The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 7 October 2014

Session 4

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HEALTH AND SPORT COMMITTEE
26th 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:

Derek Barron (Royal College of Nursing Scotland and Mental Health Nursing Forum Scotland)
Karin Campbell (Social Work Scotland)
Dr John Crichton (Royal College of Psychiatrists in Scotland)
Colin Fraser (Glasgow City Council)
Dr John Gillies (Royal College of General Practitioners Scotland)
Beth Hall (Convention of Scottish Local Authorities)
Dennis Robertson (Aberdeenshire West) (SNP) (Committee Substitute)
Dr Ruth Stocks (British Psychological Society)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

The Robert Burns Room (CR1)

Scottish Parliament

Health and Sport Committee

Tuesday 7 October 2014

[The Convener opened the meeting at 09:46]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the 26th meeting of the Health and Sport Committee in 2014.

I intimate apologies from Richard Lyle. Dennis Robertson, the Scottish National Party substitute, is with us again today. I welcome him.

I ask everyone to switch off mobile phones, as they risk interfering with the proceedings. I also point out that some committee members and some of our support staff are using tablet devices instead of hard-copy papers.

The first item on our agenda is a decision on whether to take in private item 3, which is consideration of our draft report on health inequalities. Does the committee agree to do that?

Members *indicated agreement.*

Mental Health (Scotland) Bill: Stage 1

09:47

The Convener: We proceed now to our normal format for a round-table session.

I am Duncan McNeil, the convener of the Health and Sport Committee.

Colin Fraser (Glasgow City Council): I am a mental health officer from Glasgow City Council and am here as a member of the MHO forum for Glasgow social work.

Bob Doris (Glasgow) (SNP): I am an MSP for Glasgow and the deputy convener of the Health and Sport Committee.

Beth Hall (Convention of Scottish Local Authorities): I am part of the health and social care team with the Convention of Scottish Local Authorities.

Dennis Robertson (Aberdeenshire West) (SNP): Good morning. I am the MSP for Aberdeenshire West and SNP substitute for the Health and Sport Committee.

Dr John Gillies (Royal College of General Practitioners Scotland): Good morning. I am chair of the Royal College of General Practitioners Scotland.

Gil Paterson (Clydebank and Milngavie) (SNP): I am the member for Clydebank and Milngavie.

Dr Ruth Stocks (British Psychological Society): I represent the British Psychological Society.

Colin Keir (Edinburgh Western) (SNP): Good morning. I represent the Edinburgh Western constituency.

Aileen McLeod (South Scotland) (SNP): I represent South Scotland.

Dr John Crichton (Royal College of Psychiatrists in Scotland): I am representing the Royal College of Psychiatrists.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I am an MSP for Mid Scotland and Fife. While I am at it, I declare interests as a fellow of the Royal College of Psychiatrists and of the Royal College of General Practitioners, and as honorary chair of psychology at the University of Stirling.

Derek Barron (Royal College of Nursing Scotland and Mental Health Nursing Forum Scotland): I am associate nurse director for mental health services in NHS Ayrshire and Arran.

I am here as chair of the mental health nursing forum Scotland.

Nanette Milne (North East Scotland) (Con): I am an MSP for North East Scotland.

Karin Campbell (Social Work Scotland): I am the principal mental health officer for Highland Council and am here as the chair of Social Work Scotland mental health.

Rhoda Grant (Highlands and Islands) (Lab): I am a Highlands and Islands MSP.

The Convener: Thank you all for that. Committee members know the format well, but I point out to the witnesses that we are here to listen to them. The first question will come from an MSP to get things going, but I remind MSPs that the preference will always be to hear from the witnesses throughout this evidence-taking session.

Dr Simpson: One of the issues that concerned us originally was the fact that not all elements of the bill were being reviewed by the McManus review. Does anyone have any comments about anything that has been omitted from the bill as it now stands and that you regard as being important?

Dr Crichton: There is a general feeling, particularly in the faculty of forensic psychiatry, that there has been a wee bit of a missed opportunity, in that it would have been welcome to have had an opportunity to look more fundamentally at all the aspects of the Mental Health (Care and Treatment) (Scotland) Act 2003, including the forensic aspects that, because of various other pressures, have found their way into the bill without quite the same consultation and scrutiny.

Dr Stocks: The British Psychological Society is disappointed that the bill does not go far enough. The McManus report comments on the need for a detailed care plan, and it is felt that that would help to provide a shift in emphasis in mental health care away from the traditional medical model and towards a far more biopsychosocial approach. A detailed care plan would direct practitioners to pay far more attention to the broad range of psychological and social therapies that are required in the treatment of mental health.

Dr Simpson: I will not go into the issues around forensic psychiatry, but I think that Dr Crichton is referring to the Noel Ruddle case, which is the first one that I got involved with in Parliament. It gave rise to the first bill that was passed by the Parliament in 1999 and concerned a gentleman who was let out of the state hospital although he had a personality disorder. Emergency legislation was rushed through to ensure that another five or six patients who were about to depart on the same basis were contained, and the provisions were then put into the 2003 act. With your permission, convener, I will come back to that later.

The other issue that I raise for general discussion is the extension of the short-term order to allow additional time for tribunals to sit. As the convener will remember, we received evidence the other week that, where there had been stress in the system, the numbers involved had been substantially reduced by improved administration. I know that some of today’s witnesses have concerns—on both sides—about the extension of the time for which the tribunal can sit beyond 28 days. Would anyone like to comment on that?

Colin Fraser: When the matter was discussed, Glasgow City Council had concerns about the extension and the idea of deducting time at the other end, which it felt would be to treat the detention period almost as though it were a prison sentence, whereas the point of someone being detained is for them to get treatment. We felt that there had been improvements, but that there would be a risk that people would work to the wire, always going up to the last minute, without there being a real purpose to that.

Dr Stocks: It is important that detentions be as short as possible. However, longer periods are sometimes required in order to complete assessments thoroughly. Psychological assessment sometimes cannot be done in a short period, and it is occasionally necessary—if the assessment is to be done properly—for the period to be extended.

Dr Crichton: I will make an observation about how we are dealing with the evolving pattern of the tribunals. The tribunals have been working much more efficiently in the past few years, particularly under the current president, than was the case at the start, when they were finding their feet. Therefore, when members consider the proposed time limits it is worth reflecting on where we are now rather than on where we were some time ago, in that the view of what is a sensible time limit might have changed during the past couple of years.

The Convener: Does anyone want to respond to that? Dr Crichton has expressed a slightly different view.

Dr Simpson: May I come in briefly? At the moment, a short-term detention certificate lasts for 28 days, with a five-day extension; I think that the proposal is for a 10-day or 14-day extension. Colin Fraser’s comment about people going up to the wire is pertinent. Would it be practical to shift the duration of the certificate back to 24 days, and then to have a longer extension? That would mean that the total period of the order would not be longer, but people would come up against the wire—as it were—earlier, and an assessment could be made early in cases in which that is possible. I do not know whether such an approach would be clinically practical.

Dr Crichton: That is an interesting proposal. In many cases, a decision can be made in 24 days. Dr Stocks talked about complex psychological assessments, and many cases that require such assessments might not be resolved even if there were a two-week extension. None of the time limits that we are discussing would particularly answer that point. However, Dr Simpson's proposal is worthy of further reflection.

