who progressed work on amendments saw their labour bear fruit. I am particularly grateful to the committee's deputy convener, Margaret Jamieson, for her support throughout the process. I was delighted that her amendment 34, on age-appropriate services, was accepted yesterday.

I meant it when I said yesterday that, if the Scottish Parliament is to mean anything, this is the kind of issue on which we have to do the right thing. We did the right thing yesterday in respect of amendment 34. We also did the right thing by Bill Butler, who doggedly stuck to the issue of resources for mother and baby units. I also welcome the fact that we did the right thing by his amendment 106.

Shona Robison has done some great work on ECT and I hope that she will accept the minister's assurances on that issue. Indeed, I hope that those people in the gallery who will examine the legislation will do the same and take comfort from

the new safeguards that have been included, partly through the committee's work. I also pay tribute to Mary Scanlon's work on the bill.

Our approach to the issue of excessive security serves as a good example of how the committee, civic society, the bill team and the Executive can work together to come up with a piece of legislation that we all feel happy with and that will make a significant difference to people who are, but should not be, incarcerated in Carstairs.

As we have said before, the bill is good and principled, but money and people are needed to make it happen. I welcome the fact that that matter is under review and that the Executive has taken on board the SNP amendment. We all know what has to be done; we should now make it happen.

16:06

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I am grateful for the opportunity to speak in the debate. In the past, mental health has not had the attention that it rightly deserves; indeed, it has been referred to as the cinderella of the NHS. However, the Mental Health (Care and Treatment) (Scotland) Bill, which we have debated over the past two days, clearly reverses that lack of attention.

We would not have had the opportunity to debate the bill if it had not been for the collaborative approach that was adopted by the many individuals and organisations that advised committee members, ministers and their officials throughout the process. I want to record my thanks to them all for their patience and understanding when we sometimes struggled to reach decisions on aspects of the bill with which we were unfamiliar. I am personally indebted to Children in Scotland for its assistance and support in pursuing with me amendment 34, which was eventually accepted by the Executive.

I must especially mention and thank the Health and Community Care Committee clerks: Jennifer Smart, Peter McGrath, Graeme Elliott and Hannah Reeve. They ensured that committee members received papers on time; that witnesses were available; and that the grouping of amendments was clearly set out for us. It is unfortunate that not many members of the press are here to record that. Those people worked for many hours beyond 5 o'clock, even on a Friday, and their work has allowed us to debate the bill over the past two days.

Many have said that we have had insufficient time for proper scrutiny, but I do not share that view. The committee listened, read, made visits and discussed matters, and, as we have seen, very few divisions were required at stage 3. There has been no political posturing during the bill's progress from its publication to this stage 3 debate. All committee members set aside their political views in the interests of those who stand to gain from this updated piece of legislation. The Millan committee set the tone for us and I sincerely hope that its members welcome the approach that we took to achieve what I believe is a welcome piece of legislation.

It will be some time before the legislation is fully implemented and more work is required on work-force planning for the future. Funding streams must be explored to find out what is being provided by whom and to whom. That necessary examination will provide a sound basis upon which to implement the bill, and I am confident that the legislation will serve well those who have mental disorder.

I support the motion, as amended, to pass the bill.

16:10

Mr Adam Ingram (South of Scotland) (SNP): It would be churlish of me not to give the bill in its finalised form a warm welcome, even though I believe that we have missed opportunities to redress the balance of power between service users and care professionals, whose writ has always loomed large in this area.

The Minister for Health and Community Care has given us assurances regarding the use of community-based CTOs and that advance statements will not be casually overridden. I am sure that whoever is responsible for those matters in the second session will be held to account on those pledges.

I am pleased that the bill, when enacted, will represent a break from the traditional approach, which focused on the need to maintain public safety at the expense of individual rights and freedoms—or, more crudely, the lock-them-away mentality. The emphasis in this bill is on providing care and treatment—it is right that that is reflected in its title—while, of course, still ensuring that the safety of the seriously ill patient and the general public is assured. It is important to acknowledge that the bill deals with people who are in extremis and among the most vulnerable and stigmatised in our society. I believe that the bill's provisions are progressive and enlightened and will help to roll back the dark tide of fear, ignorance and prejudice that has engulfed people with mental illness and, of course, their families.

A great deal of credit must be given to the Millan committee, whose careful consideration of the issues and wide consultation, undertaken over a two to three-year period, provided both the intellectual underpinning and much of the detailed work that were required to draft the bill. That is not

to say that the first draft of the bill when it reached Parliament did not have major flaws and omissions. I commend warmly the work of the Health and Community Care Committee, as well as the ministers' willingness to compromise, for the restoration of the rest of Millan's recommendations for the most part.

The big concern that remains centres on the principle of reciprocity and the question whether sufficient resources will be allocated to ensure that the bill's provisions will be properly resourced and fully implemented. I find it difficult to believe that the implementation of the bill will not come without enormous pressures on the resources that are available. Having looked at the evidence that was given to the committees, particularly to the Finance Committee, I realise that I am not alone. The British Medical Association stated in its evidence:

"the costs of the implementation of the Bill to NHS Scotland have been significantly underestimated."

It also said that there are

"significant hidden costs associated with the Bill, principally arising from an increase in workload."

Recurring issues that were highlighted by all those who gave evidence included the costs of more mental health officers, psychiatrists and psychologists, the provision of training and whether sufficient funding will be allocated to local authorities.

The Deputy Presiding Officer: I will have to hurry you, Mr Ingram.

Mr Ingram: I will just wind up.

At last year's conference in the Hub, which coincided with the launch of the bill to Parliament, a staggering 88 per cent of delegates from across the mental health community expressed the view that we do not have a sufficiently comprehensive range of services to deliver reciprocity. That scepticism must be dispelled and, for that purpose, I commend Malcolm Chisholm for accepting Shona Robison's amendment to his motion. I also press the minister to support the establishment of a mental health task force, along the lines of the task force that we have for cancer care, to drive forward implementation and provision of comprehensive community services.

16:14

Janis Hughes (Glasgow Rutherglen) (Lab): I associate myself with the remarks thanking the committee clerks for their sterling efforts on this gargantuan bill. I am sure that they are delighted that they can finally get their lives back, now that the bill is coming to its conclusion.

As Margaret Jamieson mentioned, the number of organisations that contributed along the way is probably unprecedented, certainly when compared with any bill that I have been involved with. Thanks must go to those organisations for the amount of work that they put into providing us with information and for trying, on behalf of the people whom they represent, to shape the future of mental health care in Scotland.

I thank the witnesses who came to the committee, who gave some of the most poignant evidence that I have heard. Their evidence was extremely useful to us in shaping how we saw the bill develop at its later stages. They must be thanked for their efforts and for their courage in appearing at the committee, which must be quite a daunting experience the first time. The bill will make a fundamental difference to the lives of those with mental illness.

I will focus on a couple of issues. The principle of compulsory treatment orders caused considerable consternation, and gave committee members some difficulty. However, there was great consensus in the committee. I supported the principle of the orders, and the committee felt likewise, but we needed a good deal of discussion about, and assistance with coming to terms with, some of the issues involved. We must recognise that for some people, being treated in the home is not always the best solution. A significant number of people view hospital as the appropriate place for treatment, and see the home as a sanctuary. We heard that expressed eloquently at stage 2. We should not underestimate that factor, and I am delighted that we have now amended the bill to take account of it. I appreciate that one size does not fit all; we must judge each case on its merits.

Another issue that I felt strongly about was the need to provide age-specific services; I spoke about that yesterday. We heard at length about some of the consequences of not providing such services. I am delighted that, when it is passed today, the bill will ensure the provision of age-specific services. As we heard from Children in Scotland, one in 10 children under the age of 16 will experience a mental illness severe enough to affect their daily lives. It is vital that we help and support those children and young people through their problems.

Entrapped patients have been mentioned. In the 21st century, the fact that patients are looked after in high-security facilities, when it has been agreed that that level of security is not necessary, is a disgrace. The bill gave us an opportunity to deal with that situation, and I am not saying that it was all plain sailing, but we have now agreed to amend the bill and, in the fullness of time, we will end the plight of entrapped patients.

There is much more in the bill to be celebrated. It creates new flexible and user-centred orders for compulsory care and treatment, as well as establishing mental health tribunals and stronger

rights for service users to be involved in decisions about their care. The bill gives us an opportunity to improve the lives of Scots and is the most radical reform of mental health law for 40 years. It was vital that we got it right, and I believe that we have done that. I commend the bill to the Parliament.

