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Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 30 September 2014

Session 4

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HEALTH AND SPORT COMMITTEE

24th Meeting 2014, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Colin McKay (Mental Welfare Commission for Scotland)
Dr Joe Morrow (Mental Health Tribunal for Scotland)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health and Sport Committee

Tuesday 30 September 2014

[The Convener opened the meeting at 10:36]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the 24th meeting in 2014 of the Health and Sport Committee. As usual, I ask everyone in the room to switch off their mobile phones and other wireless devices to minimise any potential disruption. I also draw to the attention of officials and the public that some officials and members are using tablet devices instead of hard copies of their papers.

Agenda item 1 is a decision on whether to take in private item 3, which is consideration of our work programme. Do members agree to take that item in private?

Members *indicated agreement.*

The Convener: Thank you.

Mental Health (Scotland) Bill: Stage 1

10:37

The Convener: Item 2 is stage 1 scrutiny of the Mental Health (Scotland) Bill. We have one panel of witnesses. I welcome Dr Joe Morrow, president, Mental Health Tribunal for Scotland, and Mr Colin McKay, chief executive, Mental Welfare Commission for Scotland.

I offer you both the opportunity to make some introductory remarks, after which we will move directly to questions. Do you need to toss a coin to see who goes first?

Colin McKay (Mental Welfare Commission for Scotland): I will kick off, although I have not prepared anything.

Thank you very much for inviting us to give evidence. I make it clear that the tribunal, which is a statutory body, authorises and makes decisions on measures of compulsion. The commission does not make decisions on detention, so Dr Morrow will be much better placed to tell you about the detail of how some of the compulsory treatment processes operate in practice. The commission monitors the operation of the Mental Health (Care and Treatment) (Scotland) Act 2003 and have information to give you on how the act is working.

The commission also visits people who are subject to compulsion under the act. Where we have concerns about people’s welfare, we investigate those. We also publish guidance and advice on the operation of the act, particularly around ensuring that it properly balances the ethical, medical and legal issues that need to be taken into account when decisions are made about care and treatment. We have a particular responsibility for ensuring that the Millan principles are promoted and upheld in the operation of the act.

Briefly, the commission’s general take on the bill is that, as the Government has made clear, it is relatively modest. It is helpful as far as it goes, and it has a number of provisions that will improve the efficiency and operation of mental health legislation.

We have one or two general points. First, the Millan report was a visionary report but it was also carefully balanced between the protection of people who are subject to compulsory treatment and the important principle of ensuring that people do not have to be detained or sectioned in order to get the care and treatment that they require. Millan was greatly exercised by that; we cannot have a situation in which, in order for people to get a gold standard of care or even an acceptable standard of care, doctors have to force them to be detained.

There are important aspects of the Millan report and the 2003 act in relation to voluntary care, particularly the duties on local authorities in sections 25 to 27 and the duties to promote advocacy. We have concerns about whether those duties, which are quite strong and powerful and are very much part of the scheme in the act, are being fully fulfilled in practice. Some of the other evidence that the committee has received tends to support that point. There is a general anxiety that some of the aspirations of the 2003 act are not being fully met.

However, we also recognise that local authorities are under great pressure; mental health officers in particular are under pressure both from the increasing use of the 2003 act and from the use of the adults with incapacity regime.

Although we do not have any huge concerns in principle about the way in which the bill increases the duties on MHOs, we have real concerns that, unless the Government invests in some kind of strategic review of the provision of MHOs, it will not be possible for the protections in legislation to work effectively. It is important to remember in that context that 44 per cent of compulsory treatment orders are now carried out in the community so the role of local authorities is increasingly important.

Although, in general, we think that the bill is good and helpful, we have concerns about a number of areas where timescales are being extended. We are sometimes not entirely sure of the justification for extending timescales for statutory bodies to do certain things, whereas some of the timescales in relation to patients and their rights are being contracted. We hope that the committee will examine those provisions very closely.

There has been quite a long delay in sorting out issues around excessive security. The bill seems to be taking a step back and saying, “Let’s start again and try to get it right this time.” That may be technically the correct approach, but we will be looking for some clarity and some clear timescales around improving appeal rights in relation to excessive security.

It is important that you look at the bill’s delivery of the McManus recommendations. In the context of the wider implementation of McManus, the bill has a modest and perfectly sensible provision to create a register of advance statements in the hope that that will help to promote the use of advance statements. We strongly believe that there should be a much greater use of advance statements, but that will not happen just as a result of that measure. There needs to be a concerted look at the barriers and at why people do not use advance statements. Service users need to be helped to use them, and there needs to be an advance in relation to the extent to which they have increasing control and the ability to negotiate and participate in decisions that affect them, even if they have an impaired level of capacity or understanding.

Dr Joe Morrow (Mental Health Tribunal for Scotland): Convener, I can give an opening statement if you want me to, but I am very keen that we get on to questions from committee members on areas of interest to them.

I will be very brief. The tribunal exists to administer justice in this arena. Throughout my presidency of the tribunal, the focus has been on the patient and on their participation. Those are often referred to as the Millan principles.

I think that the bill is generally a good thing. According to its policy objectives, it seeks to improve the efficiency and effectiveness of Scotland’s mental health system, and I think that some of the amendments that it makes will make the legislative framework much more efficient and effective and hence much more focused on assisting the patient in the process. It also makes a number of technical amendments that, as far as those of us who have to deal with certain technical legislative issues are concerned, are long overdue and are therefore welcome.

10:45

I also greatly welcome the creation of the victim notification scheme. As president, I sit on a large number of compulsion and restriction order cases that involve victims, and I have been quite moved by the effectiveness of the process with regard to the involvement of victims at tribunals. It has certainly been significant in providing a humane system of mental health law and, as such, I greatly welcome the creation of the scheme.

