The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 18 November 2014

Session 4

Tuesday 18 November 2014

CONTENTS

HEALTH AND SPORT COMMITTEE
30th 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:

Cathy Asante (Scottish Human Rights Commission)
Professor John Britton (UK Centre for Tobacco and Alcohol Studies)
Kenneth Campbell QC (Faculty of Advocates)
Sarah Crombie (Victim Support Scotland)
Katherine Devlin (Electronic Cigarette Industry Trade Association)
Sheila Duffy (ASH Scotland)
Karen Kirk (Legal Services Agency)
Claire McDermott (Scottish Government)
Jeremy Mean (Department of Health)
Dr Jill Stavert (Edinburgh Napier University)
Dr Andrew Thomson (British Medical Association Scotland)
Jan Todd (Law Society of Scotland)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

The Adam Smith Room (CR5)

Scottish Parliament

Health and Sport Committee

Tuesday 18 November 2014

[The Convener opened the meeting at 09:45]

E-cigarettes

The Convener (Duncan McNeil): Good morning and welcome to the 30th meeting of the Health and Sport Committee in 2014. I ask everyone in the room to turn off their mobile phones as they can interfere with the sound system. Those present may note that some committee members and clerks are using tablet devices instead of hard copies of the papers.

The first item on the agenda is a round-table session on e-cigarettes. The committee has been waiting for some time to hold this first exploratory session on the subject. As usual with a round-table session, I ask everyone to introduce themselves.

I am the member of the Scottish Parliament for Greenock and Inverclyde and convener of the committee.

Dr Andrew Thomson (British Medical Association Scotland): I am a general practitioner in Angus. I am a member of the British Medical Association board of science and a member of the BMA's Scottish council.

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

Jeremy Mean (Department of Health): I am from the Department of Health in England.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I am an MSP for Mid Scotland and Fife. I apologise for being late due to trains.

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

Professor John Britton (UK Centre for Tobacco and Alcohol Studies): I am a respiratory consultant in Nottingham and director of the UK centre for tobacco and alcohol studies.

Richard Lyle (Central Scotland) (SNP): I am an MSP for Central Scotland.

Aileen McLeod (South Scotland) (SNP): I am an MSP for South Scotland.

Claire McDermott (Scottish Government): I am from the Scottish Government's tobacco policy team, and I am leading the consultation on e-cigarettes and tobacco control.

Colin Keir (Edinburgh Western) (SNP): I am the MSP for Edinburgh Western.

Katherine Devlin (Electronic Cigarette Industry Trade Association): I am president of the Electronic Cigarette Industry Trade Association.

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

Sheila Duffy (ASH Scotland): I am from ASH Scotland.

Rhoda Grant (Highlands and Islands) (Lab): I am an MSP for the Highlands and Islands.

The Convener: Thank you, everyone. Richard Lyle will ask the first question. I note for the panel that we do not intend to ask questions all the time—just when there is a break in the conversation. I will look to panel members in preference to committee members for contributions at all stages during the session.

Richard Lyle: I thank the committee for granting my request to hold a session on e-cigarettes.

The e-cigarette is a new invention that has come in during the past few years. There are concerns about what is in e-cigarettes and about what they are.

A number of organisations have made comments about e-cigarettes. In particular, I refer the committee to the report from YoungScot and the youth commission on smoking prevention, entitled "Young Scots support a smoke-free generation by 2034". The report states:

> "We want to see a ban on the sale of all e-cigarettes in shops and retail outlets—the product must be regulated and distributed as a medicinal product only."

I have a question for Claire McDermott with regard to the Scottish Government's position on e-cigarettes. As I understand it, there is no law against selling the product to children and the industry is self-regulating. However, as we know, anyone who walks into a shop may purchase something, and it concerns me that children could walk into a shop and purchase an e-cigarette. I know that the Scottish Government is considering a ban on the sale of e-cigarettes and that it is undertaking a consultation. Can you tell us where we are on that?

Claire McDermott: Yes. The consultation was launched on 10 October and will run until 2 January. We await the programme for government to see what the legislative timetable may be, but we will seek to consider the consultation responses as soon as possible. The Minister for Public Health has made it clear that he is committed to introducing legislation in this area.

Richard Lyle: Thank you for that.

The Convener: We will see whether we can get a response on some of the other issues. Richard Lyle mentioned the recommendation to ban e-cigarettes, and I think that United Kingdom legislation is already in place. Can we have some feedback on the general questions that arise from Richard Lyle's comments?

Katherine Devlin can go first.

Katherine Devlin: I feel that I ought to respond on this one, as I represent the industry. I will speak in the broadest possible terms, if I may. On the precautionary principle, as expressed in the concerns and suggestions that Mr Lyle raised, we have to be enormously careful that we do not do more harm than good. We have been very pleased to see the Scottish Parliament's approach to the issue, which is to consult widely, bring forward very few ideas initially and take time to gather further evidence before doing anything too drastic.