The Convener: Do you want to respond, Dr Stocks?

Dr Stocks: If psychological assessment is requested early enough, there should generally be enough time to do it. Occasionally a longer period is required than is envisaged at the outset. I take Dr Crichton's point about assessments sometimes being lengthy, regardless of when they start. However, the earlier they can be instructed, the better. That takes me back to my point about making psychological assessment a priority in people's care, so that it is on everyone's minds.

The Convener: I suppose that the proposed new rule could mean that people would end up waiting longer, rather than addressing the point about getting things done properly and quickly. That is the nub of the issue, is it not? Perhaps Mr Fraser will help me out there. No?

Colin Fraser: No—but I take Dr Stocks's point about the need for psychological assessment.

I am a bit concerned about how the provision is drafted and the tone of the suggestion that the additional detention at the front of the process can be compensated for by taking a wee bit of time off at the end. The point is that there should be assessment and treatment, rather than some kind of balancing up in terms of the justice of the matter. I am not sure that that is the right way to think about the issue. The natural tendency is for people to work to the wire, and if short-term orders are extended it is almost inevitable that that will happen.

Bob Doris: The committee took evidence last week from the Mental Health Tribunal for Scotland and the Mental Welfare Commission for Scotland. I asked why a short-term detention certificate lasts for 28 days and whether the period could be reduced. Both witnesses broadly agreed that it takes between three and four weeks to get all the relevant reports ready so that an informed assessment can be made, so the number has not been plucked out of thin air. On balance, do the witnesses think that 28 days is about right?

10:00

We also heard last week that 70 to 80 per cent of tribunal hearings take place within the 28 days plus the five-day extension period, so the proposed additional five days would not be needed in those cases. It was suggested to us that the main reason for an extension from five to 10 days is to reduce the need for the repeat tribunals that happen in 20 to 30 per cent of cases and to give relevant family members more time to make statements and representations.

I suppose that that brings us to the crux of the matter. There is always a balance to be struck in relation to the rights of individuals who are detained. Last week we heard that 28 days is about right and that the intention behind the proposed extension is not to let people work right up to the wire but to reduce the number of repeat tribunals and give families more time to have a say. Do the professionals who are here today concur with that view? The committee has to make a judgment.

Dr Crichton: I broadly concur with that. I read the evidence from the commission and the president of the tribunals. We are talking broadly about similar timeframes, and it is difficult to say precisely what the correct timeframe is when we are talking about a week either side. We are trying to strike a reasonable balance, and ultimately we need to suck it and see. We will need to review how things are going.

It is clear that there have been some issues, which have led to the proposal in the bill. The only observation that I make is that perhaps some of the conclusions have been drawn as a result of experience when the tribunals were settling in and not working as efficiently as they are currently working. However, if the tribunal and the commission are saying that particular groups are disadvantaged by the current timeframe, I do not think that the professionals will have a strong view about a week either side.

Dr Stocks: Let me say again that we would be concerned if there was a deadline that the responsible medical officer felt could not be met if more specialist assessments, such as a psychological assessment, were instructed. We would also be concerned if such assessments were not instructed because of fear that the deadline would be missed. I appreciate that there is a difficulty in deciding exactly how long the period should be, but if there is pressure on the system at a time when psychological reports are not routinely instructed, we would be concerned if there were a timeframe that made such instruction less likely in the future.

Derek Barron: For the record, I should have said that I am here on behalf of the Royal College of Nursing Scotland.

I asked some of my colleagues across Scotland about the issue from the nursing perspective. They were not convinced that an extension from five days would make a significant difference, on the basis that a lot of extensions happen because solicitors ask for a second opinion. My colleagues acknowledged the point that Bob Doris made: that an extension might enable the named person or relatives to gather more information. On balance, they are not convinced by the proposal, but they recognise the argument about better access.

The Convener: I suppose that in the future the area will need to be thoroughly examined to ascertain whether the bill has made a difference. There seem to be questions about whether it will address the issue.

Rhoda Grant: Would there be a benefit in the bill allowing for a period—say five days—when the patient would be informed about the tribunal, so that they would be able to pull together second opinions and reports? The timeframe would not be shortened for the tribunal, but it would be extended for the patient, which would mean that a second tribunal might not be required. Is there merit in thinking about what proportion of time is available to whom?

Does that make sense? I sense that the panel does not understand what I am saying. I am looking at blank faces.

I suppose that what I am saying is that, rather than a patient going to a tribunal and asking for an extension because they need extra time to pull together the reports that they require to represent themselves properly, they should be allowed to do that sooner. The tribunal would need to present them with the paperwork within the five days as currently happens, but rather than go to a tribunal to ask for an extension, they can ask for an extension to gather their papers without having to go to two tribunals.

The Convener: That might have been a better question to ask last week to the representative of the people who run the tribunals. There is an attempt to reduce repeat appearances, and all the stress that they involve. The issue is that, as we instinctively feel from life experience, extending the time will not actually solve the problem at all. If we work within those limits, there will be no pressure, if you like, to increase the 70 per cent who go through successfully now to 80 or 90 per cent. Of course, the figure will go up because the timeframe will go up, so that stat will look pretty good, but what are the consequences of that for the individual who is caught up in the procedure?

Dr Crichton: There are issues of access to appropriate specialists to provide independent reports for patients who seek them, but often folk will know very early on with a 28-day admission that longer detention powers are under consideration and the ball can be started rolling. The conversation has perhaps been about the provision of timely reports, but the period is also about response to treatment and observing the person in a specialised environment in order to try to get clarity on diagnosis and the other questions that we have to address in relation to compulsory measures. That is worth thinking about, too. The time limits do not allow us as much time in every case to assess whether longer detention is the correct way forward. That is particularly the case with section 52 remands, which we might come to later.

Dr Stocks: We are talking about a difficult decision. As a number of people have mentioned, it would be interesting to know who is in the group of people who do not meet the 28 days and whether there is a pattern. I think that it was Mr Barron who suggested that that is often because a second opinion is requested. Those are generally the more complex cases, and it may be that it is a subset of people who require additional specialist assessments and a more thorough look at their situation who need additional time, while the vast majority of cases can be dealt with in the shorter time period.

The Convener: It might be worth examining whether there is any detail on the groups or individuals to which the issue particularly applies. We can maybe check that out and ask for some more information.

A related issue that we heard about in evidence last week is capacity among mental health officers and the importance of that role in the system. Does anybody want to comment on that?

Colin Fraser: I associate myself with the statements in the Mental Welfare Commission for Scotland’s written submission to the committee. There are serious implications for mental health officer resourcing. The proposals involve significant extra work for MHOs, which was of concern to the forum and when it was discussed in a group at council level in Glasgow.

In particular, there is concern about the proposals that a named person must sign up to be a named person. I am not clear whether there have been further developments in the thinking on who the prescribed person would be; our assumption is that that role would fall to MHOs in large part. We quite often have named persons who live in different cities, and our out-of-hours standby service can often give consent to detention at 2 o’clock in the morning—there is no way that a named person could be accessed in those circumstances.