I am sure that the committee understands this, but I want to explain why we support the extension of the period of detention beyond the expiry of a short-term detention certificate from five to 10 days. I know that there are a number of views about this issue, which initially arose out of the number of duplicate hearings that it took to reach a decision. That was a serious issue for the tribunal that I have worked away at, and it has now been eradicated. However, the tribunal supports the extension to 10 days to give the patient and named person more time to prepare. A patient will often receive an application for a compulsory treatment order at the end of a short-term detention, after which they have five days to instruct a solicitor, put an advocate in place and arrive prepared at the hearing. In many cases, it is day 3 by the time that the named person, who is a very significant protection in the system, is engaged, and hearings are often put off to allow the patient and named person to prepare.

I will continue to work to improve the situation in relation to multiple hearings. At one stage, and for a variety of reasons, we were down to only 20 per cent of cases going to a second hearing. However, we have evidence to suggest that a wee bit more time will allow more mature thinking to be carried out with the patient, solicitors and advocates to be instructed and the named person to get involved.

It has been suggested to me that there is no need for such a measure, because the tribunal has done such a good job in getting the number of multiple hearings down. That is not where I am coming from; I believe that that is a separate issue. I am committed to the efficiency and effectiveness of the administration of justice in the tribunal, and I will continue to progress that as part of our improvement mode, which focuses on the patient. Our support for the extension from five to 10 days is really to help us focus on the patient's involvement.

We also need to bear in mind that, until they get through the tribunal, the patient is mentally disordered—after all, having to appear before the tribunal is stressful for them as well as for their carer or named person—and having a wee bit more time for consideration will allow us to support the process. I am in the committee's hands, but I have said regularly that this is not about making the tribunal more efficient; it is about giving the patient time. That is generally where we are with regard to the bill.

I never know what to say about these things, but it is about time that the 2003 act was tidied up. Given the amount of practice and development that has happened under that legislation, we need to focus on tidying things up, and in that respect I welcome the bill.

The Convener: Thank you both. We now go to questions.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Can I ask a specific question and then a general one, or would you rather that I stuck to the general one at this point?

The Convener: Just proceed, Richard.

Dr Simpson: I want to clarify an issue that Dr Morrow has just raised. Do you feel that the proposed powers in the bill actually give the named person, carer or independent advocate the power to seek an extension to 10 days? Who will be able to seek that extension? Is it the tribunal? Is it the responsible medical officer? I am much more comfortable with the principles that you have laid out, but I want the bill to be clear that it is for the named person, carer or independent advocate to request more time.

Dr Morrow: The 10-day period will be set out in law, so the bill will allow for a period in which to put into place everything that you are talking about. I would intend to intimate the hearing as soon as practicably possible. That would involve a wee bit of work with the patient, the patient's advocate and the named person, so that we do not end up a day short, with everybody lined up, but then having to put off the hearing for a further period.

I welcome the idea in the bill that such a period could come off any other period of detention. I have no desire for a patient to be detained for any longer than necessary. There are suggestions that the time could come off the overall period of detention or any interim period.

There is a difficulty under the current legislation. If we have to put off a hearing, we are allowed to do so for up to 56 days over two periods. Those are called interim orders. That can radically extend the period of detention, simply because we are not at a stage of preparedness in relation to the named person or the patient.

Dr Simpson: It is your anticipation that, if we get the bill right, the use of interim orders to take things forward would reduce. There would be a more definitive result, either to detain or not to detain.

Dr Morrow: Yes. It goes back to the old mantra used by the Ministry of Justice: right first time. We are talking about a different setting but when we are dealing with the suspension of the liberty of a person with a mental disorder and with forcible medical treatment, which must be at the highest end of any state intervention, we must do that as quickly as possible, without dragging it out any longer than necessary.

The Convener: I invite committee members to ask supplementaries strictly on this issue, which concerns the tribunal, so that we can then move on. Are members satisfied that it has been explored and that we now have good evidence?

Dr Simpson: Perhaps Mr McKay could comment. The MWC's submission included a bit about the matter.

Colin McKay: We took a slightly different but balanced view in our response. We recognise and very much agree with the wish to reduce the number of interim and repeat hearings, which we know to be extremely distressing for the patient and the family. The more hearings there are, the more likely the patient is to disengage from the whole process.

We are more persuaded of the argument that, if the extension allows the service user or patient to prepare and to get legal advice and a medical opinion so that the matter can be dealt with at the first hearing, that is a good thing.

Against that, we have some nervousness about the proposed 10-day extension being automatic. I have great faith in Dr Morrow and his administration of the tribunal, but there is always a risk that, in practice, when timescales are stretched out, people will start to work to those new timescales. Effectively, the extension would be for everybody, so it could be quite a long time before a decision to detain someone and potentially to give them forcible and compulsory treatment was reviewed.

If Parliament decides to provide for the extension, we would like some commitment to ensuring the good outcome that we want, which is that far fewer interim hearings happen—and possibly a provision whereby, if that does not happen or if it turns out that there are other negative consequences, the measure could be scaled back again. There might be ways to allow the timescale to be reduced by order.

At the moment, we are not sure that the case is yet proved. I do not know whether the committee is taking evidence from some of the legal bodies that have responded, such as the Law Society or the Legal Services Agency’s mental health representation project, but it might wish to do so. It is interesting that those organisations have said that they do not welcome the proposed powers, although if the powers are intended to give such organisations more time, I would think that they would welcome them. It would be interesting to test their views on that.

Dr Simpson: I should have declared my connections with psychiatry and the Scottish Association for Mental Health. SAMH has proposed a sunset clause that might satisfy Colin McKay and the Mental Welfare Commission. If we try out the suggestion but include a sunset clause, that might be a reasonable way to proceed, because there would be a review by Parliament.

Colin McKay: That would make sure that the things that we want to achieve happen and the things that we do not want to achieve do not happen, and that would be helpful.

Dr Morrow: There is absolutely no evidence that the tribunal’s practice has ever been to delay dealing with a case that could be moved forward.

On the issue of increasing the extension period to 10 days, I would almost give the committee a commitment that I will work extremely hard and focus on making sure that a decision is delivered for the patient as soon as possible. The tribunal’s results in reducing the number of multiple hearings, interim hearings or adjournments during the past six years have been radical. I am committed to that, not for some kind of structural or legal reason but because it is the best practice that I can provide in administering the justice system for a mentally disordered patient who appears before the tribunal.