If we were to remove all the products from the market, the risk is that we could see all those people who have made the switch to electronic cigarettes returning to tobacco smoking, which would clearly not be good for public health on a population level or for individuals.

Professor Britton: I agree with Katherine Devlin. I should say up front that I have no financial interest in or any conflict of interest with the industry and what it has to say.

Electronic cigarettes offer a huge potential benefit to public health by helping smokers to shift to an alternative source of nicotine. If all smokers in Britain were to do that, we would be talking about avoiding hundreds of thousands, if not millions, of premature deaths. When legislating and controlling the inevitable abuses of the market that will come with electronic cigarettes, and given their inherent risks, which we still know relatively little about—although we know that they are much less hazardous than tobacco—it is very important that we manage those risks, but not in a way that throws the baby out with the bathwater, because there is a huge potential public health prize in these products.

Jeremy Mean: I agree with what John Britton said in the context of the UK Government taking an approach that is as evidence based as possible, recognising that there is not as much of an evidence base as we would like in order to be able to make good decisions about this category of products. We have tried to think about the risks and benefits, and rather than ban products that have, as John Britton said, great potential, we have taken a more measured approach in thinking about what regulatory framework and structure is necessary to enable the products to be made available.

On the risks and benefits, the position that the Department of Health has taken is that continuing to smoke is the riskiest thing that anyone can do—it costs 80,000 lives a year in the UK. It is important that we evaluate carefully anything that can help to manage those risks, and that we think about the potential benefits. As John Britton said, the market is such that we cannot be confident that the range of products available is safe, so we cannot recommend their use. However, what we do not want to do is remove from the market something that potentially has great value. We need a regulatory framework that gives us confidence that the products are of quality and will help people to cut down, to quit and to reduce the harm of smoking.

Claire McDermott: Likewise, we recognise—we develop this idea in the consultation paper—the potential for e-cigarettes to act as a cessation tool. However, as Katherine Devlin said, we do not think that there is enough evidence yet to make a decision on electronic cigarettes. That is why we ask the question in the consultation document. We are still seeking people's views to inform future policy development. One of the reasons why we have not taken action is that we recognise that individual organisations and service providers can act to implement their own policies if they feel that there is an urgent need to ban the use of e-cigarettes on their premises.

The Convener: Richard Lyle made a point about the sale of e-cigarettes to children and young people. I think that we are clear about the effects of nicotine on that younger group, are we not?

Jeremy Mean: The UK Government will shortly be consulting on an age-of-sale restriction of 18 and on a proxy purchase prohibition—that is, prohibiting adults from buying the products for younger people. If the regulations are passed, they will be in place next year. That is the intention in the UK.

John Britton is probably better placed than I am to talk about the impact of the products on younger people.

Professor Britton: None of us would want any of our own children, or anybody else's children, to start using nicotine for no good reason. That includes electronic cigarette use as well as smoking. I do not know what the figures are for Scotland but, across Britain, by the age of 25, 40 per cent of people have been smokers, and 25 per cent of people still are smokers.

There is a dilemma about young people's use of electronic cigarettes: if young people who would never have become smokers are using electronic

cigarettes, that is a negative step for their health and for population health. If the use of electronic cigarettes is predominantly among young people who would otherwise smoke or who are already smokers, the same potential benefits come to them as come to adults who make the switch. It is a very difficult balance to strike.

At the moment, the evidence from young people, according to the ASH surveys that are carried out by YouGov, I think—not those by Robert West, who does not consider information about smoking among children in particular—indicates that e-cigarette use among never-smokers is extremely low: it is of the order of 1 or 2 per cent.

Katherine Devlin: I make it clear to the committee that we have always asked for a mandated age restriction. We introduced the voluntary code in 2010, and we are very pleased that it has gone wider than our membership. We absolutely support the mandating of an age restriction.

The difficulty that we hear about from enforcement officers and from retail colleagues who are out in the marketplace selling the products is that, as it is not mandated, the voluntary code is not enforceable. Retail outlets where members' or sellers' products are placed will not necessarily respect an age restriction unless it is mandated. I repeat: we support a mandated age restriction, although we completely agree with Professor Britton's perspective on the potential benefits to children who already smoke.

That said, it is really important for the committee to recognise that there ought to be no difference between the treatment of nicotine-containing electronic cigarettes and the treatment of those that do not contain any nicotine. Unfortunately, to date, all the regulatory proposals and frameworks that we have seen from pretty much anywhere in the world fail to make that clear, so the products that do not contain any nicotine are frequently left outside regulatory discussions. We think that that is a significant mistake, because those are products for inhalation. Just as with nicotine-containing electronic cigarettes, we would not like to see children being sold non nicotine-containing electronic cigarettes.