The proposals will certainly involve an extra visit by the MHO. I am concerned that we are having problems retaining MHOs at a national level—the numbers are going down and the national workforce is ageing. In 2011, we had 120 MHOs in Glasgow; in 2013, we had 94. That is during a period when their workload has dramatically increased, particularly in relation to adults with incapacity requirements.

The number of adult incapacity applications relating to the older population has been increasing steadily over the past few years, but it has increased dramatically in relation to people with learning disabilities. Some of that is to do with the self-directed support agenda. Although an impact was anticipated, that impact has possibly been underestimated.

At the point when, if anything, our MHO workforce is in slight decline, our workload is increasing significantly. We need to be very careful with some of the bill's proposals because I have no doubt that they will add significantly to the workload.

On the proposal that the MHO be required to produce a report at review stage, I wonder whether there is instead scope for amending the forms so, rather than simply including a signature, there is a statement of the MHO's opinion. If that opinion was put in at that stage, that would go some way to addressing some of your concerns without requiring the significant extra work that would be involved in producing a separate report.

I have concerns that a number of the proposals would have significant workload implications for MHOs.

Beth Hall: I will echo some of Colin Fraser's points, based on the work that we have done with our members on existing pressures on MHOs and the shrinking workforce. The numbers of adults with incapacity are projected to rise, which will impact on existing duties, such as guardianship. Information has been published showing that cases have been increasing by about 10 to 12 per cent per annum since those duties were introduced. The trajectory is upwards against a decline in the workforce.

Last week, the Scottish Law Commission published a report that is proposing a new scheme on the restriction of liberty, which would place additional pressures on MHOs. Against that backdrop, in looking at a bill that would introduce additional duties for MHOs, we concur with the Mental Welfare Commission's call for a national strategy on MHO workload and capacity and recruitment and retention. We would want such a strategy to go further and also look at projected demand, what that means for capacity requirements and how that would be resourced.

On the bill's specific proposals, we had other concerns where we were not able to reconcile what was said in the explanatory notes and the financial memorandum. It looked as though the latter's estimates were based on a narrower interpretation of the duties that appear in the bill. The Mental Health Tribunal for Scotland also picked up on that. It shared the view that MHO reports would be triggered in far more circumstances than the financial memorandum anticipates.

I can give more detail on that later and say what we think the likely requirement would be. Overall, however, we should think carefully about any new duties within that context until a proper review is undertaken.

10:15

Derek Barron: This is not my area of expertise, so I asked some of my colleagues in North Ayrshire Council and the lead nurse there, and they concur with what Colin Fraser and Beth Hall said about the workload issue and the resourcing issue. To put additional responsibilities for MHOs into the bill would cause great difficulties in terms of workload.

The Convener: I suppose the question for the committee is whether it would cause great difficulty in implementing the bill as is intended. I do not intend to dismiss or play down the anxieties that we have heard, but in most cases people are worried when change is proposed. We would still be able to go ahead with implementing the bill and its objectives, would we not?

Beth Hall: The financial memorandum gives some estimates of the number of additional reports that would be required by measures in the bill, and specifically section 2, which relates to section 101 hearings. It estimates that an additional 20 reports per annum will be required. However, the financial memorandum bases that estimate on different, narrower circumstances than are contained in the bill. The Mental Welfare Commission and the Mental Health Tribunal for Scotland have also picked up on that discrepancy.

If we look at what the bill actually says about just the section 101 reports and we take Mental Health Tribunal for Scotland figures, the number of additional reports would be not 20 but 493. The same issue of discrepancy with the financial memorandum applies with section 41. The difference is significant enough to be a big problem.

Dr Crichton: We would, of course, welcome the input from mental health officers in a wider range of circumstances, but we have some concerns that that might cause delays in appropriate treatment in various areas. An example is transfer for treatment directions. We have some national prisons, and MHOs from various parts of the country will be called upon to provide reports, sometimes in urgent circumstances.

As a general comment—I would not take away at all from the comments from our social work experts in the room—it has struck me as a curious thing that, for psychiatrists, the approved medical practitioner training is really quite modest, involving an online module and a day's course, which compares rather starkly with the comprehensive training of mental health officers. I wonder whether we have the right balance in that, and also whether we have the right balance of expectation in all mental health social workers generally being expected to be mental health officers, as we would expect all psychiatrists to be approved medical practitioners.

Karin Campbell: I concur with what has been said about the extra duties on MHOs. The Social Work Scotland mental health sub-group has also raised concerns about the significant additional work to be placed on them. However, it is important to look at why those reports are being required. They are seen to be best practice, and it is important not to dismiss that. We need to remember what the bill is about.

Although we require to do more work, we need to look at how we will do that and what support we need to be able to do that rather than not do it, because the bill as it is being presented is specifically to support people who are mentally unwell and have mental disorders; those people need the legislation for their protection and their wellbeing.

Training for MHOs is another issue that was mentioned, and it is important to look at that very comprehensive training. The MHO workforce is ageing, so how do we make MHO training attractive to people? We have a lot of mental health officers in Scotland who are not going to be around in the next 10 years—they are going to retire—so we need to focus on how to encourage people to undertake the training and become MHOs.

Bob Doris: Karin Campbell has hit the nail on the head. First, the committee will of course explore the numbers that were outlined, whether it is a question of 20 additional reports or 493. We will look at the pressures, at workforce planning and at recruitment retention. Those points matter, and we will be asking the relevant people in Government and elsewhere the questions.

The bigger picture is: are those reports required? Are they essential? Are they highly desirable? Are they just a slight advance on how things are now? I have not really heard from people about how desirable the reports would be. I want to make a judgment on whether that is the right thing to do, and then I want to make a judgment on how we resource it and enable it to happen.

I feel that, so far, the discussion has been on whether we can resource the reports and enable them to happen. We will look at those figures as a committee, and I am sure that we will make a well-rounded decision on that issue in due course. However, we have not heard enough—apart from Ms Campbell—about whether that step is desirable. I would like some information about how desirable or otherwise it is.

Dr Crichton: We feel that the reports are highly desirable but, from our real-world experience, we know that we can sometimes have difficulties and we would certainly need some measures whereby, in circumstances where we could not achieve the report, we could still achieve the urgent treatment required—for example, in transfer for treatment directions.

Dr Stocks: In the code of practice, it is recommended that MHOs seek advice from other practitioners who might be involved in a person's care. To that extent, we feel that the reports are highly desirable. They are desirable anyway, but it is often the case that that wider input does not happen—possibly because of the resourcing issue—so we feel that it is extremely important to continue having the reports. However, there needs to be a contribution from other professionals into those reports.

Dennis Robertson: On that point, what about the role of the general practitioner? I would think that the pathway for a lot of patients in the initial stages is through GPs, and I am wondering about the pressure on the GPs themselves, from the initial judgment to refer patients for that specialist pathway of treatment.

Dr Gillies: Thank you for raising that point. Such events in general practice are not rare, but they are unusual and they are not part of the day-to-day work. When they happen, they are often complex and require a lot of time and attention. They can often be disruptive to the more routine parts of a GP's day. GPs do not take lightly the decision to refer someone for a psychiatric opinion and for an MHO's opinion.

My understanding and experience are that, when those events happen, they are dealt with by GPs in a reasonably timeous manner. As far as I understand from the bill, there is not a large implication of an increased workload for GPs. As far as I can see, the onus falls largely on mental health officers rather than general practitioners.