All the fears and the anxieties that people talk about are not evidenced by the tribunal’s current practice. I want to assure the committee that it is not about making things more comfortable for the tribunal; it is about getting the procedure right for patients. That is why I support having a 10-day extension.

The Convener: Bob Doris has a final supplementary on this point before we move on.

Bob Doris (Glasgow) (SNP): I have lots of very brief little questions. I am sympathetic to the proposals, but there are one or two things that I want to check. For example, for someone on a short-term certificate, a five-day extension is permissible after 23 days. After that time, is it usually pretty clear whether you want to apply another form of order?

What is it about 28 days in the first place? If someone is going to go to a tribunal for a more meaningful extension or a decision on what a disposal should be, surely mental health professionals should have a pretty good idea after 23 days. If mental health professionals already have that information after 23 days or, in some cases, after 18 days, does it become quite clear to them that an extension will be required? I am just trying to get beneath the numbers. It would be helpful to know why it is 28 days in the first place.

Dr Morrow: I cannot answer that, but Colin McKay might be able to. The 28-day period is what is in the legislation. I can tell you about the practicalities, which are that we start getting the applications in for compulsory treatment orders between day 23 and day 28. That is just a matter of practice, but it does not apply to every case. Sometimes the applications come in much earlier and sometimes they come in right at the end of the 28-day period. When I have attempted to find some reasons for that, the medical people have told me that it is about the assessment process. They require the time to do a proper medical assessment and they have suggested to me—although it is not really a rule if that is what Bob Doris is looking for—that approximately three weeks is necessary to do an initial assessment and it is in that fourth week, which is day 21 to day 28, that the discussions with the multidisciplinary team are held about whether to continue towards a compulsory treatment order.

11:00

Colin McKay: I would generally reinforce that. I should also say that, like Joe Morrow, I have a legal background rather than a medical one, so you might want to ask the medical people who give evidence to you. However, what he said is also my general understanding. It will vary. Obviously, some people may be in recurrently and, if the patient is known, it will become clear much earlier what is going on and that their situation has deteriorated and they are going to need a longer-term stay. Often, though, it will take about three weeks or so just to get a sense of whether the patient will require a CTO. Very many orders will not go beyond the 28 days of the short-term order.

The time was 28 days in the Mental Health (Scotland) Act 1960 and the Mental Health (Scotland) Act 1984, so it is a long-standing period that is deemed enough time in which to make an assessment. What is more challenging now is that the tribunal requires a more detailed proposition to be put to it than the old sheriff court did back before the 2003 act was passed. We recognise that there are quite a lot of pressures on both sides to get this stuff ready at the end of the 28-day period.

Bob Doris: That is helpful, because we have a bit of agreement between the witnesses that the 28 days has not been plucked out of thin air but is based on practice that has been built up over the years regarding what is needed. The other figure that Dr Morrow gave was that 80 per cent of hearings do not lead to a duplicate hearing or multiple hearings.

Dr Morrow: That was for one good month. In fact, between 20 and 30 per cent each month go to a second hearing, but the figure for the best month that we have had was 20 per cent.

Bob Doris: The best month had 20 per cent, but the figure is on average between 20 and 30 per cent, depending on whether it is a good or bad month.

Dr Morrow: Yes.

Bob Doris: Therefore, for the vast majority of cases—the 70 to 80 per cent of hearings that do not require a duplicate hearing—are you content that the families and named persons have a full opportunity in the absence of a second hearing to make their views known?

Dr Morrow: I would not say that I was completely content, because in fact I do not know the answer to that question. I do not personally hear every case, but I know that every process possible is put in place to engage with families and named persons. Some named persons who are automatically appointed because of their relationship with the patient do not really want to be the named person, so they may not engage, and sometimes the patient does not want to have a named person.

From my personal experience, though, I can tell you that, in the cases that I hear, I am content that the families and the named persons who come before me have often had an opportunity to engage with the process.

Bob Doris: The point is that they have had the opportunity. You cannot force them to engage in the process, but in the 70 to 80 per cent of cases in question the families and named persons have had a clear opportunity to engage.

Dr Morrow: Yes. I should explain to you, though, that not all our cases are on short timescales; it is only the compulsory treatment order cases at an initial stage that are on short timescales. About 50 per cent of our cases are what are commonly called two-year reviews, so they have a much longer lead-in and people are often in a settled position, which allows much more time to engage with families and named persons. It also means that professionals may have been working with carers and named persons for a much longer time.

It is only the cases that go from short-term detention to compulsory treatment orders that have a short timescale. It is the only real timescale that we have in the legislation, and it is that group that we are trying to tackle with the extension. I do not like talking generally, but that is the group of patients who are often most unwell, so there is a difficulty there.

Bob Doris: Thank you.

Richard Lyle (Central Scotland) (SNP): Mr McKay, in your opening remarks you touched on the point that I want to question you on. I would welcome Dr Morrow's viewpoint on this also.

Section 2 will insert a new section into the 2003 act that sets out new duties for mental health officers, including submitting a written report to the tribunal when the tribunal is required to review a determination about compulsory treatment. The Mental Welfare Commission noted that it

> "would be concerned if large numbers of additional MHO reports were required".

What is the commission's estimate of the number of additional reports that would be required? What concerns do you have about the workforce and about the capacity of MHOs to do those reports? What is the Mental Health Tribunal's viewpoint?

Colin McKay: In principle, we would love mental health officers' reports all the time, but the reality is that those officers have other things to do. Mental health officers are social workers and have other important duties, so we sometimes have to balance the wish for MHO involvement with the practicalities of that.

Our difficulty with the figures is that we cannot quite reconcile what is in the policy memorandum with what is in the bill. The suggestion that there would be only a few reports seems to relate particularly to cases in which an MHO disagrees with the RMO. In those cases, we agree that the MHO should say why they disagree with the RMO, but that would be in a very small number of cases. However, the bill seems to suggest that two-year review cases would also require an MHO report. Again, in principle, we have no problem with that, but we think that there would be about 500 cases a year, which would place increasing pressures on MHOs.