16:18

Nicola Sturgeon (Glasgow) (SNP): In supporting the bill, I add my thanks to a number of people. First, I thank my colleagues on the Health and Community Care Committee. In particular, I thank Shona Robison, who has done a power of work on the bill and has been successful in achieving significant amendments, especially those on appeal against excessive security and on including psychological interventions in the definition of medical treatment. Secondly, I thank all those who gave evidence during the course of the bill. In particular, I thank the service users who spoke frankly to the committee about their experiences. We should be grateful for that. I also thank the clerks, who worked round the clock. We are all indebted to them for their support and advice to committee members.

We all support the intention and principles of the bill, and I for one am happy to see it pass into law. It modernises outdated mental health law and, in many respects, it places the interests of patients at the heart of the new framework. I am particularly pleased about the establishment of the mental health tribunal, which is a far more preferable way of dealing with mental health cases than the current sheriff court system. That is one very positive new development, and there is a whole host of others.

Members have expressed concerns about the process of the bill. I do not want to labour what they have said, but I should say that the sheer volume of amendments and the complexity of the bill will mean that careful post-legislative monitoring will be necessary. We have said much about cross-party consensus, but I will bring that to an end by giving a commitment on behalf of the soon-to-be-elected Executive that we will ensure such scrutiny after the election. Mary Scanlon will be glad to know that I have a sense of humour.

As the minister said, the SNP's amendment is similar to an amendment that the SNP lodged at stage 1, which the Executive supported. It reflects the almost—if not completely—unanimous view of those who gave evidence that the provisions of the bill would not be adequately resourced. There is a lingering concern that a shortage of money, facilities and staff in key areas might undermine the operation of the bill. A repeatedly expressed concern about the new community-based CTOs was that they might be misused in some circumstances as a result of pressure on resources. The concern that the amendment expresses has been raised at every stage of the bill, but that makes it even more appropriate for us to raise the concern again at the final stage so that we all agree that adequate resources are essential to ensure that the bill works in the way that it is intended to work.

The final point that I want to make is similar to a point that Shona Robison made. One in four people in Scotland will suffer a mental health problem at some stage in their lives, which probably makes the bill one of the most important bills that the Parliament has considered in its short life. We should all be proud of its passage into law.

16:22

Bill Butler (Glasgow Anniesland) (Lab): The bill that we are about to pass is a vital and long-overdue reform of the current legislative framework. Colleagues will know that there has been no reform of Scots law on the compulsory care and treatment of people with mental disorders for more than 50 years.

Members have correctly said that the bill will be one of the most important pieces of legislation that the Parliament has passed in its brief life. It deals with highly complex matters and, given the difficulty of the subject, has raised ethical dilemmas that have not been easy to resolve—Mary Scanlon spoke eloquently about those.

However, the bill that is before us is fit for purpose. It is designed to create new and flexible orders for compulsory care that meet people's needs and it provides a framework of stronger patients' rights for involvement in decision making about their care. When the bill is enacted, it will establish a legislative structure that is essential to make available a service that more effectively meets the needs of mentally disordered offenders, while ensuring community safety.

I want to say a little more about some issues that have exercised members of the Health and Community Care over many months. A majority of witnesses supported mental health tribunals and, like my colleague Nicola Sturgeon, I think that such tribunals will be a welcome innovation. They will help to destigmatise the process and will be less intimidating. As a result of their composition and membership, they will be capable of making informed and sensitive decisions. It is essential that their performance be closely monitored, especially in the light of the less-than-comforting performance of tribunals in England.

I reiterate my support for the provisions relating to patient representation, which I voiced in the stage 1 debate on the bill on 11 December 2002. The provisions clearly signify a real improvement on the current situation. I also warmly applaud the

provisions relating to people who are detained in conditions of excessive security. Those provisions are imaginative and enlightened; I believe them to be good and believe that they will do good.

I do not want to fail to record my appreciation for the indefatigability of the committee's clerks, who are ably led by Jennifer Smart. The huge amount of work that those officials have undertaken is worthy of the highest praise. More than 1,000 amendments were processed at stage 2, which is no mean feat. That was vital to the passage of the bill.

I also acknowledge the way in which the ministerial team worked in tandem with the committee to meet the many concerns and complex issues that arose in the course of the committee's deliberations. All committee members appreciated the Executive's positive approach. If Bruce Millan is the father of the Mental Health (Care and Treatment) (Scotland) Bill, then Mary Mulligan, the Deputy Minister for Health and Community Care, is most assuredly its midwife.

The chamber should welcome the bill whole-heartedly and approve it unanimously at decision time. It is the result of much hard work by many people. Their efforts have produced legislation that will improve the lives of many of our fellow citizens. It is a signal example of the Parliament at its best.

16:26

Dr Richard Simpson (Ochil) (Lab): Before I begin, I must ask whether I need to make a further declaration following the one I made at stage 2.

The Deputy Presiding Officer: No.

Dr Simpson: Thank you.

Passing this bill will be the end of a long process that has had the unparalleled involvement of civic Scotland. Together with the Adults with Incapacity (Scotland) Act 2000, which was passed early in the parliamentary session, the bill demonstrates clearly the worth of our Parliament. The shift that the bill represents is absolutely massive. At the beginning of my working life, as a student, there was a system of institutionalisation and an authoritarian approach to patient care that contrasts markedly with the values and mores of the bill. I remember that when I was a student in the Murray royal infirmary in Perth in the 1960s, I was immediately handed a large bunch of keys, because all the wards were locked. How far have we moved in that time?

We owe a duty of thanks to the Millan committee for the major piece of work that it undertook. It produced a report of considerable vision that also ensures that the changes are evolutionary and do not destabilise our system.

The absence of the Millan principles from the face of the bill was a lost opportunity to trumpet core beliefs that were, and are, worth stating as the essentials that underpin the bill and the principles on which interpretation by the courts must be based.

The bill differs in a number of respects from the draft English mental health bill. Its tone reflects partnership and respect for the individual, but it does not forget public protection, which seems to be the paramount element of the draft English legislation.

Of all the principles reciprocity is, for me, perhaps the most important. It will be a lasting testament to the first session of the Parliament. We may have argued over the precise words, but the intention of the whole Parliament—the minister no less than party spokespersons or other members—was clear. If the state has to deprive an individual of their liberty, the duty of care that it owes them is greater than usual—and the care that it provides must be the best. As the minister has acknowledged, the challenge is to drive forward the mental health framework. I acknowledge that substantial progress has already been made in shifting resources to the community.

In particular, I welcome the role that the bill gives to advocacy, which I sought to introduce to the Adults with Incapacity (Scotland) Bill. I welcome the fact that the Executive has introduced it to the Mental Health (Care and Treatment) (Scotland) Bill. We will need to keep a close eye on developments in that area; in particular, we will need to ensure that adequate training is provided.

I thought that the Adults with Incapacity (Scotland) Act 2000 should have made provision for advance statements, but they are recognised in the Mental Health (Care and Treatment) (Scotland) Bill. It is appropriate that we do not give such statements legal force at this time, but I am sure that they will play a major part.

Many members have wrestled with the issue of entrapment, which is the opposite of the principle of the least restrictive approach that underpins the bill. Progress has been made on that issue. The entire Parliament recognises that medium-secure units must be developed as soon as possible.

At each stage of the bill, I said that the jury was out on community orders. I welcome the Executive's undertaking to monitor and research the orders and ask it to go further by asking Professor Jung, the chief scientist, to ensure that there is a full, commissioned, random-controlled trial.

I congratulate the Health and Community Care Committee on the extremely difficult work that it has undertaken. I also congratulate the Executive

team and the bill team; I know how much effort the bill team had to put in. Criticisms have been made of the speed of the bill's passage, but I believe that the bill is excellent. Today we will pass a significant bill of which the Parliament can be proud.

The Deputy Presiding Officer: I inform members that I intend to squeeze the brief debates on the Sewel motions that are to follow on the basis that the motions were originally to be taken without a debate.

16:30

Mr John McAllion (Dundee East) (Lab): I add my thanks and congratulations to anyone who had anything to do with the bill, even the ministers, whom I do not usually congratulate on such occasions. In particular, I mention the clerks to the Health and Community Care Committee, who have performed truly heroically during the passage of the bill. Even to my jaundiced eyes, the civil servants who were on the bill team seemed to be trying to help the committee rather than to hinder it. I also thank the users and voluntary sector organisations who shaped the attitude of committee members and, in so doing, the end-product. Those people deserve to be congratulated tremendously on what they did.

There were problems with the timetabling of the bill. During the 12 years that I spent at Westminster, I always believed that bills were handled badly at the committee stage because progress was far too slow and there was far too much filibustering and time wasting by committee members. There was a struggle between the Government, which wanted to get bills through as quickly as possible, and the Opposition, which wanted to slow them down as much as possible.