I will raise one or two points about general practice later on.

Does that address your concerns?

Dennis Robertson: What I am really trying to get at is that GPs will be under significant pressure to make the initial judgment calls. As you said, they are in general practice; they have generic rather than specialist knowledge. Are there enough specialists in practices in areas in which there is a high incidence of people who require referrals? Is that aspect covered adequately in general practice and medical centres? Basically, can you call on your colleagues?

Dr Gillies: The general practitioner's point of view is that of an expert clinical generalist. That means having an understanding of the biomedical aspects of care, which means physical illness and mental health or psychiatric illness. We also have knowledge of what we would describe as the biographical aspects of care, which is an understanding of the person in the context of her family, community, culture and ethnicity. Those are the core skills of general practice, and we would draw on them to make a decision.

Obviously, specialists and generalists, which we are, work closely together. Specialists need generalists and generalists need specialists. The right starting point is still the general practitioner. She or he can make a decision about involvement. As far as I know, that system has worked reasonably well. I would be grateful for any discussion about that from specialist or psychological colleagues.

Dr Crichton: I support those comments.

We talked about why there was a period of 28 days. That has been a tried-and-tested timeframe. Another tried-and-tested observation is that the combination of specialist and general practitioner in decisions about compulsory treatment has worked very well historically. Colleagues who regularly make those decisions with their general practice colleagues give very positive feedback about that input, particularly the broader appreciation of families and communities that general practitioners bring to the decisions.

We have difficulties in areas in which people are not registered with the general practitioner, and we usually have to scratch around to find an advanced nurse practitioner from an independent area to come and assist us with second medical recommendations. I have often thought that, in those circumstances, it would be nicer to try to get an independent GP from some place, but GPs are, of course, under tremendous pressure. We are very grateful for all their contributions to the decisions.

Dr Stocks: We, too, support the role of general practitioners, and we see the more holistic view of individuals as very important in decisions about their management.

I reiterate my point that there are times when specialist input is also required. There are a number of ways to do that; psychologists are among the range of professionals who might contribute. Perhaps the views of those people could be taken into account more often.

Dr Gillies: I do not want to prolong the discussion too much, but we at RCGP are certainly on record as supporting an increased provision of psychological services for people with mental health disorders. There is some evidence that the biomedical model of dealing with mental health, which has been the predominant one for the past 30 years, has had great strengths and successes, but the paradigm is now changing. We are often frustrated in general practice by an inability to access psychological support timeously. There have certainly been improvements in that area in recent years, but there is still some way to go.

10:30

The Convener: Section 14 of the bill makes provision for certain nurses to detain people. Does anyone want to comment on that? The Mental Welfare Commission has expressed concerns about the provision.

Derek Barron: As I said the previous time I was at the committee, we are concerned about that power. We do not see it as a proper extension of the nurse's role. To be able to exercise that power, the nurse has to be able to diagnose. However, that is not what nurses do. There are very few nurses who can prescribe. We do not support the provision at all.

The only power to detain for a nurse is in section 299 of the 2003 act, which I assume we will come to soon.

Dr Stocks: On Dr Gillies's point, I was extremely pleased to hear that there is a recognition of the need for a shift in emphasis from the traditional medical model towards the more biopsychosocial approach. As psychologists, we are not presenting anything that is a challenge to what other people do. Our approach involves seeing mental health care as requiring a number of components with various interventions. We believe that, in addition to the more traditional forms of treatment, such as medicine and mental state monitoring, a range of psychological and social therapies is required.

It seems to me that the shift, which is recognised by the clinical professions, has to be brought to the attention of the general public, carers and the users of services. We recommend that the language of mental health legislation is changed. Currently, there is reference to medical treatment. Although that includes a range of types of intervention, including psychological interventions, those are not given due recognition in practice.

Only by more fundamental changes in the legislation will there be a more progressive approach to mental health care. That is what was envisaged in the existing legislation, but it has not been recognised in practice—certainly not to the extent that users of services require.

Karin Campbell: The social work mental health sub-group viewed positively the proposal to extend the time in which a nurse can exercise their holding power to three hours, because it would enable the nurse to contact the MHO and the RMO. There are a number of local authority areas in Scotland in which the hospitals are not necessarily right where the MHO happens to be, so it would be useful to allow that extra time. That would mean that people would be more likely to be detained on a short-term detention certificate rather than an emergency detention certificate, which would be better practice.

Derek Barron: In 2013-14, there were 177 uses of the nurse's power to detain. Only 74 per cent of those people went on to have a detention. Of that number, 40 per cent were emergency detentions and 34 per cent were short-term detentions; another 23 per cent stayed on in hospital without the use of a detention order.

The code of practice that was sent out by the Mental Welfare Commission earlier this year set out the process. The nurse tells the individual that they are going to use section 299, on the nurse's holding power, and there is a form to fill out. The nurse also informs the doctor, and the doctor has to be there within two hours. Only once the doctor has agreed to the detention order does anyone call the MHO.

In order for the provisions to have any impact within a three-hour period, the MHO would have to be called at the beginning of the process. If that is done—bearing in mind the workload issue that we have heard about from MHOs—that would have involved calling an MHO for no purpose whatsoever in 70 cases, either because the person decided to stay in hospital or because the person was not then detained. That means using up MHO resources, because they could have to go from somewhere remote to a hospital for no purpose whatsoever. There is therefore no advantage to the proposal.

My other issue concerns reciprocity for the individual who is detained. We are saying that we will not allow them to leave for two hours. That places on those of us who are in service an obligation to make an equal response in acting as soon as possible. There is no evidence that the extension of the period for which someone may be detained from two hours to three hours would have any impact whatsoever.

In NHS Ayrshire and Arran, we used the nurse's power to detain only nine times last year. Even in Greater Glasgow and Clyde, it was used only 27 times over the entire year. I am not sure why there has been a push for change.

I have the statistics—I think that they will be issued by the commission later this week—which indicate that there is no evidence that there will be any advantage to the proposals; nor is there any evidence that increasing the length of time for which someone can be detained will have any impact other than on the person. Our duty is to protect their human rights, not to make things easier for our workload.

Dr Crichton: One possible source of concern might be from rural and remote areas. I wonder whether other solutions could be considered. We are expanding our use of video technology and that sort of assessment. For example, telemedicine can be brought from a practitioner's home computer into the clinical workspace, with the appropriate safeguards and security. I wonder whether there may be other ways to crack this particular nut.

Bob Doris: I seek clarification on a couple of points. I have no idea whether the proposed extension to the time for detaining people is the right thing to do; I have no preconceived views on the matter. I was not sure whether Mr Barron was saying that the period should not be extended. The Mental Welfare Commission said that we probably should not extend it, as it does not think that it will lead to any greater involvement from the RMOs—rather than saying that extending the period would necessarily be a bad thing in itself, or that it would not have the intended consequence. I might have picked you up wrongly, but are you suggesting that the current power to detain should not exist? I got the sense that you were saying that it is not a positive thing in the first place.

Secondly, my understanding is that only some nurses—mental health nurses and learning disability nurses—have the power to detain. Have such nurses across Scotland taken a view on the matter and raised concerns specifically about the current two-hour detention? If they have, the committee would wish to know about that.