I will say a little about those pressures, many of which arise not just from the 2003 act but from the Adults with Incapacity (Scotland) Act 2000. In the next few days, we will publish our statistics from monitoring that act, which show that there has been a pretty consistent year-on-year rise in the use of guardianship applications under it. With such applications, mental health officers have duties to prepare reports and supervise guardians. The numbers are startling, with local authorities reporting fairly long delays in the preparation of reports for private guardianship cases.

In the next few days, we will publish our statistics on the use of the 2003 act. Over time, there has been a substantial decrease in, for example, the number of social circumstances reports that are prepared where a short-term detention is sought. We do not think that a social circumstance report has to be produced in every case but in Glasgow, for example, the proportion of cases in which a social circumstances report is prepared is now down to 14 per cent. There has also been a 5 per cent fall in the number of cases of emergency detention where an MHO has consented, as ideally they should.

Our worry is that the system has already started to come apart at the seams a bit. We have said that, actually, the issue is not so much about the provision in the bill but about the Government looking at the workforce strategy for recruitment and retention of MHOs. The Government needs to get serious about finding a way to ensure that we have the necessary degree of MHO cover for the 2003 act to work effectively.

Richard Lyle: Dr Morrow, do you know offhand whether any tribunals have not been able to go ahead because reports have not been submitted timeously?

Dr Morrow: You might allow me to say that I think that the MHOs are the stars of the mental health tribunal system. I get teased for saying that by lots of professionals who think that I am sweeter than I actually am, but we could not work without them—they are the ones who co-ordinate and make a whole lot of things happen. After this meeting, I am going to speak to MHOs in Polmont college, and I will tell them that. Until the day I retire, I will get up and tell MHOs that they are the stars of the system, because they hold it all together. They also bring a dimension that is essential for us if we are to understand the context in which we detain people.

In general, if we have no report, we often have the MHO before us to give oral evidence. The MHOs are committed to turning up at tribunals. We have very little non-attendance, and the reason for it is often to do with holidays or other reasons why any of us would not attend something. MHOs also provide reports for the tribunals.

Although MHOs have distinct and independent functions in the tribunal, they participate in the multidisciplinary teams, so they have often already contributed to the annual report, the annual review or the statement that has come before the tribunal. In general terms, from the tribunal’s point of view, we have an effective system and provision from the MHOs. Moving out of the tribunal setting, and bearing in mind that we are just set up for that judicial purpose, I recognise the pressures that Colin McKay has referred to with regard to the Adults with Incapacity (Scotland) Act 2000 and the work that is done in that respect by MHOs.

Colin McKay: Another set of helpful data that has just been published—it has just been produced by the Scottish Social Services Council—is the Scottish social services workforce data. Among the statistics that it reports are that the number of practising MHOs decreased by 3.4 per cent last year; a third of MHOs are 55 or older—the workforce is therefore ageing; and the number of MHOs on out-of-hours rota duty is at an all-time low. Perhaps that is something to do with issues around emergency detentions, which will often happen in the middle of the night. There appear to be difficulties sometimes in accessing MHOs in such cases.

Richard Lyle: I have said many times before that I previously worked with an out-of-hours doctor service. There were two occasions when we had to wait for a mental health officer to attend while they were on standby. They took a couple of hours to come along. Is the system or the service under pressure at the moment?

Colin McKay: Yes, and I think that we have said that it is under pressure. It is not collapsing, but it is under severe strain. Local authorities have to balance statutory duties that have very strict timescales with other things that they would like to do but which they often cannot do. We think that the whole system needs to be looked at.

It is not just about money; there are issues around what training people need to do to be an

MHO, how they are recruited, and how they are incentivised to want to be an MHO. There are quite a lot of meat-and-potatoes workforce issues that need to be looked at to make it attractive for social work professionals to want to become an MHO and to ensure that they are able to do an effective job when they are in post.

Richard Lyle: Finally, are we doing enough to attract people to the profession?

Colin McKay: To the social work profession?

Richard Lyle: Yes—or to become an MHO.

Colin McKay: I suspect not. Choosing to become an MHO is quite a commitment. The training requirements are quite extensive, and the option is not necessarily a huge boost to people’s careers or salary prospects. Some local authorities have the concern that, if they invest in MHO recruitment, the MHOs will then go and work for another local authority once they have been recruited. There are many practical issues around making the option attractive, and I think that it is probably not an attractive enough option at the moment.

Rhoda Grant (Highlands and Islands) (Lab): I will ask a short question on the back of that. You talked about MHOs and the increase in the time that a nurse can detain somebody for before an MHO is present. I cover the Highlands and Islands, which includes many small islands. Is there sufficient time in the legislation for a nurse to detain if there is a shortage of MHOs? How quickly can we physically get someone there?

Colin McKay: That is a tricky question, because again I suppose that two desirable things are being balanced. On the one hand, the period that the nurse holds a patient for before a decision about detention is made should be as short as possible; on the other hand, ideally we would want both the doctor and the mental health officer there.

As you will know, the power at the moment is to hold for two hours. If the doctor arrives within two hours, the person can be detained for a further hour while the doctor makes an assessment and a decision.

The bill proposes that three hours would be the new time limit. The Mental Welfare Commission has said that, on balance, we do not support that, because we think that it is potentially quite distressing for everybody if a nurse is physically holding a person until a doctor can come and examine them. While we recognise that it would be good if, across the piece, more MHOs came out, we are not sure that just extending the two-hour limit to three hours would make a difference. In some cases, the MHOs are never going to come out anyway, because they are not available.

11:15

On balance, we would not support extending the time limits. The evidence is that doctors can attend, even in remote areas; there does not seem to be a huge concern that doctors cannot make it within the two hours. We would want MHOs to be able to make it to an assessment, too, and there may be changes that can be made to systems, including on-call systems, to help that. However, we do not support extending the time period simply in the hope that that would increase the number of MHOs participating in such cases because we think that those numbers will probably be limited.

Rhoda Grant: In a lot of rural and remote areas, including Harris and many other islands, nurses are providing out-of-hours care, with no general practitioners on call at any point.