That does not happen at Holyrood; instead, bills go through too quickly. The debates on amendments at the committee stage are honest, non-partisan and open, but there is insufficient time for them. I do not think that the reputation of the Parliament will be built on the number of bills that we pass in a four-year period; it will be built on the quality of the bills that we pass. I would rather have 30 good bills than 60 bad ones. All of us must take that lesson to heart.

The bill is a good one and some of its measures are excellent. In particular, I am glad that mental health tribunals will be established to safeguard the new patient rights that will be established in law, particularly the right to individual and collective advocacy, which will make a huge difference to many users of mental health services in this country. I also hope that the tribunals will underpin the Millan principles and bring them into the real world. I am concerned not so much about what is written in the bill as about what happens in the real world, and the tribunals will make a great contribution to that.

I am delighted by the success of Margaret Jamieson's amendment 34, which is a huge step forward and which will ensure that there is a statutory right for children to access age-appropriate mental health services.

At the end of the day, the bill provides a legislative framework and sets out rights, duties and responsibilities, but it will not shape services on the ground. Therefore, I am delighted that the minister has accepted Shona Robison's amendment, which is key. It is important that the resources are made available to ensure that all the ideas that are enshrined in the bill become a reality for the patients who will use the services in the real world. I hope that that happens in future.

We had a hard job passing the bill, but the Parliament and the health committee in the next session will have an even harder job ensuring that the bill works in the real world.

16:33

Alex Johnstone (North-East Scotland) (Con): I hope that I do not seem like an interloper, but one of the main things that I have learned by sitting through the past two days is that I am glad that I did not have to sit through the whole process in the Health and Community Care Committee. The process has been a marathon and I congratulate all those who took part in it.

I speak because I think that we can learn lessons from the bill that will stand us in good stead for the future. As an Opposition business manager, nothing would have given me more pride than to steal a bill from the Executive before the end of the session, so it was disappointing that the Mental Health (Care and Treatment) (Scotland) Bill was the one that came closest to the wire. I highlight the fact that the bill is good and that I look forward to voting for it tonight, but that conclusion is based more on the balance of probability than on my having been persuaded beyond reasonable doubt, due to the many amendments that were lodged late in the process.

Some people might argue for a second chamber, so that we can revise and review as part of the process, but, for more than one reason, I am not one of those people. Our procedures are robust enough to take care of all the requirements, but the one problem is that we have submitted our legislation to procedures at breakneck speed. In the past few days, I have become light-headed at the rate at which we have passed amendments. I congratulate the ministers, particularly Malcolm Chisholm, who was responsible for the group with 112 amendments—he dutifully went through every one and explained them in detail.

Above all, the lesson that the Parliament and the Executive must learn for the future is that when legislation of such complexity is to be taken through, it needs time and must be given the time for proper scrutiny at every stage. If such scrutiny is given, the demands for second chambers and substantial changes to our procedures will fade into insignificance.

Finally, I will say a few words about the SNP amendment. It has been said by Mary Scanlon and others that the amendment simply states the obvious. I do not think that there is any harm in stating the obvious. The trouble with common sense is that it is not so common. In this case, stating the obvious gives final direction to the bill and will give it the opportunity to achieve the successes in Scottish mental health care that it has the potential to deliver.

16:36

Karen Gillon (Clydesdale) (Lab): I support the bill and the impact that it will have on the state hospital and the patients and staff there, especially in relation to the provision of appropriate treatment. If many of the patients in the state hospital had received appropriate treatment and early intervention, they would not have found themselves in the situation they are in. The moves that are proposed in the bill and the changes that will be made will enable us to prevent patients from reaching the state hospital, and that is a positive thing.

The second issue is entrapment. As the constituency member, I have probably visited the state hospital more often than any other MSP. There are simply too many people inappropriately detained in the state hospital. Their detention is inappropriate for them and for the other patients. The fact that the patients have such a wide range of illnesses means that it is difficult for staff to provide the appropriate treatment and support for patients who require to be in the state hospital and, at the same time, to deal with those who should be placed elsewhere.

If we are to tackle mental illness head-on, local provision of appropriate medium-secure facilities is essential. However, we must ensure that our constituents are adequately consulted. As the member for the constituency in which the state hospital is situated, I can tell members that local people will not be falling over themselves to have medium-secure units in their areas. There are many myths and lies out there about mental illness and many reasons why people say that there is a threat to local communities. As MSPs, we have a duty to ensure that those myths are dispelled, and we have a duty to ensure that people who are under our care are placed appropriately. In a modern society, if someone does not require to be in a facility such as the state hospital, they should not be there.

The Parliament has a collective responsibility to ensure that, in future, the facilities are appropriate. Some of us will have to make difficult decisions and statements and will have to say some hard things when such facilities are built, but if we are serious politicians, that is what we will have to do. I urge all members, for the sake of all patients in the state hospital, and for the sake of all of us who have suffered from mental illness in the past or who will suffer in the future, to ensure that the motion as amended is passed and that the resources are made available to support perhaps the most vulnerable members of our society.

16:39

The Deputy Minister for Health and Community Care (Mrs Mary Mulligan): This short debate has crystallised what has been apparent throughout the parliamentary proceedings on the bill: there has been a real consensual desire to do what is best for people with mental disorder.

I take the opportunity to join the tributes that have been made to all those who contributed to the development and preparation of the bill. The bill team put an awful amount of work into the bill and had quite a task in supporting me throughout the process. I am grateful to the team for that. I also thank the many voluntary organisations, health care professionals, social work interests and—as Janis Hughes and others said—individuals who have contributed to the process in a personal way.

Finally, I thank the Health and Community Care Committee for its balanced and constructive input. I am glad that it contributed to the debate at stage 2, which meant that I could occasionally take a break from what were fairly long proceedings. I hope that people will reflect on the outcomes of the bill and feel that it has been worth while.

I think that the Parliament does itself an injustice if it lets the large number of amendments that were considered at stages 2 and 3 obscure the reality that many of those were lodged either in response to commitments made at earlier stages or simply to improve the drafting and the bill's accessibility, which is important.

I believe that we have a bill that is fit for purpose and that has a flexibility that will enable a ready response to developments in care and treatment. I know that it is perhaps a cliché to say so nowadays, but in this case it bears repeating: the Scottish Parliament made the bill possible. Again, we are out in front of our colleagues in England and Wales, where mental health legislation is yet to be introduced. The Mental Health (Care and

Treatment) (Scotland) Bill is another success story for devolution and, with the Adults with Incapacity (Scotland) Act 2000, we now have a corpus of mental health legislation that is the equal of, if not better than, anything else in the world.

Members around the chamber raised the question of resources, as does Shona Robison's amendment. The Executive has done what it said it would do at stage 1. We have launched a comprehensive assessment of existing mental health service provision, which will enable us to determine how the current range of facilities, supported by the additional resources that we are making available, will be able to meet the bill's objectives. Once Dr Grant's findings are published, I am sure that further discussions will be had with the Health and Community Care Committee and that further monitoring will take place.

We have also heard concerns about work-force issues. Those are also being addressed, although I do not have time to go into them in detail. However, we recognise the problems and they are being tackled.

As Malcolm Chisholm said, we will now press ahead with the implementation process. I believe that we can take great pride in the bill, but we cannot rest on our laurels, because there is much work to be done. It is remarkable what we have achieved in this session in the mental health field: a major push on mental health promotion, led by the national advisory group, which Malcolm Chisholm leads; a comprehensive initiative to tackle the scourge of suicide; a major anti-stigma campaign in the shape of the "see me" project; and the Breathing Space telephone support line, which was set up to help those who are feeling down. The bill is a reflection of the Parliament's resolve. Mental health is truly on the map and we are determined to keep it there.

Sexual Offences Bill

The Deputy Presiding Officer (Mr Murray Tosh): We now have two brief items of business. The first is consideration of motion S1M-4022, in the name of Jim Wallace, on the Sexual Offences Bill, which is United Kingdom legislation. I call the Deputy Minister for Health and Community Care, Hugh Henry, to move the motion. I will be grateful, minister, if you will restrict your speech to five minutes.

16:43

The Deputy Minister for Justice (Hugh Henry): Following the Justice 2 Committee's consideration of the Sewel memorandum on 18 March, I wrote to the convener on the same day to explain in more detail the reasons behind our proposals to amend the schedule in the Sexual Offences Bill that lists offences that can trigger sex offender registration. In that letter, I sought to clear up any misunderstanding and I am happy to be able to do so again.

The Sexual Offences Bill was first introduced at the House of Lords, but it will need to pass to the House of Commons for its consideration. For the avoidance of doubt, the list of offences for Scotland in schedule 2 of the bill as introduced in the House of Lords is simply a re-statement of the list that currently appears in paragraph 2 of schedule 1 to the Sex Offenders Act 1997. Those offences are a mixture of common law sexual offences, such as rape, and statutory sexual offences, such as incest. All the offences that are listed trigger registration automatically. The key word is "automatically". We believe that the approach of having specified sexual offences for which conviction in itself triggers registration is right. That view was endorsed by the expert panel on sex offending, which Lady Cosgrove chaired.