Derek Barron: You asked whether the power to detain is a positive thing. Yes, it is. The power is not used as well as we would like it to be. The Mental Welfare Commission published its updated guidance earlier this year, and we will be doing additional training. We would like far more nurses to use the power to detain, because that brings with it the protection of the 2003 act for the individual. However, we feel that some de facto detentions are happening without the provisions of the act, which is unfair on individuals.

On the second point, there is no concern from mental health nurse leaders across Scotland regarding the two-hour period. Our concern is about extending that time. We do not see any need to do that, and I do not think that it would be within the ethos of the 2003 act or of our approach to human rights. We do not think that such an extension would provide any advantage, yet it would impose a restriction that is perhaps not required.

Bob Doris: I will digest that point. I am not trying to be awkward, but I was not clear about the point that you were making.

A point was made earlier about detention being given in 74 per cent of cases once the RMO had arrived; often that was just a short-term detention, but it was given.

In the minority of cases, in which detention would be required for the safety of the individual, what would be the consequence if the nurse did not have the power to detain? I accept that the more power of detention that is given, the more the rights and freedoms of individuals in society are infringed. However, there has to be a balance because, at the same time, we are seeking to protect vulnerable individuals. Is there any benefit in an extension from two to three hours? I am trying to tease that out.

Derek Barron: My view and that of my colleagues in nursing—associate nurse directors in mental health and so on—is that there would be no advantage in an extension. The proposal may be workload related. We do not even know where the proposal came from; it certainly did not come from nursing. In fact, we would prefer to go back and do more work with our nursing workforce on the use of the power to detain.

Bob Doris: There is no reason for asking this other than that I am interested to know. When you talk about taking the views of senior nurses throughout Scotland, has the RCN done a deep survey of nurses in mental health, for example nurses on the wards in mental health units and those who work hands on, at the coalface, with learning disabilities? Are you describing a grass-roots view or a senior clinician view? It may be both, which is fine, but I want to get a flavour of where the view is coming from.

Derek Barron: It is both, because we engage with our staff. In my area, we have a mental health nursing advisory committee, which has mental health and learning disability nurses on it. We get the feelings from them, whether it is a brand-new staff nurse on a ward or community team, or somebody who is more experienced. I speak on behalf of senior staff, who are accountable for detention and responsible for monitoring it. We do not see any advantage to an extension. Not one nurse has come to me and said, "If we'd had three hours, things would have been better."

Bob Doris: That is really helpful. Thank you.

The Convener: Are there any additional comments?

Dr Gillies: In sections 21 and 22, on advance statements, the bill seeks to place a duty on health boards to ensure that a copy of an individual's advance statement is placed in the medical records and a copy is sent to the Mental Welfare Commission. That seems like sensible practice.

Health boards, and presumably hospitals, have their own records. General practice has separate records. Good practice would obviously be that the advance statement is shared with the patient's GP, as well as with the hospital. We know from practice that that does not always happen. I wondered whether there could be a duty on health boards to ensure that GPs, specialists and other clinicians who had an input into a patient's care were made aware of the advance statement.

The advance statement often comes through the general practitioner, but that is not always the case. Everyone should be kept informed. Advance statements are significant and they must be looked at carefully in the context of, say, a recurrence of a serious mental illness.

Dr Crichton: One place where the advance statement should reside is the emergency care summary. As that rolls out and becomes more available to emergency mental health services, there will be greater awareness of its use in mental health services. It is essentially a matter for the code of practice and professional development, rather than statute.

Dr Gillies: I agree. I just wanted to raise it as an important issue. The emergency care summary has been hugely useful, but it includes very basic data about drugs, allergies and intolerances.

The key information summary, which is being rolled out electronically across Scotland, might be the best place for the advance statement to sit. If it sat there, the explicit consent of the patient would be involved. I would agree that that would be the way forward.

10:45

Derek Barron: I was going to suggest the key information summary. We should pursue that roll-out. There will be technical difficulties with how we do it, but that should not preclude our trying to do it.

However, not everyone can access the emergency care summary or the key information summary. The emergency care summary is currently available only for out-of-hours practitioners, so it is not broadly available across mental health services and it is not available on our wards, where access to it is needed, and neither is the key information summary. I am not saying that we should not do as Dr Gillies suggests, because he is right and the key information summary is one central place to put the statement. We might have technical difficulties with how we do that so, when we roll it out, we need to be cognisant of that.

Dennis Robertson: The point that Dr Gillies makes is essential. For their follow-up care, patients will probably sit with the general practitioner. That will be the case not only for the patient but, perhaps, for their extended family or carers. I take his point that GPs do not always get sight of the advance statement. How often does that happen? I am aware of cases in which it did not happen, which, unfortunately, meant that the patient did not have the required follow-up care and the GP was basically in the dark about the treatment or recommendations from psychiatry or psychological services.

Dr Crichton is right that the advance statement needs to be in the code of practice, but it needs to be acted on. It cannot just sit there and be nice words. It is to the benefit of the patient and we need to ensure that it is followed up.

Dr Stocks: We mentioned in our written submission that there is a need to take account of the fact that service users often change their minds. Although we recognise that there might be a benefit in having a central register, there also needs to be some way of ensuring that the advance statement is kept up to date.

There is not always a good understanding among staff working with service users about how to create an advance statement. It would be useful to have some guidance in the code of practice but, as we have learned from previous experience, not enough attention is always paid to the code of practice. Training in how advance statements can be created and kept up to date may be required for staff working in mental health services across the board.

The Convener: Is there a role for advocacy in making people aware that they can and, possibly, should have advance statements to influence difficult circumstances? How common is it for a patient to have a statement or to have that information anywhere?

Colin Fraser: My experience is that advance statements are relatively rare. They are an aspect of the legislation that did not take off as much as people had hoped and anticipated. It is always a bit of a treat when we come across one. We are often asked at tribunals whether there is an advance statement and, more often than not, the answer is no. It is an area of work that, perhaps, merits revisiting in terms of guidance and training.

I agree with Dr Stocks's comment that people with existing advance statements change their minds and, if there is a mechanism for recording an advance statement, there needs to be a mechanism for reviewing it and ensuring that the information is up to date.

Derek Barron: The answer to your question, convener, about whether there is a role for advocates is yes, there is. However, there is a much greater role for, for example, community nurses, who are engaged with people when they are less ill. The advance statement is about what somebody wants to happen when they become ill, so we have to be careful that the practitioner is not the one who generates it.

I agree with Colin Fraser that advance statements are rare. Some of them are not very good, in that they say things that are just not doable. The Social Work Scotland mental health sub-group mentioned a pro forma. We have asked the Mental Welfare Commission for Scotland to think about doing a pro forma so we can have one.

However, a lot of people choose not to have advance statements and we must be cognisant of that. I also have a huge concern about our having a central repository for those statements. The national health service in general does not have a fabulous track record of having massive, centralised systems that work in terms of who is allowed to access the data and when they can access it. Also, unless the system is available 24/7 it is pointless, as services need to be able to access a person's advance statement when that person becomes unwell or is going to be admitted so that they know what the person wants to be done. Not all boards in Scotland have electronic systems that could make the advance statements available, and where would be the central point to get them from? In addition, as Dr Stocks said, if someone changes their mind, how do they ensure that their advance statement is updated from the moment that they change their mind?