Colin McKay: The nurses’ holding power would typically be used when people are in-patients. The issue is about when a person says, “I’m not staying here—I’m going”, and the nurse responds, “You’ll have to wait here until a doctor comes to examine you, because we think you’re not well enough to go out on your own.” That is a slightly different situation from nurses providing care in the community. I am not sure how often they would use the nurses’ holding power, if that is the situation that you are describing.

Rhoda Grant: Okay. My main question is about the named person. There are concerns about the position under the 2003 act if someone has not stated their decision not to have a named person or if the appointment of a named person is causing a problem. Families and carers are concerned that they may not be involved because the person does not want them to have access to their medical records, which is a fair enough comment. How do we balance all those needs while ensuring that we get it right for the patient?

Colin McKay: Dr Morrow will be able to say much more about how that operates in the hearings system. However, our general position is that we are broadly supportive of what McManus said: people should choose to have a named person. That carries with it the need to pass a significant amount of information to that person.

We are about to produce a report on the operation of the named person system; we will share that with the committee when it is published in the next few days. Generally, we find that, for a lot of relatives, the experience is confusing and distressing; sometimes, the first that they hear about the named person role is when a bundle of papers comes through the letterbox with information that can be personal and, as I said, distressing.

We agree that the system is not working. We should probably move towards a situation whereby if a person wants a named person, they should have one and we should do much more to explain to the patient and, indeed, to the named person, what the role involves and how they can participate effectively in a hearing. That takes us back to the importance of the role of the mental health officer in liaising with the family, as well as their advocacy role.

Although we generally support that, we worry about carers and families, particularly where the person may be so unwell that they are not able to say what they want or whether they want to appeal. There are provisions under which carers and family members can participate in the tribunal, although they do not have, for example, the formal rights to appeal that a named person has. Evidence from carers organisations has suggested that carers should have a right of appeal, particularly if a person is not able to do so themselves. There is perhaps something in that—if we are to take away the named person role, the legislation might need to do more to allow carers and family members to step into the patient's shoes where the patient is too unwell to make such decisions.

Dr Morrow: It has been fairly well established that if the family and carers can be integrated and can participate, the overall outcome for a patient in a tribunal setting is better.

As many of you will remember, the Mental Health (Scotland) Act 1984 set out a special role for the primary carer, and the introduction of the named person in the 2003 act sort of developed that role. The difficulties that have emerged relate to the patient's having no say in who the named person is; the automatic legal procedure is that you work through their relatives, one of whom becomes the named person. The patient has no say in that; indeed, the named person themselves might not have any say, other than to say no.

In such situations, there might be highly sensitive material kicking around a tribunal setting that it might or might not be of assistance to share with family members who are named persons; whatever the case, we are obliged to serve that material to the parties. The new provisions allow for much more proactive engagement by the patient in the choosing of the named person, and promote the idea that the individual who is so chosen has to buy into the process.

Let me just talk personally about this matter. My mother had a long-term mental disorder, and under the old system I was her primary carer. As a young man, I simply did not want to receive the material that I received. I did not want to know those things about my mum. I knew that she required care and that she required me to be engaged in the process, but I have to say that, as a young 20-something at the time, I was not experienced enough to understand what the detail meant. Indeed, the roles could be reversed; if the patient were a son or daughter and the named person their mother or father, the son or daughter might not want the mum and dad to know such detail. At the moment, there is almost a compulsion to send out such material, and I am not sure that it leads to the best relationship for getting families and carers engaged in the process. As a result, I feel that the proposals will wise up the system, respond to what the patient and named person say and result in much more buy-in.

I do not want to suggest, however, that the named person does not play an absolutely critical role. They will often stand up for patients when they are at their most critical and vulnerable stage and provide a context that helps the whole tribunal understand where to go next. The named person's role is important, but it is also important that we get the right person and the right relationship between them and the patient to ensure that on-going activity is not compromised.

I make no apology for speaking personally because I think that such comments often put the point across. I still have information in my head about my mother that I wish I had never been given by the doctors. It would not have meant that I would have cared for her or responded as her principal carer any less, but I think that the information changed the relationship. As a result, we need to look very carefully at the interplay between patients and named persons.

Rhoda Grant: My understanding is that the bill provides for a more proactive approach; however, if that approach is not taken, we go back to the provisions in the 2003 act, which brings us back to the case in point. Do we need to find some other way instead of simply reverting back to the 2003 act in cases where the patient says that they do not want a named person—or, indeed, have named a certain person? Do we need to think about the role of family and carers to ensure that they have some input but do not have to receive the level of information that you have described? Would that allow us to protect someone's privacy while giving their nearest and dearest the opportunity to express a view and, if not to represent them, then to make clear what would be in their best interests?

Dr Morrow: That is the bit that I find hard. I am here in a judicial capacity and not in a general policy capacity, but I think that the judicial outcomes are more positive for a patient when the family are engaged. We need to seek proper ways of achieving that. I recently dealt with a hearing not far from here in which, if the patient's mother had not been there to give input, we would have missed significant points for the patient and the tribunal's decision making. There is merit in getting that engagement right and looking at how families are involved.

Families' engagement in a patient's care and treatment is a solid principle for me. That does not always work—we all know the complexities of families—but it is a solid principle to work on and it has good outcomes judicially and in general for patients in the long term.

Colin McKay: I generally agree with what Ms Grant suggests. The named person role is not quite right to do what we need to do, but we need to find a way to bring people's insight and their knowledge of a person before the tribunal, when that is appropriate. If the person involved has profound depression or a florid psychosis and cannot say that they want to exercise certain rights, it is sometimes appropriate for a carer to do that.

The legislation provides for a curator ad litem to be appointed when a person cannot instruct legal representation, but the person can have a curator only once the process has begun. It is difficult for somebody else to challenge an order on a patient's behalf. We need to strike a balance that allows the nearest and dearest to have a say—particularly when people cannot make the decisions for themselves—but without all the baggage that goes with the named person.

The Convener: Colin Keir has a supplementary question on the named person. If anyone else has questions on that theme, I will take them before moving on.

Colin Keir (Edinburgh Western) (SNP): I have every sympathy with the witnesses' view on the named person. I have been there, although I have not been involved in a tribunal, and I know that it can be tortuous. I thank Dr Morrow for talking about his experience, which rang a few bells for me because of what happened 15 or 16 years ago.