We will seek to instruct a Government amendment to close a gap in the bill that the expert panel identified. At present, an offender might be convicted of a non-sexual offence, such as breach of the peace, but there might be evidence of a significant sexual element in the offender's behaviour. There is currently no way to ensure that he or she is subject to the requirements of the sex offender register.

Richard Lochhead (North-East Scotland) (SNP): The minister might recall that, when previously we debated amending the 1997 act and the supervision of sex offenders, we discussed Steven Beech, who is a sex offender who lives under supervision in Aberdeen after Cambridgeshire constabulary gave him a one-way ticket there. I understand that talks on that continue between the Scottish Executive and the

Home Office. Will the minister assure Parliament and the people of north-east Scotland that those talks are a priority and that it is hoped that a positive outcome will be achieved not only on Steven Beech's location, but on costs? It costs the Scottish taxpayer £200,000 a year to supervise that individual.

Hugh Henry: As Richard Lochhead knows, the process could work in the other direction. We are in contact with authorities in Grampian about that case and we continue to be in contact with our colleagues in the Home Office on it and other issues. It would be inappropriate for me to go into any detail other than to say that we will keep the matter under review.

We propose to close the gap that I described by introducing amendments to extend the list in schedule 2 to the bill to include any offence. However, the difference is that registration will not be automatic, unlike with listed sexual offences. Instead, the judge will examine the circumstances of the offence and decide whether the offender ought to be subject to registration because there has been a significant sexual element in the offence. We want to ensure that if the sentencing judge considers that an offender's behaviour displayed a sexual element that is significant enough to warrant additional measures to protect the public, the legislation is in place to enable the offender's being subject to registration.

We consider balance to be essential, which is why we want to retain and re-enact the existing list of sexual offences that—because of their nature—trigger automatic registration. As I explained to the Justice 2 Committee, a good example of that approach is the new human trafficking offence in the Criminal Justice (Scotland) Bill. It would be inappropriate for that offence to trigger automatic registration in every case, but our amendment will enable the judge to examine the circumstances of the offence and to order registration as appropriate.

The committee was also concerned that we might miss out important offences by retaining a list. I assure members that we will not be complacent about the need to keep an up-to-date list of offences that trigger automatic registration, as opposed to those that the judge should consider case by case in accordance with the Cosgrove recommendations. The bill contains a clause that will by order confer a power on Scottish ministers to add to the list of offences in schedule 2 at any time.

In recent years, we and our Westminster colleagues have acted swiftly to introduce safeguards and to strengthen the sex offenders register. The measures in the bill represent a further significant step in addressing the risk that sex offenders pose to our communities. I urge members to support the motion.

I move,

That the Parliament endorses the principle of protecting society from persons who pose a risk of causing sexual harm and agrees that the provisions within the Sexual Offences Bill that relate to devolved matters and which re-enact the Sex Offenders Act 1997, extend the categories of offenders required to register, increase restrictions on sex offenders and strengthen the notification requirements and operation of the Sex Offenders' Register should be considered by the UK Parliament.

16:48

Michael Matheson (Central Scotland) (SNP): I welcome the bill; especially part 2, which will apply to Scotland. That part contains provisions to reduce the time scale for several notification requirements for sex offenders. In some cases, the time scale will be reduced significantly from 14 days to three days. The proposals will promote public safety. I also welcome the intention to amend schedule 2 to allow judges to decide whether an offence has a significant sexual element and whether the offender should be subject to the notification requirements.

I note from the Justice 2 Committee's deliberations on the bill that it expressed concerns; for example, it questioned whether the provisions were required and whether common law could deal with the matter. However, having read the minister's response to the committee's concerns, I believe that amendment of schedule 2 is appropriate, which is why the SNP will support the Sewel motion.

However, I am concerned about the Sewel motion's handling and the use of the Sewel convention. The bill entered the House of Lords on 28 January and received its second reading there on 13 February. When the Justice 2 Committee considered the Sewel motion, it expressed concerns that the motion was being brought before the Scottish Parliament after the second reading had taken place. I remind members of Lord Sewel's comments in the House of Lords in July 1998. He stated:

"we would expect a convention to be established that Westminster would not normally legislate with regard to devolved matters in Scotland without the consent of the Scottish parliament."—[*Official Report*, *House of Lords*, 21 July 1998; Vol 592, c 791.]

The minister is well aware of the Scottish National Party's concerns about the idea of the Sewel convention. However, if we are to have a convention, motions should at the very least be placed before the Scottish Parliament before the House of Lords or the House of Commons has started to proceed on a bill. Unless we address that issue, some of the concerns that the Justice 2 Committee has highlighted will not be addressed. I hope that the Deputy Minister for Justice will assure us that any Sewel motions that are lodged

in future will be lodged at an early stage in the parliamentary proceedings of the House of Commons or the House of Lords.

16:51

Bill Aitken (Glasgow) (Con): Sewel motions are always calculated to cause some excitement in the SNP. However, on this motion, the SNP's comments have a degree of resonance, because there can be no doubt that the matter has been expedited to the point at which some confusion would inevitably arise. There have been some hard lessons to be learned in the Parliament over the past three or four weeks. Far too much has been crammed into the final meetings of the Parliament and this motion is yet another example. That will clearly have to be looked at in the days ahead.

There is no serious disagreement on the policy intentions of the bill, which are worth while. The only caveat I offer is that I am still not entirely certain that the matter would not have been better dealt with by stating that statutory and common-law offences in which there is a significant sexual content should be included, rather than listing the offences involved. That would have dealt with serious breach of the peace.

Hugh Henry *indicated disagreement.*

Bill Aitken: The minister shakes his head. I know that it is a matter of opinion, but I think that it is an omission that could, with foresight, have been filled.

We have no difficulty with the policy content. The Conservatives will support the motion.

The Presiding Officer: I call Pauline McNeill. In view of her point of order yesterday, I hesitate to restrict her time, but I ask her to manage just two minutes.

16:52

Pauline McNeill (Glasgow Kelvin) (Lab): I will do my best.

Many members would agree that the system is not yet perfect, but every Sewel motion must be considered on its own merits. I agree with the Scottish ministers that it is important that the subject that is before us be dealt with in a United Kingdom framework.

I welcome the fact that committees will at least have a chance to consider Sewel motions. However, as members can read in the Justice 2 Committee's report, we are a bit concerned about the timetable. There were one or two concerns expressed that will, I hope, be allowed to be put before the House of Commons when it considers the bill.

The committee wanted a wee bit more time to reflect on issues that Bill Aitken and Michael Matheson have mentioned. One of the matters about which we felt there should be consideration is whether the bill should contain simply a list of offences and common-law crimes. Suffice it to say that we are asking for Scotland's common-law system to be protected and that common-law offences be not merely listed in the same way that English offences would be. That is an important point.

We asked the minister whether human trafficking might in future be considered by a judge to be a crime that has a significant sexual element. The minister is right to say that the circumstances would have to be examined so, to that extent, it is right to give judges discretion in such cases. However, perhaps we will have to return to that crime and review the matter on its own merits. Some of the ringleaders in human trafficking should be caught by sex offenders legislation and should be on the sex offenders list. Perhaps Parliament could consider that in future. Under the bill, we will be giving judicial discretion: if a judge thinks that a crime has a significant sexual element to it, the offender could be placed on the sex offenders register. For the moment, that is right.

I hope that it is possible for some of the points that the Justice 2 Committee made in its report to be passed on in the process so that those matters can be considered in future.

I support the Sewel motion.

16:55

Hugh Henry: Bill Aitken might misunderstand the situation. The issue of a breach of the peace of a serious sexual nature will be dealt with by the bill; it will be a matter for judges.

The points that Michael Matheson raised are part of a broader debate, which has been addressed. The Executive sent a note to the Procedures Committee to point out a useful way of moving forward. We received a reply dated 18 March from Murray Tosh, the convener of the Procedures Committee, which said that the committee would have no objections to the proposals in paragraph 5 of the Executive's memorandum being implemented at once. What has been suggested reflects many of the concerns that have been expressed in Parliament over time.

Although I note Michael Matheson's opposition in principle to Sewel motions, I think that we have acted reasonably in this case.

Railways and Transport Safety Bill

16:56

The Presiding Officer (Sir David Steel): We move to consideration of a second Sewel motion—motion S1M-4023, in the name of Iain Gray, on the Railways and Transport Safety Bill. I invite Lewis Macdonald to move it.