The Convener: We do not need to worry about any of that, though, because it is a rare occurrence for a patient to present with an advance statement despite the fact that we all agree that having one could be helpful. Maybe we need to turn the argument upside down and say that, although those problems will present, we should recognise that it is a good thing that someone wants to opt into the system. Maybe by making that happen, we will overcome some of the difficulties.

Derek Barron: We can do it in NHS Ayrshire and Arran because we have an electronic health record for mental health. All our advance statements are available 24/7—in fact, I could access one just now, although I obviously would not do that. We need the ability to do that. However, you are right to question whether we need to spend a lot of time doing that for a system that people are not opting into.

Dr Gillies: This has been a really interesting discussion. I agree with Colin Fraser that advance statements are pretty rare. I hoped that we would see many more of them when they became available because, when they have been available for a patient, they have often been hugely helpful in guiding professionals on how to deal with the patient.

On Derek Barron's point, I assumed that the Mental Welfare Commission for Scotland was sent a copy so that it was aware of the data and statistics on advance statements rather than so that they could be used in the day-to-day care of patients. I still think that it would be useful to have some hard data on advance statements, and I agree that it would be really useful to encourage them. However, I would be concerned about advance statements going into the electronic care summary, as that will become more widely available over time. Patients would often be rather concerned if an advance statement were made available in that way. The place for them would be a key information summary, which should—to answer Dr Stocks's point—be updated regularly in consultation with the patient.

Dr Stocks: In previous evidence to the committee, someone from one of the third sector organisations spoke about how their research shows that service users are not producing advance statements because they believe that they will not be paid attention to so there is no point in making one. That is very worrying for society. Given any opportunity to influence the bill, we need to ensure that it promotes collaborative care for people who suffer from mental health problems and that we are doing everything that we can to ensure that people feel empowered. It is important that they feel that their view, when they are well, about how they would like to be treated when they are unwell is going to be paid attention to.

Dr Crichton: There are some examples of good practice in this area. Patients in forensic mental health services are subject to the care programme approach, and we are rolling out innovations in that approach to make it more patient centred. However, within that process of regular review, the advance statement is revisited periodically. That information is shared with primary care and other forums, and it goes on to electronic databases in the health boards that have those systems up and running so that it is accessible to on-call and emergency services.

We can make the advance statements work a lot better. They work for those with severe and enduring mental illness, and those who are subject to the care programme approach or its equivalent, but their use becomes more problematic for those with less serious conditions.

Karin Campbell: The convener asked whether advocacy should play a role in the use of advance statements. We think that it should, as there are elements that such an approach could pick up on. I know, as I am based in the Highlands, that the Highland user group has been very proactive in that respect. Even while the 2003 act was being implemented in 2005, the group was doing a lot of work with its members on advance statements. I do not know whether the number has been reduced or there is less uptake now than there was back then, but I know that advance statements were viewed as very positive, especially for people with severe and enduring mental illness who required treatment on more than one occasion.

Perhaps user groups could become more involved with the issue, as they would be able to support their members in producing advance statements and understanding the benefits.

Derek Barron: I agree with that entirely. I was in the room when someone from the third sector said that people do not believe that their statements will be listened to. That is not necessarily evidence—it is the view of a few people, and I am not sure that it is entirely accurate.

The previous chair of the Highland user group stood up at a conference and actively promoted the use of advance statements. However, he said, "They are really good things, but I don't have one." He actively chose not to have one, and people must retain that right.

To come back to the point that Dr Gillies made about the Mental Welfare Commission, we send advance statements to the commission, which is the protector of human rights. If a board does not follow the terms of someone's advance statement, we have a duty to inform the commission, and it will look into the matter specifically. The statement goes to the commission as a protective mechanism. There will be occasions on which we do not follow an advance statement and we have to answer for that. That is the purpose of the mechanism.

Colin Fraser: I reiterate the point that, rather than highlighting the low uptake for advance statements and organising around that, the priority should be to increase uptake. The statement is a really important part of the legislation, and it is unfortunate that the number of people who are making use of that availability has been so low. It would be interesting to do some research to try to find out why so few people make use of advance statements. I agree with Derek Barron—the statements are voluntary, and nobody is forcing people to use them—but it is striking how low the numbers are. That requires attention, as we at least need to know why.

Dr Simpson: Mr Fraser has partly made the point that I wanted to make. Is there any research on whether it is a myth that advance statements are not followed? The protective mechanism was written into the original 2003 act. The purpose was that, if someone had an advance statement, the MWC knew about it and could determine whether the treatment that the person received conformed with that statement. If it did not, the commission could ask why that was the case. It is disappointing to hear that there is a view that the statements are not worth the paper they are written on. It would be interesting to ask the MWC whether the situation has been properly analysed and how often there has been a problem.

Also, the convener raised the issue of advocacy. I will move that on a bit. There is a qualified right to independent advocacy—I think that the 2003 act refers only to that being a right if practicable. There is a view that it should be an absolute right. That might help us with the advance statement issue, too. Should we have a much firmer statement in law rather than only informing people that they have the right to advocacy if it is practicable?

11:00

Beth Hall: We are aware of issues with the availability of advocacy services across the piece. Across Scotland, a number of reports have indicated that provision can be patchy. However, in taking the decision to go down a legislative route to try and solve the problem, we must be very careful and clear that the proposed additional duties will solve it. First, we need to get a better understanding of what the issues are and what is leading to the problems. I am not sure that we have that understanding as yet. Therefore, I suppose I would want to pose back a question: do we have a good understanding of what is happening here?

Dr Stocks: Is the issue not more about making sure that local authorities and health boards fund the provision of advocacy services? It seems to be well recognised that provision is patchy, but in some areas it seems to work very well. We responded on that issue in our written submission. I must confess that that response is based on my knowledge of my job as a clinical psychologist working in Greater Glasgow and Clyde. We have an advocacy service that is fully funded by the health board—I am not sure whether the local authority contributes as well—and the advocates are embedded in the work of the health services. Every patient in forensic services, where I work, has access to an advocate.

The advocates also become a part of the culture and the environment, so they learn about how mental health services work and they get to know the professionals whom they sit beside at care programme approach meetings. It is much easier to advocate for someone in those circumstances. There are probably many other examples of good practice across the country from which we could learn. However, the point is to make sure that the financing is there to employ advocates.

Beth Hall: I agree with those points, but I want to add a little bit about local authorities' work. They have a duty under the Social Care (Self-directed Support) (Scotland) Act 2013 to look at the marketplace of services in their area and to think about how they can develop that to ensure that it is sufficient to meet need. That includes looking at funding such services and looking at the balance between investing resource in direct service provision to the individual through, for example, self-directed support and personal budgets, and having resource available to fund universal services and specialist advocacy provision.

I agree that there is a funding issue, but that begs bigger questions that I am not sure will be solved by creating a stronger duty.

Dr Crichton: I endorse the general comment that advocacy has exceeded expectations. In areas where advocacy is well resourced, advocates become part of the mix that promotes patient welfare and rights. If we are a little bit disappointed in the take-up of advance statements, we are not disappointed in the use of advocacy where it is available.