The witnesses have mentioned most of the difficulties. The family member who is the named person does not necessarily want to get into understanding the problems of whatever part of mental health is concerned, such as a hereditary condition, for argument's sake—they might be blocking out their own possible future difficulties.

The named person has responsibilities. If somebody has to say that the approach is not right for the person who is being cared for, what happens if that is not accepted? How do we get through that in a sympathetic manner so that the system does not look as if it is overwhelming the named person and the person whom we are dealing with?

Dr Morrow: You describe a complicated set of relationships. Positive work is done among the professionals before a hearing, so such issues are often brought out before a hearing. The MHO and the responsible medical officer raise such issues sensitively and appropriately to nurse the situation forward.

We are a judicial body, but my thrust has been to make the process as sensitive as possible. Such matters are often aired at a hearing. People talk about the difficulties of being the named person and about when that is and is not appropriate.

11:30

The final point is that we have a rarely used mechanism for revoking the named person. It is used sometimes because the professionals take the view that something has become entrenched and the named person is not acting in the best interests of the patient. Such situations are always hard, because it is rare that a carer would do other than focus on what they thought was in the best interests of the patient.

A number of things go on, but in practice I am not aware of too many difficulties in this area and we have, as I said, 3,500 hearings a year. Not many difficulties arise, mainly because of the highly professional input at the early stages.

The advocacy services in Scotland do excellent work. They are underrated, but they certainly do a lot of relationship work; I am sorry—I mean that they are undervalued, not underrated. I rate them very highly, but they are undervalued. They do a lot of the work that you are talking about by running between two parties to assist the communication to take place. There are lots of bits of the system that help to prevent conflict.

Colin McKay: Much of this is to do with the quality of communication and interaction before the hearing. It is about the mental health officers and the other professionals having the time and space to have a proper engagement with the family rather than people just having papers served on them. I endorse what Dr Morrow said about advocacy.

Returning to the other themes around the 2003 act, advocacy is a crucial safeguard in terms of facilitating the conversation about whether someone wants their parent, spouse or whoever to be their named person. That is a difficult decision to make and a person needs somebody to help them make the decision and, once they have come to a view about it, to ensure that it is heard.

It is crucial to ensure that advocacy is available; that includes advocacy for carers, because they often require help. Sometimes the service user knows the system better than the family does and it might be a completely new and bewildering world for them. Advocacy for carers is therefore a very important part of the mix.

Dr Simpson: In the event of a named person not being appointed, does the tribunal have the right to require the appointment of an advocate?

Dr Morrow: We do not have the right to do that, but in most cases the patient has the right to have an advocate. We would suggest that that is the route to go down.

Dr Simpson: And in practice?

Dr Morrow: In practice, the advocate is often appointed or someone else is appointed.

Dr Simpson: That is fair.

Dr Morrow: We should also be conscious that we do not have so many layers of representation for the patient that the patient gets smothered underneath it all. The MHO has an independent role for the patient and the RMO has an independent and caring role. The patient can also have a solicitor and an advocate, and they have a named person, who can also have an advocate or solicitor. The trick for the tribunal is to provide all the protections that are required for us to do our task but not to smother the patient’s voice by having layer upon layer of representation. An advocate is one of the options that can assist a patient.

Dr Simpson: I am concerned that the decision has now been made that the person has a right to say, “I don’t want a named person at all” and that that will not be overruled. Under the new proposal, would the tribunal in those circumstances have the right to go beyond suggesting the use of an advocate and to say in particular cases that it is critical that there is an advocate? Do you want that power?

Dr Morrow: As I understand the law at present, we do not have that power. Do I want it? I have not thought about it, but I think that having such a power would have a lot of implications, including resource and availability. I would need a variety of things. If the committee wants me to address that issue, I can respond in seven days with my thoughts on it. The response would not necessarily be about administrative justice, but I would take on board negotiating with Colin McKay about that. I have never thought about that issue, but I can respond on it if you want.

Dr Simpson: That would be helpful.

Dr Morrow: I will write to you and negotiate with Colin McKay on that. We will probably do a joint thing. I do not think that it would be too difficult.

The Convener: Thank you for that.

Aileen McLeod (South Scotland) (SNP): Section 21 of the bill deals with registering advance statements and will place on the commission a duty to maintain a central register of advance statements. Most of the written evidence that the committee has received is supportive of those provisions, but some concerns have been raised about the privacy of the register. Obviously, advance statements can contain highly personal information that can be rooted in traumatic experiences. I am interested in how the commission will ensure that privacy will be maintained. For example, SAMH has proposed that the Mental Welfare Commission for Scotland should just note that a specified person has made an advance statement, when the statement was last updated, and where it is kept. That would not require disclosure of highly personal information to people who were not directly involved in a person’s care.

Colin McKay: We are quite happy to consider any system that will reassure service users. I can give a general assurance because the commission already holds sensitive information about patients; we get notification of every episode of detention, whether it be emergency, short-term or a compulsory treatment order. We see all the reports: we hold the data and we keep it securely.

There is, in the bill, obviously an issue about who has the right to see that information. There is a balance to be struck: if the advance statement is to be effective, people have to know that it is there, and they have to be able to find out what it says so that they can pay attention to what it says. The system will have to ensure that if a doctor is having to decide on use of a difficult treatment—electroconvulsive therapy, depot medication or whatever—and they understand that an advance statement is in place, they can easily find out what the person has said and give due weight to it. I am happy to consider how we can do that in a way that will ensure that people have confidence in the system.

The broader point that I will make about advance statements is that I cannot see this particular provision, of itself, being transformational—welcome though it is. The real question is why people do not make advance statements. It is often because they do not understand what an advance statement is, or they do not believe that it will be effective. There is quite a lot of evidence for that. I go back to what Jim McManus said: we need to make a concerted effort to understand why people feel reluctant to make advance statements, what might help them to think that it would be worth their while, and help them to make an effective statement. The Scottish Recovery Network and others are working in some areas with service users and are evangelising about advance statements, which has had an impact. One of the other things that we do is look at how often advance statements are overridden.