Motion moved,

That the Parliament endorses the principle of introducing alcohol and drug testing for mariners as set out in the Railways and Transport Safety Bill and agrees that the relevant provisions in the bill on these issues that relate to devolved matters should be considered by the UK Parliament.—[*Lewis Macdonald*.]

The Presiding Officer: The fact that Mr Macdonald only moved the motion has taken me by surprise. No member has asked to speak on it, so Pauline McNeill could have had another minute.

Parliamentary Bureau Motions

16:57

The Presiding Officer (Sir David Steel): The next item of business is consideration of two Parliamentary Bureau motions. Mr Robson may take his time in moving them. [*Interruption.*]

Bill Aitken (Glasgow) (Con): Such was the noise in the chamber that I was unable to hear Mr Robson. It would be helpful if he repeated that.

The Presiding Officer: I hope that Mr Robson will not mind moving the first motion again, for the benefit of Mr Aitken.

Motion moved,

That the Parliament agrees that the draft General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 be approved.—[*Euan Robson*.]

The Presiding Officer: I now ask Mr Robson to apply his mind to motion S1M-4033.

Motion moved,

That the Parliament agrees that the draft Rehabilitation of Offenders Act 1974 (Exclusion and Exceptions) (Scotland) Order 2003 be approved.—[*Euan Robson*.]

Motion without Notice

16:58

The Presiding Officer (Sir David Steel): We will have to move decision time forward.

The Deputy Minister for Parliamentary Business (Euan Robson): I seek leave to move a motion without notice to bring forward decision time to now.

The Presiding Officer: I am minded to accept such a motion. Do members agree to that?

Members *indicated agreement*.

Motion moved,

That, under Rule 11.2.4 of Standing Orders, Decision Time on Thursday 20 March be taken at 4:58 pm.—[*Euan Robson.*]

Motion agreed to.

Decision Time

16:58

The Presiding Officer (Sir David Steel): There are six questions to be put as a result of today's business.

The first question is, that amendment S1M-4024.1, in the name of Shona Robison, which seeks to amend motion S1M-4024, in the name of Malcolm Chisholm, that the Mental Health (Care and Treatment) (Scotland) Bill be passed, be agreed to.

Amendment agreed to.

The Presiding Officer: I was not present when the minister accepted the amendment. Life is full of surprises.

The second question is, that motion S1M-4024, as amended, be agreed to.

Motion, as amended, agreed to.

Resolved,

That the Parliament agrees that the Mental Health (Care and Treatment) (Scotland) Bill be passed but, in doing so, supports the view expressed by many giving evidence on the Bill, and by three committees of the Parliament, that the aims of the Bill will not be met unless services and facilities are adequate to meet the demands placed on them.

The Presiding Officer: I have much pleasure in declaring that the Mental Health (Care and Treatment) (Scotland) Bill is passed. [*Applause.*]

The third question is, that motion S1M-4022, in the name of Mr Jim Wallace, on the Sexual Offences Bill, which is UK legislation, be agreed to.

Motion agreed to.

That the Parliament endorses the principle of protecting society from persons who pose a risk of causing sexual harm and agrees that the provisions within the Sexual Offences Bill that relate to devolved matters and which re-enact the Sex Offenders Act 1997, extend the categories of offenders required to register, increase restrictions on sex offenders and strengthen the notification requirements and operation of the Sex Offenders' Register should be considered by the UK Parliament.

The Presiding Officer: The fourth question is, that motion S1M-4023, in the name of Iain Gray, on the Railways and Transport Safety Bill, which is UK legislation, be agreed to.

Motion agreed to.

That the Parliament endorses the principle of introducing alcohol and drug testing for mariners as set out in the Railways and Transport Safety Bill and agrees that the relevant provisions in the bill on these issues that relate to devolved matters should be considered by the UK Parliament.

The Presiding Officer: The fifth question is, that motion S1M-4032, in the name of Patricia Ferguson, on the approval of a statutory instrument, be agreed to.

Motion agreed to.

That the Parliament agrees that the draft General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 be approved.

The Presiding Officer: The final question is, that motion S1M-4033, in the name of Patricia Ferguson, on the approval of a statutory instrument, be agreed to.

Motion agreed to.

That the Parliament agrees that the draft Rehabilitation of Offenders Act 1974 (Exclusion and Exceptions) (Scotland) Order 2003 be approved.

Suicide Emergency Telephone Hotline

The Deputy Presiding Officer (Mr George Reid): The final item of business today is a members' business debate on motion S1M-3897, in the name of Kenny Gibson, on a suicide emergency telephone hotline.

Motion debated,

That the Parliament notes with concern that in 2000 there were 880 reported suicides in Scotland, 676 males and 204 females, although the true figure could be higher; is conscious that many thousands of other people attempt to take their own lives each year; regrets that only a minority of the population know the telephone number of the Samaritans or any other organisation they could contact for help when feeling suicidal; believes that, to assist in achieving the goal of a 20% reduction in the incidence of suicide by 2013 set by the Scottish Executive in its *National Strategy and Action Plan to Prevent Suicide in Scotland*, everyone should be made aware of an all-Scotland telephone number to call for help; acknowledges that in the United States anyone can call a nationwide toll free number from anywhere in the country, 1-800-SUICIDE or 911, to ask for help which is provided swiftly if they say they are in "suicidal danger"; believes that the Scottish Executive should set up a suicide prevention crisis hotline, whereby calls from suicidal individuals are treated as an emergency, through using the existing 999 emergency number from which they can be referred directly to a dedicated suicide prevention 24 hour hotline, and further acknowledges that the purpose of this line would be to save lives through dissuading suicidal people from killing themselves and that the Executive should, once such a line was established, take steps to let the public know about it.

17:01

Mr Kenneth Gibson (Glasgow) (SNP): This is a timely debate following our debate on the passage of the Mental Health (Care and Treatment) (Scotland) Bill, during which the subject of suicide was occasionally touched on.

In speaking to the motion today, I must first thank Mark O'Dowd and Gavin Brown of Glasgow Junior Chamber of Commerce, who first proposed a national suicide helpline called "project suicide". I also thank the 21 MSPs who signed the motion. Junior Chamber Scotland is now fully behind the idea and the chairman of Bishops Solicitors has agreed to become the project's legal adviser.

I also congratulate the *Daily Record* on its high-profile "save our kids" appeal. Following the tragic suicide of 12-year-old Emma Morrison, the *Daily Record* has raised £40,000 from readers to help Penumbra assist suicidal teenagers receive the counselling services that they need. I wish the *Daily Record* all the best in its campaign to raise £200,000.

Scotland has an appalling suicide problem. In 2000, at least 880 people committed suicide—the actual number may have topped 1,000. In addition, at least 1,500 people attempted to commit suicide. Those are horrific figures for such a small country. Scotland has a suicide rate of 18 per 100,000, which is twice that of England. Our suicide rate is also 50 per cent higher than that in the United States, despite the greater opportunity for suicide there because of the widespread availability of firearms. Since 1991, Scotland's suicide rate has increased by an alarming 26 per cent. More young men now die by their own hand through suicide than die through drug overdoses and car crashes combined.

The reasons for an individual taking his or her own life are often highly complex. Within the limited time available, I do not intend to explore the reasons why the difference in suicide rates between England and Scotland is so acute or why people chose to kill themselves. Those issues were explored in my previous debate on suicide on 6 April 2000. Today, I wish to consider a proven method of saving lives through suicide prevention.

What people in crisis need is an easy-to-remember telephone number that people at risk of suicide can call for help. The number must be not only free but easily recognised and remembered nationwide. It is important that a hotline gets everything right. There can be no accidental disconnections or stressed operators, because callers needs urgent help. The call may be the person's last lifeline, so the ability to connect directly to a trained crisis worker is important.

A person on the brink of suicide may not think clearly or reach for the phone book. They run through all the options in their head and if they cannot think of anything, they kill themselves. That is why a well-publicised, easy-access freephone number is so vital, as it will pop into the mind instantly and save lives. Currently, Scotland lacks a national freephone number that someone can call in the event of a suicidal crisis. The telephone numbers of organisations such as the Samaritans are not widely known. American research has shown that having to contact directory inquiries may inhibit a suicidal caller from making such a call.

Both the United States and Australia have set up national suicide hotlines that operate under umbrella networks that link crisis centres across each country. That type of programme is affordable, easily adaptable and works effectively to reduce suicide rates.

The American system is called Hopeline USA. It was established in 1998 by Reese Butler after the death of his wife by suicide. Hopeline is an umbrella organisation that links crisis centres throughout the USA. When the Hopeline number is dialled, the caller is immediately linked to the closest crisis centre without an intermediary. If

there is no answer after four rings, the caller is transferred to another centre. That is done eight times before the system hangs up. That means that, on every call, the person can be put through to eight separate centres within 32 rings. As a result, the probability of a caller reaching a person to talk to is extremely high.