On strengthening the right to advocacy, I would want to see the evidence of those areas that struggle to provide it.

Derek Barron: I agree with Beth Hall, because I am not sure about the advantage of putting an advocacy duty into the bill. I would prefer to find out where people are struggling just now and address those areas, rather than taking the blanket approach of putting a duty into the bill. We do not struggle on advocacy, and we provide it, including in dementia units. We approach advocacy as a right and a responsibility. I am not clear what advantage there would be in putting it into the bill. There must surely be an advantage in doing so—otherwise, why do it?

The Convener: I think that that issue has been well aired. Do committee members have any other questions on it?

Dr Gillies: Could I—

The Convener: I am just asking committee members.

Dr Gillies: I beg your pardon.

The Convener: You are fine. Did you want to come back on that issue, Dr Gillies?

Dr Gillies: No. I had a comment on another subject.

The Convener: That is okay. I was just about to move on to other subjects, because we are probably in the last 25 minutes of this session. Beth Hall and Derek Barron mentioned issues that they hoped to raise, so I will give you all the opportunity now to refer to areas that are of particular concern to you. If you want to put them on the record, that would be helpful to us all. If the issues stimulate more debate, the session will be all the better for that. Beth, you said that you would come back to some issues, so I will give you the floor. I will accept bids from other panel members to speak on issues that they feel have not been aired yet.

Beth Hall: I will try to be brief. I have two additional points that relate to the first point that I made around MHO reports being triggered in a broader range of circumstances. I draw the committee's attention to sections 41 and 26 of the bill. Section 41 relates to compulsion and retention orders and section 26 relates to transfer for treatment directions, which we touched on. My point is a general one about the need to consider the resource implications for those provisions. I would be happy to provide further detail on that in writing later if that would be a better use of time.

The Convener: Yes, that would be useful.

Beth Hall: My final point is that I welcome the extension of the victim notification scheme. However, many of our members expressed concerns about what would happen as a result of that. For example, it could place offenders who have learning disabilities in quite a vulnerable situation. We would need to consider what additional measures we would want to wrap around that in those circumstances. My colleagues from the professions may want to say more about that.

Those are the key points that I wanted to make, and I am happy to provide more detail on them in writing.

The Convener: Those were three good points on important areas. If other panel members wish to say anything about that contribution, please do so.

Dr Crichton: I perhaps should have declared at the beginning that I am chairing a group, which is being sponsored by the Scottish Government, on the implementation of the victim notification scheme. We are at an early stage of deliberation, but one of the issues to ponder is that we have been involved with victim liaison for some time and that it is not new. However, the participation of victims in shrieval tribunals, for example, has been rather haphazard and patchy, and has depended on whether people happen to know that they have the right to go to the tribunal and ask to be treated as an interested person. There is an opportunity for making a much more sensible provision for victims.

At the minute, our discussions are concentrating first on restricted patients, which is the right initial focus. It is probably also the right and practical way forward to base the victim notification scheme in the Scottish Government, at least initially. That will allow us to get it right for that particular group of individuals, after which we can consider whether extension is appropriate to other compulsion order cases. In that, we should use as our guide the victim notification scheme for non-mental health cases, and peg ourselves to that.

Dr Simpson: On victims, I recently received a communication from the organisation Hundred Families, which deals with the families of the victims of homicides in which mental disorder has been involved. I am not sure whether its figures are correct, but it suggests that there have in Scotland in the past 10 years been 137 homicides in which mental health issues have been involved. That is 15 per cent of all homicides in Scotland, which is a greater proportion than the figure in England, which is 10 per cent. More concerning is that of those 137 homicides, only two have involved incident reviews, whereas in England there have been 321 reviews from 576 homicides.

I just put that on the record because, although the bill deals with victim notification, the victim may not be around—we may be talking about the families, as well. I just raise the issue and ask whether anyone has any initial comments on those figures which, if they are valid, show a rather stark difference of approach between Scotland and England.

Dr Crichton: I am pleased that the chair of Hundred Families is part of the expert group and is contributing to it. The figures that he has used are taken from the national confidential inquiry into suicide and homicide by people with mental illness, which is based in Manchester. If a practitioner is unfortunate enough to have a patient who either kills somebody or commits suicide, they fill in a questionnaire that is sent to the national confidential inquiry. I am pleased to say that the apparent figure of 15 per cent is largely because of the greater problem with substances in Scotland, so the figure includes people who might be in contact with alcohol and drugs services. If we burrow down into the data and look at the absolute rate of, for example, schizophrenia-associated homicide, we find that Scotland is exactly the same as England and Wales. That is a really important message to get over.

Close family relatives of someone who is killed have always been considered to be victims—they are sometimes referred to as secondary victims. That is true of the current victim notification scheme in the criminal justice system and it will be true under the proposals. The particular beef of Hundred Families is about the inquiries that are made following a tragedy, on which we in Scotland take a very different approach from that which is taken in England. It is timely to have a discussion about whether we have the balance right. The new chief executive of the Mental Welfare Commission spoke about the topic at a Royal College of Psychiatrists meeting two weeks ago, at which we discussed whether the balance is right in the commission's published inquiries. I think that Hundred Families has a point in saying that a discussion about the commission's role in investigating such tragedies and about what it puts in reports would be timely.

Dr Simpson: That is helpful. Thank you.

Derek Barron: I am not sure of the Mental Welfare Commission's role in relation to the issue, so I think that that point is an aside. The role that we are talking about is for Healthcare Improvement Scotland, and it is about scrutiny. Over the past couple of years, it has developed a robust process through which incidents of suicide or homicide by persons within mental health services must be robustly reviewed and reported on. We report to Healthcare Improvement Scotland on that, and to the MWC. We have to remember that the MWC exists to protect human rights, whereas Healthcare Improvement Scotland is there to scrutinise what the services have done. The two work together. Therefore, although Hundred Families may be saying that and it may have been true 10 years ago, it has certainly not been true in the past couple of years. We are well scrutinised by HIS. We have to do reports and publish them on our board websites, as well as produce action plans and the follow-up actions.

11:15

We have fatal accident inquiries, as well. The procurator fiscal looks at what we have done and what has happened and then makes a decision, along with the families, on whether to have an FAI as well as a board inquiry. I am not sure what else is being asked for on top of that. Having been through several of those inquiries, I know that they are quite robust.

Dr Simpson: That is very helpful indeed. It gives us a much better picture than the quite narrow one that I was getting. Perhaps we should ask HIS to give us some more information, as well.

Dr Gillies: On the victim notification issue, when we consulted our members, they welcomed the proposal. Certainly I can think from over the years of several instances in which victims and the families of victims have been severely distressed when offenders have been released, whether or not those offenders have mental health problems.

There are two other aspects. If one looks at crimes that are short of homicide or murder, there are people with mental disorders whom one would hope to rehabilitate partially or completely following those events. It is important to ensure that the victims and the families of victims are informed and that the victim notification proposal is taken forward in a practicable way.

We also have to bear in mind that there are humanitarian considerations for the person with the mental disorder. Where treatment is available, it should be made available to them, from the humanitarian point of view and from the point of view of avoiding consequential repetition of such events when the person is released. There is quite a delicate balance to be struck.