It would be interesting to join up all that and to decide what would help a person to draft an effective advance statement. When is a person wasting their time when they say something that will not be upheld because it is not a practical thing to say, and in what circumstances can they have an effective say? A lot more work needs to be done with service users to understand the barriers and to help them to make a worthwhile statement.

On the point about privacy, we are happy to consider what assurances we can offer.

Aileen McLeod: Thank you. That was helpful. To follow up, what are the barriers to people completing advance statements and what training is available to help people to draw up advance statements?

Colin McKay: We have to recognise that one of the barriers is that people feel generally disempowered within the system so they do not feel that an advance statement will be a worthwhile tool for them. They think, “If I am ill, the decision will be taken for me anyway, so what’s the point?” That is the kind of attitude that we need to change; we need to change the sense of disempowerment and use the advance statement as a tool for people to get some of what they want, as part of their dialogue with the professionals who are involved in their care.

The Convener: Dr Morrow, do you want to add to that?

Dr Morrow: No. I will not respond to that, if that is okay.

Dr Simpson: Can I ask a quick supplementary on that?

The Convener: Yes.

Dr Simpson: The bill will remove the requirement for notification of short-term orders to the MWC. Will not that result in a disconnect from the register? If you are not informed about an STO, how will you let those who make the order know that there is an advance statement on the register? Will the register be published? I assume that it will be confidential.

Colin McKay: I think that it is the requirement for notification of emergency detentions that is being removed.

Dr Simpson: Is the provision purely in relation to emergency detentions?

Colin McKay: I think that it is. We suggested that provision, because a notification was often just a phone call left on our answering machine in the middle of the night, so it felt as though we were not able to do anything about it. However, we hear about orders as they come in.

As I said, it is important that, if advance statements are made, the local services are made aware of that so that they can operate without having to check in with us.

Gil Paterson (Clydebank and Milngavie) (SNP): Colin McKay said in his introductory statement that, in some regards, patients’ rights will be “contracted” under the bill. The proposal in section 15 is to reduce the appeal period in relation to the transfer of patients from one hospital to another from 12 weeks to four weeks, which is a substantial difference. However, it seems that the bill is trying to allow for medical care for patients. What are your views on that?

Colin McKay: Again, there is a very difficult balancing act. We understand entirely the point that, if a person genuinely needs to be in the state hospital, there are significant risks involved in their care and treatment, and there are particular things that the state hospital can do that cannot be done safely by local services. It is not good for a person who needs that level of care and security to be denied it for long periods, even though they may not want it. We entirely get that but, against that, we have to recognise that somebody who is ill enough to need to be in the state hospital or to be transferred into it from another hospital is pretty ill, so it seems to be a bit heroic to expect them to negotiate, or to engage with a lawyer and prepare an appeal within 28 days. I know that there is a suggestion that people just need to lodge some sort of appeal that says that they do not want to be in the state hospital, which will meet the timescales, but I do not think that that is the appropriate approach.

We have suggested two things on that. First, given that the proposal is for a very large cut from 12 weeks to 28 days, perhaps there will be a meeting somewhere in the middle. Alternatively, if a patient is transferred before an appeal is determined—which ought to be possible if they need the care—there needs to be a guarantee that the place that they came from will be held until the appeal is determined. For us, the worst-case scenario is that a patient transfers to the state hospital, appeals successfully but is then told, “I’m sorry, but you’ve lost the bed that you came from.” We are in favour of provisions that allow early transfer where it is needed, but that also ensure that the patient has the right to go back to where they came from, should they win an appeal.

Gil Paterson: I gather that you are not against the principle of restricting the timespan for the good of the patient, but you say that we need to guard against problems with the mechanisms in between. In effect, you are asking that we fit into the legislation that the individual would, for a time, lose their right. They would, I think, be placed against their wishes, because they would have already said that they are against the move, but that would only be temporary. The issue might not even relate to their mental situation—they might have some other ailment that needs to be treated and which might exacerbate their mental condition. You are saying that there could be some middle ground.

Colin McKay: Yes. Appeals to the state hospital would usually be made on the basis of a person's mental condition because either their risk level or concern about their mental health had increased. The balance that we must strike is to allow the person to move quickly to an appropriate care regime, when there is evidence that they really need to be in a different place, while maintaining the right of appeal for long enough to ensure a reasonable chance that the patient will be able to exercise it effectively. We are concerned that 28 days is not long enough to cover all circumstances.

11:45

Gil Paterson: What, in your opinion, would be a more suitable length of time?

Colin McKay: I do not think that such figures can be scientific. Our feeling is that going from 12 to four weeks is a bit drastic, and the issue might be as much about maintaining the ability to appeal after the patient has gone to the state hospital.

The other point is that the patient might not know what things will be like until they get there. Of course, they will eventually have the right to appeal a placement in the state hospital, but we feel that six weeks is better than four. However, I am not saying that that figure has a particularly scientific basis.

Gil Paterson: I suppose, then, that I should ask whether there is any evidence with regard to the normal time for this process—if there is such a thing as a normal time. Could that guide us?

Dr Morrow: The questions are very important, because they relate to the rights of the patient. I want to preface my response with a few comments; First, in such situations the patient's rights have almost already been compromised because they have already been compulsorily treated and detained in hospital. The state does that because it needs to provide care and treatment. We can look further at those rights, but the fact is that the state has, through legislation, decided that the patient in question should be detained for care and treatment.

Secondly, the cases with which I have dealt that have moved to the state hospital, and in which the patient has appealed against the transfer, are often highly complex with high risk factors. Although my instinct is, because that would set a boundary, to give a figure of three, four, five, six weeks or whatever, the fact is that the complex care that is required in such transfers is, in my experience, often individual to the patient, so it would be hard to give you the sort of framework that you are looking for. It would be helpful if we could do that, but I am not sure that we can.

Bearing in mind that a patient's rights have been suspended because they are already being treated against their will, we should remember that any such move happens for complex reasons. We deal with such appeals as a priority and, in many cases, I deal with them myself. The aim is to redress the balance, which the committee is trying to explore, of the judicial process offering protection for the patient while allowing the state to intervene. The matter becomes so complex because the problems are so individual and because it is about the patient and where they are.