Mr Keith Raffan (Mid Scotland and Fife) (LD): I ask Mr Gibson to reassure me on the important question of whether there would be duplication. The Samaritans have a long-established and very good reputation in dealing with the tragic problem of suicide. Are we not in danger of duplicating and, perhaps, of not making the most of the Samaritans' expertise? Should we not be giving that organisation more support?

Mr Gibson: I hoped to touch on that matter as I went on. The Samaritans exists to listen to people. If someone phones the Samaritans and tells them that they want to commit suicide, they do not believe that it is their job to talk people out of it. Their job is to listen and, if someone decides not to kill themselves, as far as the Samaritans are concerned, that is their choice. The organisation helps many people but we are talking about a more interactive service. I will go into that in more detail.

Hopeline uses two numbers: a toll-free number—1-800-SUICIDE—and 911. Those numbers are easily remembered and heavily publicised. It is vital that the number is easy to recognise, free, and operates 24/7. At Hopeline, trained crisis workers carry out a lethality assessment as soon as a call is received. Callers who are not considered to be at immediate risk are referred to a local crisis centre once the reason for calling is determined. If the caller is at high risk, the decision for intervention is made by the on-call supervisor who dispatches help.

Hopeline started with private money but now has a three-year grant for research and development as well as overhead costs. The project currently costs approximately $1.7 million per year to run: $1 million goes on administration, including publicity, and $700,000 goes to telephone and computer use and development, yet the organisation covers the whole USA. With new telephone and computer technology, the cost is virtually the same whether there is just one region or the entire nation is linked.

Hopeline gets 600 calls per day and received 650,273 calls between 1998, when it began, and 1 March this year. It approaches crisis centres to get them involved and linked to the network. A crisis centre requires at least 200,000 hours of training to become a part of the network. There are other strict guidelines for becoming part of the network. For example, each crisis centre maintains a database of hundreds of services currently available in the community in which it is located, ranging from intervention centres, shelters for runaway youths, domestic emergency departments of general and psychiatric hospitals, and specifically focused education and outreach programmes, such as school-based suicide prevention and crisis response teams.

The basic tenet is that every citizen has the right to necessary assistance in a life-threatening crisis. That value reflects the philosophy that active intervention must be used in such situations. Crisis intervention services offer an effective means of reducing harm to oneself or others by providing primary suicide prevention, bereavement assistance to survivors, intervention and community information about those issues.

Secondary prevention and intervention are also provided for persons who have attempted suicide, for the chronically self-destructive person and for victims of violence. Components of services in life-threatening crises are lethality assessments, rescue services, services for victims of violence or suicide survivors and community education. The bottom line is to keep the individual alive. Dispatch teams, including professional workers, are sent to save people. The suicidal person might then be examined by psychiatric liaison, or he or she might be hospitalised, often followed by out-patient therapy, both for the suicidal person and for his or her family. Intervention and the breaking of confidentiality are used only as a last resort after all other options to save a life are exhausted. If consent for help is still not given, intervention will occur without it.

At all times, callers are dealt with on a non-judgmental basis. Crisis workers offer a balanced and realistic attitude to the person and do not expect to save all potential suicide victims by themselves or to fix all their problems.

The Australian system, which is based on the American one, is called LIFE—living is for everyone. Since its establishment with Government support, suicide rates are at their lowest for a decade. Last year, there were 132 fewer suicides than in the previous year. Its motto is that one suicide is a suicide too many.

According to researchers at the University of Montreal, studies have shown that the suicide rate in areas in which a hotline is available declines faster than in areas where there is no hotline. Other studies have found that hotlines have a beneficial effect in helping attempters to avoid repeated non-lethal suicidal behaviour. With technological advances, setting up hotlines has becoming increasingly simple and inexpensive.

The Executive has a national strategy and action plan to prevent suicide in Scotland—it is called choose life. Unfortunately, in my view the strategy

lacks ambition and is currently funded only for three years. For example, the target of reducing suicide rates in Scotland by 20 per cent over 10 years will still leave Scotland with a higher suicide rate than in 1991, and a rate that is 60 per cent higher than that in England. We must aim higher.

Scotland has excellent anti-suicide organisations, such as Breathing Space—a telephone helpline funded by the Executive, which aims to provide an anonymous and confidential point of contact that is easy to access. It is an excellent service, but although the hotline has received 6,500 calls since its inception, it can be hard to reach. Nevertheless, its success shows the need for an all-Scotland, easily accessible network. Money was allocated for Breathing Space for only three years, beginning in 2001. There are no immediate plans to extend the funding, which is due to run out shortly. The helpline, which serves greater Glasgow and Argyll and Bute, is available only from early evening until 2am. It is important for a helpline to operate 24/7.

A number of crisis centres and organisations provide help, including not just Breathing Space, but the British Association for Counselling and Psychotherapy, ChildLine, Depression Alliance Scotland, the NHS helpline, the Samaritans, Stresswatch Scotland, and the University of Edinburgh's nightline. Linking those organisations nationally is vital.

The 999 emergency service at present covers police, fire, ambulance, coastguard, mountain rescue and cave rescue. Under current practice, as many as three public telecommunications operators may handle one call. Some people are placed in long queues of up to 10 minutes before being connected with the proper authority. If someone is suicidal, they need a crisis worker right away. Further resourcing of the emergency services is therefore essential if a hotline is to work effectively. However, with the support of the Scottish Executive and the minister, any problems can be overcome and many lives can be saved.

17:11

Donald Gorrie (Central Scotland) (LD): Kenny Gibson has raised an important topic. I listened with interest and learned a lot about the way in which suicide lines operate in other countries. At the end of his speech, he hit on the main point that I would like to make. It is important to organise and co-ordinate all the groups that are already involved in the area, both voluntary, such as the Samaritans, and professional, such as social work departments.

One of the things that we are not always good at in this country is combining the voluntary and the statutory. We risk duplication and waste. The Samaritans do not supply exactly the same service as the one that Kenny Gibson proposes, but they give good advice and help to people who are in the earlier stages of deep depression that might lead to suicide. My plea is that we should go ahead with a helpline, but try to co-ordinate existing services and build on them. We should have a phone number that everyone can remember. Perhaps we could also put some resources into making the phone numbers of the Samaritans and other organisations better known, which would not cost all that much.

From what Kenny Gibson said about costings, I took it that the people in America are volunteers, not paid staff, although obviously some paid staff help to run the helpline. Training is important in the American system, as Kenny Gibson said, and I know that organisations such as the Samaritans have good training. Really well-trained volunteers can play a huge part, with the support of paid people.

The issue is important. The fact that so many people commit suicide—especially so many young people—is a blot on our country. I have known, or have known of, bright young students whom one would have thought had their whole lives before them but who committed suicide. There is obviously some defect in our society that we have to address. Why do so many people in Scotland commit suicide? It is not due only to Calvinism, drink or the usual things that we blame. We have to deal with that.

Kenny Gibson has raised an important issue. I strongly support a co-ordinated attack—if that is the right phrase—on suicide. In that way, we could make life in Scotland a lot better.

17:15

Colin Campbell (West of Scotland) (SNP): I would not pretend to have much knowledge of this subject but I have just reviewed in my head the few instances of suicide that I have come across in my lifetime. I remember meeting, at the age of six, older boys—probably about 10 years older than me—who were obviously grief stricken because one of their friends, whose younger relatives I knew, had died the previous night. It was not until about 10 years later that I found out that that boy had hanged himself. To this day, I do not know whether his family knew why the boy did it. I assume that it remained totally unexplained.

The next example that I have was when I was a young teacher. A mother of two children, one of whom was in primary school and the other in secondary school, was pregnant when her husband was killed in a car crash. After the baby was born, she hanged herself. That is explicable as a combination of grief and post-natal depression.

Once, I opened a note that told me that the person who wrote it was going to kill themselves. Although I was not that person's parent, I felt a huge sense of failure, responsibility and misery. As it turned out, however, it was more of a cry for help than a reality. Although a suicide attempt was made, at least the person was able to explain how they felt and get some kind of support.

In the past two or three months, a former colleague phoned me to tell me that the son of another former colleague had, totally inexplicably, killed himself. He was a bright, go-ahead young student. On the phone with that parent, I shared a good deal of misery.

The reasons why people commit suicide are difficult to understand. I have never felt that bad about anything, although I have had ups and downs. Grief, bewilderment, a broken heart, self doubt, guilt, hopelessness, seemingly insurmountable challenges or self expectations that have not been met—all of those can impinge on people and make them think of suicide.

An important point about the system that Kenny Gibson is proposing is that, however it is organised, the telephone number should have the immediacy of 999 and there should be somebody at the other end who can talk to the person and take information. Such a system could save lives.