Colin Fraser: As chair of the MHO forum in Glasgow, I brought the bill proposals before the forum; the victim notification proposal was the most hotly disputed subject. People had strong views about the resource implications of additional responsibilities for MHOs and so on, but from an ethical point of view, that proposal was the subject that caused people the most difficulties and was the one on which I had to take a show of hands to establish the position of the people in the room.

The show of hands came down in favour of the broad view that if you are a victim, you are a victim and it does not matter what route you have come down to get to that position. However, the minority position—it was a slight minority—was concern that there should be a more nuanced and stratified approach to different types of mentally disordered offender. People could perhaps see the point of transfer for treatment directions, but there were real concerns about the vulnerability of people with mental health difficulties and the risk of their being exposed post-discharge, which had to be recognised. I merely flag up that that proposal was, ethically, the most contentious of all the bill's proposals and it generated quite a lot of heat.

The Convener: Thank you for that. I thank Beth Hall for raising that issue, on which we have had a good discussion.

Dr Stocks: We have already spoken about the need to promote a biopsychosocial approach in mental health care, and about efforts to give greater attention to the broad range of therapies that service users would benefit from, of which psychological therapy is one.

I have already mentioned that the terminology could be looked at and I have spoken about the need for more detailed care plans, as was mentioned in the McManus report, as well as the need to make better use of specialist expertise. We have spoken about some of the ways of doing that, and I would like to add that the British Psychological Society would like the tribunals to seek reports from specialists more often, and we would also like future legislation to give consideration to extending the ANP role to other disciplines, including psychologists and, potentially, nurses and occupational therapists, if that was considered to be appropriate. I am thinking about cases in which the primary treatment may not be strictly medical. For psychologists that would be particularly in relation to people who suffer from learning disabilities or other cognitive problems, people who suffer from autistic spectrum disorders and people who suffer from personality disorders. Certainly, many psychologists have the expertise to be able to give the information that is required when people are to be considered for compulsory measures, and I do not doubt that there are other professions whose members might feel that they could play a role in that respect.

We have spoken about the resource problems in relation to mental health officers, but I think that there are also resource problems in relation to psychiatry. I know that the extension of the excessive security tribunals is going to lead to additional burdens on psychiatrists, so it might be that there is a need to look at who else can contribute to the function of the application of compulsory powers.

Dr Crichton: The issue was discussed a great deal in relation to Westminster's Mental Health Act 2007. In England, there are no longer responsible medical officers; instead there are responsible clinicians.

I think that in psychiatry, we had difficulty in articulating why we felt uncomfortable about that, because, of course, we wish to promote multidisciplinary working and an expansion of the role of our colleagues. I think that that is because we are sometimes a bit shy about saying what medical people bring to the table. The two things that they bring to the table in particular are a tradition of making clear diagnoses, although we are not the only profession to do that, and their experience of non-consensual treatment. We learn through dealing with unconscious patients or people who are clearly incapable of consenting to treatment—first of all in the medical receiving bay or in the casualty department—and we make sensible decisions accordingly. Those two professional backgrounds are brought by a medical perspective.

There is a question of equality of esteem with regard to psychosocial treatment and its contribution, but that perhaps might be addressed through tribunals asking for appropriate evidence from colleagues. I am not particularly convinced that changing the complement of who makes compulsory detention recommendations is what is required.

Derek Barron: As I have stated before, we in nursing are not in favour of the provision.

At 9 o'clock of an evening in Crosshouse hospital, the doctors toddle off home—I am talking about those in mental health; the doctors in the accident and emergency department are still there. After the doctors have gone, advanced nurse practitioners are on duty all night, from 9 o'clock until 9 o'clock the next morning. They are also on duty at the weekend.

I am not against extending the nurses' role. One thing that those nurses cannot do is diagnose or detain people under the act. The vast majority of nurses—either mental health nurses or learning disability nurses—are not qualified to make diagnoses. In order to apply the act, a person must be able to diagnose the problem. We diagnose what is wrong with the person and treat them accordingly. Advanced nurse practitioners can also prescribe, as non-medical prescribers. Again, I stress that it is not that we do not wish to advance the role; the issue is appropriateness. There is no support from within nursing—mental health or learning disability—for the extension of the ANP role to nurses.

Dr Stocks: I will make a couple of points. First, I do not see the issue as being to do with parity of esteem among professions; I just think that psychologists, certainly, can play a valuable role. It is about ensuring that patients get the best assessment and that the best decisions are made, based on a comprehensive understanding of the circumstances. In cases in which the mainstay of treatment is psychological, surely a psychologist is well placed to advise.

The point that Dr Gillies made earlier applies in that regard. Things are moving on. In the past, it might have been only psychiatrists or medical practitioners who were able to gain the experience that gave them certain competencies, but things are changing. Lots of psychologists have experience of working with people who are detained, and are competent to diagnose a patient's mental disorder.

The Convener: Does anyone else want to raise an issue that they think might not have been covered?

Dennis Robertson: May I ask a quick question about people who are making the transition between child and adolescent mental health services and adult services? What difficulties does detention present, in the context of resourcing?

Dr Stocks: We have said that insufficient attention has been paid to the situation of young people under mental health legislation. I cannot comment on the resource issues, other than to say that educational psychologists will become less available now that the funding for their training has been stopped. The point was made in a previous meeting. We regard that as a serious problem in the context of young people's mental health. I think that most people agree that it is important not to stigmatise young people and that if difficulties can be dealt with by an educational psychologist when the young person is at school, the young person might be prevented from having to move into formal adult mental health services. The issue has not been given enough attention in the current revisions; it needs to be addressed.

Colin Fraser: Forgive me if I am a wee bit behind the curve on this. I want to raise an issue that is of concern to my colleagues, but it might already have been addressed in a previous meeting. In relation to the role of the second doctor in applying for a compulsory treatment order, the impression has been given that the responsibility for arranging that might somehow be transferred to the local authority. What currently happens is that the RMO contacts the GP. My colleagues are quite concerned about that, but I do not know what the current thinking is. It can be challenging for consultants to get hold of GPs in certain circumstances. It is difficult to anticipate what would happen if it were the responsibility of the MHO to deal with the GP. However, the thinking might have moved on. I would welcome comments on that.

The Convener: I do not recall the issue having been raised yet—I am looking around my colleagues. You have raised it now.

Dr Crichton: On the length of the assessment period when the court grants an assessment order under section 52 of the Criminal Procedure (Scotland) Act 1995, I think that sometimes people use the shorthand of treating that period as being the same as the assessment period during a short-term detention. We should be making up our minds about treatability criteria in a similar length of time.

However, section 52 cases can be very complex and can involve the most extreme circumstances. Section 52 allows for a period of in-patient assessment without a treatability requirement. There is a strong consensus among college members that sometimes we need a bit longer before we can nail our colours to the mast and say that someone fulfils the treatability criteria. I was involved in a case before the court of criminal appeal this year and I have another case coming up next year, both of which might have gone down a much less contentious route had the period of the section 52 assessment order been a little longer.

The Convener: If no one wants to respond to Mr Fraser and Dr Crichton's points, I thank everyone for attending and for their written and oral evidence. Thank you for your valuable time. I hope that we will be able to use your evidence effectively in the report that we produce.

As agreed, we move into private session.

11:30

Meeting continued in private until 12:19.

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