Colin McKay: We must also consider the ability of local services to meet patients' needs. This is a complex issue in which a balance must be struck; after all, sometimes the issue is not the person in question but the quality and range of local services, as we find with people who have learning disabilities and who might have very complex needs. In an ideal world, they would not go to the state hospital, but it might be that the services that they need are just not available locally. In such cases, it is important that the judicial system tests very vigorously the acceptability of saying that a person must go to the state hospital because there has been a breakdown in their placement in a local service. Those cases take time to prepare and argue out; the fallback for us is that the person needs to be able to go back to where they came from, if that is what the judicial determination is, whenever it is made.

Gil Paterson: I do not want to put words in your mouth, but I think that you are saying that you are sympathetic to the proposed approach, as long as people's rights are safeguarded.

Colin McKay: Yes. I think that that is right.

Dr Morrow: Yes.

Nanette Milne (North East Scotland) (Con): Both witnesses have stressed the importance of the right of access to independent advocacy. I understand that advocacy is not available consistently throughout the country. SAMH has said to me that it is concerned that there is nothing about advocacy in the bill. The Government says that legislation is not necessary in that regard. What are the witnesses' views? Should the matter be in the bill or can it be sorted out by other means?

Colin McKay: I agree that the evidence from, for example, the surveys that the Scottish Independent Advocacy Alliance undertakes is that the availability of advocacy is patchy. However, by and large, if someone who is enmeshed in detention proceedings seeks an advocate, they will get one.

The 2003 act deliberately did not say, "You shall have an advocate if you are subject to a CTO application", because the whole point is that advocacy can help someone to negotiate a care package that might make compulsion unnecessary, so it is vital that it is available to people before things have broken down to the extent that the professionals are saying, "We cannot get you to agree to treatment, so we will have to force treatment on you." Such an approach was very much what Millan wanted and what the 2003 act set out to deliver.

It would be hard to strengthen the advocacy duty in the 2003 act, because it is already strong. It seems to me that the answer is to do with accountability in relation to that duty—perhaps we need more on that. The Government might commit to proper auditing of the availability of advocacy and the performance of local authorities and health services. It might be possible for the legislation to give a steer in that regard. Local authorities are assessed by the Care Inspectorate on how they fulfil their statutory duties. I am not sure whether the discharge of the duties on advocacy has ever been looked at.

The answer is something to do with building in a better accountability mechanism, whether that operates through the commission, the Care Inspectorate or some other means, to ensure that when people want advocacy they can get it, whatever stage they are at in the process—given the evidence that that is not universally the case at the moment. The issue is more about building in accountability than about strengthening a duty that is already pretty strong.

Dr Morrow: We have good experiences of fairly active advocates on many of our cases. I recognise that we are often at the hard end of the decision making; advocates are needed at that stage but they are also needed elsewhere. We have pretty good coverage for tribunals. The advocate's principal role is to facilitate communication between the patient and the professionals, the named person and the tribunal. That is a very significant role.

Early on, with the Scottish Independent Advocacy Alliance, I initiated the writing of guidelines for advocates who were appearing in the Mental Health Tribunal. Everyone is agreed on what they should do, which gives an element of accountability for practice in the tribunal.

The committee should take into account what Colin McKay said about coverage, about negotiating care packages and about other things that happen outside the tribunal.

We have good experience of advocates. If members of the committee have time—as I am sure you do—to speak to service users and ask them about the function of advocates, you will find that they talk highly of the support that they are given.

I recommend a very good book called "Skydiving for Beginners: A Journey of Recovery and Hope" by Jo McFarlane. It has a chapter on her experience of advocacy and how it supported her through a particular period. Because you would all benefit from reading it, I would be happy to put up the money to buy you all a copy. If you get it from the Independent Advocacy Alliance, you can put it on my account. It is well worth reading if you are dealing with this bill, for a variety of reasons, but I particularly commend the section on advocacy.

The Convener: I also take Mr McKay's point that there is a question of equity. It depends on where someone is, the advocate that they get and the audit and measurement of what is available, how freely it is available and what quality it is. All that is very important, I am sure you agree.

Dr Morrow: Yes.

Nanette Milne: Thank you. That was very helpful.

The Convener: We have concluded our general questions but I am aware that Richard Lyle and Bob Doris want to ask some additional questions.

Richard Lyle: We are getting near the end of the session, so I want to say that I am quite happy to read the book, but I do not want to go skydiving.

I wonder whether there are any other issues that the witnesses would like the bill to address.

Dr Morrow: I am content that it has covered what it can at this particular stage. I have expressed the view in writing to my members that it will not be long before we will have to take an overall look at mental health legislation, but at this stage the bill addresses where we are in the progress of mental health legislation.

Colin McKay: I generally agree with that. I reinforce my point that the bill is a useful tidying-up exercise but the interface with incapacity legislation and adult support protection legislation needs to be addressed. The Scottish Law Commission will report tomorrow on the problems of people being deprived of their liberty by being placed in care homes or other kinds of care settings when they are not able to agree or disagree. That will be another strain on the system.

My general sense is that the 2003 act and the Adults with Incapacity (Scotland) Act 2000 were leading pieces of legislation—for a time, they genuinely led the world. However, there is a danger that we do not start to think about the next wave, particularly about supported decision making. We have a fantastic framework for times when we have to take decisions away from people and allow other people to make them, but we need to move towards supporting people and empowering them to maximise their choice and control in the system so that the use of mental health legislation becomes the exception rather than the rule. Advocacy and advance statements are part of that. Those points are not so much for this bill but I urge parliamentarians to consider them in their future plans.

Richard Lyle: Thank you.

Bob Doris: The points that I was going to raise have been raised by some of my colleagues.

The Convener: I thank both the witnesses for their time and valuable evidence. I am sure that we will reflect it in the committee's final report.

Dr Morrow: Thank you, convener and members. I wish you all well with your work.

Colin McKay: Thank you.

The Convener: As we agreed earlier, we will now move into private session.

11:59

Meeting continued in private until 12:56.

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