The less happy outcome is that, despite the conversation and the counselling that might take place, the person might decide to kill himself or herself anyway. However, given that all the things that I suggested might cause people to think of suicide are the feelings that are felt by the bereaved families after the person has committed suicide, the system could be helpful in another way. Although it would not make up for the loss of the person's life, if the reasons for that person killing themselves were known and could be passed on to the bewildered and grief-stricken relatives of the deceased, the system would be valuable in that regard as well. The system would be helpful to those who are thinking of suicide and to those who have to live with the consequences of suicide.

17:18

Mrs Lyndsay McIntosh (Central Scotland) (Con): I congratulate Kenny Gibson on securing this debate on a topic of great significance to me and to members across the chamber—this is not a party-political issue, but one that should attract united sympathy and support.

Members might not be aware of what prompted my interest in the incidence of suicide. My concerns were raised when I visited a charity in Glasgow that provides counselling and support services, not only to those contemplating suicide, but to the family members left behind when a suicide is successful.

I felt privileged to be invited to attend a meeting of a support group for mothers whose children had committed suicide. I heard from them about the lack of support that was available to them. I listened with horror as those women told me of their sons' or daughters' internal turmoil that led to their attempts to take their own lives, about their efforts to seek help for their children, about the pitiful lack of psychiatric support and about how they were coping.

They told me about the isolation that they felt, about people crossing the road to avoid them and of the whispered comments about their abilities as parents from people who did not understand their situation. The visit was one of the most emotionally draining that I have ever undertaken as an MSP. As Kenny Gibson pointed out, it is timeous that we debate the motion on the day that we pass the Mental Health (Care and Treatment) (Scotland) Bill.

Other members have also taken a keen interest in suicide prevention. I recall the sympathy for the cause that Richard Simpson expressed when we spoke to members of the Scottish youth parliament on 24 August last year. There can be no doubt that we must put in place services for our young people. We all lose as a result of the loss of life and the hopes dashed. Who knows what those young people could have achieved or what contribution they could have made if events in their lives had taken a different turn.

When I hear evidence on this subject, I am genuinely fearful for those who, despite exhibiting a calm and balanced demeanour when appearing at counselling sessions or using telephone helplines, can be tipped over the edge by the thoughtless comments of others who are unaware of their internal turmoil—months of work are then not enough.

Kenny Gibson asked the Parliament to note the loss of life. He also asked the Executive to set up a suicide prevention crisis hotline. I wholly support that objective. We need a number that is easy to remember and a hotline that gives ease of access and, crucially, direct access to support.

It is so easy for someone to take their own life. I have heard many versions of how people do so, from counsellors and from those who have been left behind. Members will have to believe me when I say that they do not want to hear the details.

I too want to pay tribute to the *Daily Record* "save our kids" campaign. I was aware of the original destination for the funds that were raised and appreciate the paper's continued support. Like Donald Gorrie and Colin Campbell, I have known people who have succeeded. When suicide

touches our lives, we never forget it. I am wholly supportive of all efforts to address the plight of those who contemplate suicide. I commend the motion and I commend Kenny Gibson for bringing the issue to the attention of the Parliament.

17:22

Irene Oldfather (Cunninghame South) (Lab): I did not intend to speak in the debate. I came along to listen, but I thought it important that Kenny Gibson realises that he has cross-party support for his motion and for what he is trying to do.

I recall that, about four years ago, Kenny Gibson came along to support me in a members' business debate on under-age tobacco sales. We have made progress on that, as the Lord Advocate is undertaking pilot work to prosecute those who sell tobacco to those who are under-age. I hope that action is taken as a result of tonight's debate. As we approach the end of the first session, it is important to acknowledge that members' business debates have played an important role and made a contribution to the Parliament.

Kenny Gibson highlighted the problem of suicide prevention and active intervention. I am sure that all members would agree on that. Suicide affects all age groups and all social strata and I want to highlight the need to educate people about the warning signs.

I have previously raised the case of a constituent, but I will raise it again, as it is important. My constituent went to an accident and emergency ward and told a consultant that he was having suicidal thoughts and that he had made four previous suicide attempts. I was horrified to discover that the consultant had sent him home, telling him that he should pull his socks up.

That happened in a hospital that has access to counselling and psychological services. It demonstrated to me that, if someone has a broken leg or a serious illness or if they come in to accident and emergency with cardiac arrest, we will deal with them. However, if someone has a serious "mental health" problem, they remain invisible. I want to highlight the point that there is still a need to educate not only social service professionals, but health service professionals. I hope that tonight's debate will help to highlight both that issue and the problems faced by people who suffer from mental illness.

I commend Kenny Gibson for securing the debate and am happy to support him.

17:25

Linda Fabiani (Central Scotland) (SNP): I also commend Kenny Gibson for securing the debate and congratulate him on all the work that he has carried out on this subject, before and since his election to the Parliament. He secured a member's business debate on the subject at the start of the Parliament and has doggedly kept at it. I welcome the idea of an emergency suicide hotline.

At the time, I welcomed the Executive's national strategy and action plan on suicide. I still do, and I hope that the minister will consider expanding it to incorporate some of these proposals and accept the national hotline as an idea that should be developed.

The two-day debate on the Mental Health (Care and Treatment) Bill, which was very welcome, highlighted the lack of psychiatric services. I think that the story that Irene Oldfather has just told is probably all too common. This morning, I phoned a partner nurse to ask about her experiences in this respect. I was horrified to learn that there is a real problem with 15-year-olds. Some hospitals will consider providing child psychiatric services to children who are 14 and under, but will provide adult psychiatric services only to those who are 16 or over. As a result, there is a lost year in which someone who might be crying out for help cannot access it.

The nurse also told me about the case of a teenager who, when she tried to access urgent psychiatric services, was asked, "Is it really urgent or can it wait a couple of weeks?" If someone is suicidal, the matter is urgent; it cannot wait.

We obviously have a statutory obligation to help people in such a situation. As Donald Gorrie pointed out, however, we must also recognise the contribution of the voluntary sector in that respect. Some marvellous things are happening in that sector to help people with their problems. For example, Kenny Gibson mentioned Stresswatch Scotland in Kilmarnock. I am a patron of that organisation and have been impressed by how their networks go out into local communities. Its support work is very much carried out at ground level by volunteers.

Another approach that I want to mention is a bit more innovative. Theatre NEMO—which was set up by Isabel McCue, and developed by her, her son Hugh and Tricia Mullen of the National Schizophrenia Fellowship Scotland—is a theatre group that is dedicated to helping people who have been affected by mental health problems. It is all about participation in the arts as a means of stimulation, self-help and building self-esteem. About 40 people and, importantly, their carers attend meetings of the organisation, and the amazing thing is that the shyest of people—those who really do not want to participate in life—participate fully in drama and the arts and become very descriptive when they are on stage. It is a wonderful way of building people's esteem.

South Lanarkshire Health Board has recognised the value of such an approach and has asked Theatre NEMO to put on two short plays at a forthcoming health board seminar. Perhaps when we come back to the next Parliament, we should think about how the performing arts can directly benefit communities. Certainly we should encourage such an approach. I should add that the company has recently received an equipment grant from the communities fund, which is good news. Another important point that Isabel McCue made is that, because Theatre NEMO is not seen as a mental health project, it does not have the kind of stigma that would stop many people attending.

Kenny Gibson's motion is worthy of support. Indeed, I ask the minister to support it. We took a big step forward today with the passing of the Mental Health (Care and Treatment) Bill. We would, however, like the Executive's action plan to be expanded to include the suicide hotline proposal and to enable us to consider other innovative ways in which we can help people who really feel that their lives are not worth living.

17:29

Mr Keith Raffan (Mid Scotland and Fife) (LD): I congratulate Kenny Gibson on securing the debate, but I have reservations and concerns about his proposal.

I am very glad that the Parliament has debated the Mental Health (Care and Treatment) (Scotland) Bill for the past two days. In the full range of health care, mental health care is, in a sense, the poor relation. We would all be rather startled if a bill called the physical health bill were introduced in the Parliament. We would expect debates on specific issues such as cancer treatment, coronary heart disease and diabetes. The fact that we use the generic term "mental health" shows how little attention we pay to an extremely important area. That lies at the heart of my concern. Just as there are many types of mental illness, such as dementia and schizophrenia, which Linda Fabiani mentioned, so there are many causes of suicide.

My concern is that with a suicide prevention hotline there should be at the end of the phone people who are trained in specific areas. The primary reason for my concern relates to drug misuse, which is an area of great interest to me. Drug misuse and alcohol misuse, or any addictive condition, is a compulsive-obsessive disorder. That is as far as I will go with a definition, because I am neither a psychiatrist nor a doctor.

One does not know whether depression, for example, leads to drug misuse or drug misuse leads to depression; there is probably a mixture of both. The abuse of alcohol and hard drugs is seen as a kind of anaesthetic to cope with depression, which is perhaps brought on by an overload of problems with which an individual cannot cope. The 12-step fellowships adhere to the definition of alcohol or drug misuse as being a disease. It is certainly a mental illness and psychiatrists and specialists in the area talk about dual diagnosis; very often the addict has other severe problems, most usually mental health problems and also physical ones.

There is the problem of crashing or withdrawal after drug misuse. Depending on the type of class A drug used, very severe depression can result. Members might have seen the reports this week relating to the consequences of the use of MDMA, known as ecstasy, and the severe depression that the use of even one ecstasy pill can bring on. I never quite trust media reports, but I look forward to reading the scientific research on which the reports are based, as far as I am capable. As we know, something like half a million ecstasy pills are consumed for recreational purposes every weekend.

My particular concern is that we do not know the long-term or sometimes even the medium-term consequences of drug misuse, many of which may result in mental health problems. If somebody has been using drugs and is then in a highly depressed or crashing state, they need to speak to somebody who is an expert in that field.

Mr Gibson: Will the member give way?

Mr Raffan: I will give way in a second, although I do not think that I am allowed, because I am in my last minute or very close to the end.

We also have to consider addicts who reach so-called rock bottom before they get into recovery, as at that point the drugs do not work any more and they are frequently very depressed and need help.

Mr Gibson: I apologise to Mr Raffan for perhaps not clarifying the situation a wee bit earlier. The proposed hotline is about linking existing organisations. I mentioned a lethality assessment, whereby the person at the end of the phone is trained to assess, as far as is humanly possible, the situation a person is in and refers them to an appropriate organisation, such as the Samaritans. The person at the end of the phone might have to deal with someone who has taken a drugs overdose. In America, centres that are linked in have to have 200,000 hours of training. We are not talking about volunteers who have a few hours of training; we are talking about specialists who know what they are about and who know that they could provide the last chance to save someone's life.

The Deputy Presiding Officer: You have up to six minutes, Mr Raffan.

Mr Raffan: I do not think that someone who had taken a drugs overdose would be on the line; they would be admitted to accident and emergency and it would be a question of dealing with the physical symptoms first, rather than the mental ones. What Kenny Gibson just said highlights the point that Donald Gorrie and Linda Fabiani made about having access to a range of organisations with specific expertise.

In fact, there is one just round the corner—Crew 2000 is very active in the club and rave scene in Edinburgh and it is expert in the physical as well as mental consequences of using MDMA and other recreational drugs.

The only other issue that I would raise in response to Mr Gibson is the cost of this initiative. There is some controversy about NHS 24, not least among specialist general practice nurses who feel that the £37 million would have been better invested in the practices so they could do this job. If the training is going to be as long as Mr Gibson requires, the cost of this hotline will be very high.

17:35

The Deputy Minister for Health and Community Care (Mr Frank McAveety): Like everyone else, I thank Kenneth Gibson for his doggedness. He has pursued this issue for years. As Irene Oldfather said, there may be opportunities to advance much of what has been said this evening, so I do not want to close the door on Kenneth's suggestion. Members have highlighted areas for further discussion, such as access, information and cost.

I would like to clarify what actions the Executive has taken in the past couple of years, particularly since debates have taken place in the Parliament, and perhaps to touch on points that members have raised. I welcome what Keith Raffan said. There is some correlation between drug and alcohol misuse and young people's suicides, but that is not the only story. It is an important element and it must be addressed, but there are many and varied other factors that impact on the significant increase in teen suicide.

Mrs McIntosh: Does the minister agree that one contributory factor is the extent of bullying in schools? I have been horrified at what I have heard when I have met the parents of children who have taken their own lives. We do not do enough to support children when they are being bullied at school.

Mr McAveety: In a previous capacity, I had to intervene to prevent a youngster's self-esteem being minimised because of bullying; that child was suicidal. I have also taught youngsters who have lost their lives through bullying or a lack of self-esteem or self-value in their own homes or communities.

Newspapers play a role. Members appreciate the work that has gone into the "save our kids" campaign in the *Daily Record.* Recently, there was controversy about one of the organisations that access funds from the Executive were intended to assist. Those funds are now going to Penumbra, a mental health charity, which will also receive project funding from the national programme on mental well-being. In that way, we can support that work.

Kenny Gibson has mentioned the dramatic difference between the statistics for Scotland and for the rest of the UK. We must address that difference. We could probably spend many sociological nights analysing the factors that affect it, which range from addiction levels to the way in which we in Scotland consume or mix alcohol and drugs.

Some of our youngsters have an unfortunate sense of nihilism. As Donald Gorrie said, there are many folk who are very talented and who one would think have opportunity and creativity in their lives, but the down side of that is the depression that can result in suicide. I know about icons for young people. Ian Curtis of Joy Division and Kurt Cobain of Nirvana are examples of individuals whose other health problems impacted on their sense of self-esteem and resulted in the tragic loss of their lives at a young age.

There are many issues that we must try to address. I want to comment on some of the specific matters that members have mentioned. I am concerned about Linda Fabiani's question about whether a 15-year-old is getting appropriate access because they might fall between psychiatric support services for children and those for adults. I will certainly take up that issue for Linda if she will write to me about it.

Some strategies are being adopted. In Glasgow, there is a nurse-led service at the Victoria hospital, which serves the south side of the city. It provides an opportunity to address the issues of adolescents who are harming themselves and at risk of suicide. That service can be developed as innovative practice is rolled out to GPs across Scotland.

Kenny Gibson mentioned the choose life programme. It represents a substantial investment of more than £12 million over the next three years and we would like to see it continue. We intend to extend the first three years—from 2001 to 2004—of breathing space funding beyond 2004 under a national programme to try to ensure that we address lessons that we learn from the project's development in Strathclyde and Glasgow. On accessibility, the statistics are not dissimilar to

those relating to equivalent helplines. We believe that there is strength in that respect.

We launched the choose life strategy in December 2002. Like many members, we recognised that existing organisations engage in many of the activities in question. There is no doubt that the quality of training and the level of expertise across the range need to be improved. Individuals have many skills that the Samaritans have identified ways to deal with. We are in discussions with the Samaritans in the United Kingdom to address how they can deal with the exceptional circumstances in Scotland, consider the statistics and be more than just the conventional listening organisation that people have perceived them to be in the past. Perhaps the Samaritans can consider ways of being more proactive in addressing concerns that members have raised.

We have an opportunity to learn lessons from the programme, which we certainly want to move forward. There are conventional 999 emergency services helplines. Two or three members rightly said that much more effective knowledge and experience is needed, even if only to allow people to refer people onwards and ensure that they get to the most appropriate places.

One important issue that has not been dealt with in the debate but which we need to reflect on more carefully is that people might like a local service and an understanding of the communities from which they phone. I would be happy to address that issue with the health team and other colleagues. The downside of such a service is that people might know the person who is seeking support. A balanced choice must be made. Perhaps there might be a plurality of choices and people can make distinctions.

Obviously, the review of mental health services that is taking place in many health boards in Scotland provides an opportunity to improve the quality of services that people receive—and particularly the services that young people receive. The attitude and behaviour of some adolescents results in their being seen as challenging or threatening. We need to have greater understanding.

Equally, we need to recognise ways in which there can be a resource base that can meet needs. Keith Raffan touched on an issue that bears further explanation. Kenny Gibson sought a commitment from the Executive in respect of resources and staff. I do not want to exclude discussing that matter and would be happy to discuss it in the future.

I want to conclude with some key points. Part of the Mental Health (Care and Treatment) (Scotland) Bill tried to de-stigmatise mental ill health. National campaigns are committed to recognising that each of us might face mental illness. Undoubtedly, we all have personal and professional experience of individuals who have had to deal with ill health and mental ill health. We need to try to find a better way of addressing such matters.

Many other aspects of Scottish life contribute to many statistics that Kenny Gibson mentioned. We are in the final week and a half of the first session of the Parliament. Beyond May, the future of each member may be challenging. Perhaps we may seek services as a result of the stress of the election campaigns. The central issue is that some small areas in which we have made a contribution can genuinely make a difference for the people of Scotland in the long term. I am happy to engage in dialogue with Kenny Gibson and any other members who seek to deal with the matter now or beyond May, if I am returned to the Parliament.

The Deputy Presiding Officer: That concludes the debate on telephone hotlines.

There is a note from the security staff, who recommend that members leave by the lifts and through the public entrance at Mylne's Court, as there is a large demonstration on the pavement outside. Members have the choice.

Meeting closed at 17:44.

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