Richard Lyle: I should make it crystal clear that I am not attacking e-cigarettes. I know a number of smokers in this building who have given up and who have been on e-cigarettes—although I have to confess that I am not one of them.

I think that Professor Britton said—I hope that I wrote this down right—that we know little of what is in an e-cigarette. Can you explain to us what is in an e-cigarette? People are concerned about that. What is contained in the liquid? I know that people can get liquorice, strawberry or raspberry flavour—or whatever flavour they want—but what else is in the liquid?

Katherine Devlin: The basic ingredient is predominantly propylene glycol, which is well understood—it has been studied for many years, and Professor Britton is perhaps in a better position to talk about it than I am. There is also vegetable glycerine, or glycerol, which is also fairly well understood. Those are both GRAS—generally recognised as safe. There is a very small concentration of nicotine—I use quite a high concentration, at 2.4 per cent, but that is a very low level of nicotine.

There are also flavourings—they are usually food flavourings, although, in the case of tobacco flavours, sometimes flavourings from tobacco absolute are used, and those obviously fall outside food flavouring standards. Some products also contain food colourings.

As the committee may be aware, we are in the process of creating a pre-standard—a publicly available specification—with the British Standards Institution, which seeks to cover emissions gathering and analysis, so that we can understand fully not only what is present in the liquid but, far more importantly, what is delivered to the user in the vapour that they inhale.

10:00

We are looking at gathering the emissions, analysing the analytes that are present in those emissions and then doing a full toxicological health risk assessment so that we have a better understanding of the impact on the human body of using the products.

It is with a certain amount of shame that I cannot provide that data to you today—and that it was not provided before the products went on sale. That is an error—a mistake. We should have done that analysis already. However, this has been a process of growth for the industry. Many of the businesses in the sector are not professional businesses. They were often created by vapers who got really excited about the products and decided to create a business. It is now necessary to try to push some standards on them in order to force the standards up, so that people know exactly what goes into the product, what comes out of it and what effect that will have on the human body.

Sheila Duffy: Part of the problem with this debate is that we are not talking about one standard product; we are talking about up to 500 brands and well over 7,000 flavourings. Some of those flavourings, although approved for food use, work quite differently in the body when heated and inhaled.

Our position has been that we would love to see people who are addicted to tobacco being able to use these products instead of tobacco or to quit a tobacco addiction. However, there are so many unknowns, and at the moment the little evidence that we have supports both an optimistic approach and a cautious approach. We believe that regulation needs to look at maximising the potential benefits and minimising the potential harm. The products must work towards our vision for a generation free from tobacco in 2034.

Dr Thomson: It is very heartening, as a GP, to hear the view of the industry that it wants to make sure that e-cigarettes are not available to our children. Certainly, my interest in this issue as a clinician was first sparked when a parent came to me with a primary school child who had been found in the playground with an e-cigarette—that is wrong on so many levels.

I am very keen for e-cigarettes to be removed; I am very keen for them not to be seen in shops and displays at children's height, so that children can no longer see those primary-coloured products or take them off the shelf to find out what they are. There needs to be a move to get the capsules—with the actual nicotine-containing liquid—into a child-safe form so that there is no risk to our children of them accidentally getting hold of that liquid and ingesting it. Although nicotine can cause vomiting and so on in overdose, it is not guaranteed that a child will bring up the liquid, so they may suffer harm.

It is also heartening to hear that the industry is keen to do a full health study. My concern as a clinician is whether that is happening after the horse has bolted. There is huge use of e-cigarettes, yet we do not have good evidence as to their safety. I absolutely accept that e-cigarettes will do less harm than continued tobacco use. However, I am concerned that the use of e-cigarettes does not always take someone who is using tobacco down the path either to 100 per cent e-cigarette usage or to quit nicotine as an addiction altogether.

There is certainly emerging evidence that e-cigarettes are being used to reduce people's reliance on tobacco, but those people possibly then maintain their tobacco use for longer. The evidence, certainly in terms of clinical harm, is that the length of period of tobacco use is potentially more harmful than the intensity of tobacco use. That is a significant concern.

There is a need for more evidence. Certainly, the BMA is very keen to see the quick development—or as quick as research ever allows for—of more evidence around the issue to the point at which I, as a GP, can feel confident to recommend the products to my patients as part of nicotine replacement or smoking cessation therapy. As part of the whole gambit, however, there has to be awareness of the evidence that all nicotine replacement therapies are more effective when they are combined with behavioural therapies rather than people just taking products off the supermarket shelf. We need to use e-cigarettes as a product to help reduce the impact of tobacco, but we must not take our eyes off the huge amount of harm that is caused by tobacco use in the UK, as other panel members have mentioned. I want us to be in a place where the evidence is there, but that evidence is going to take a very long time to develop and we need to be brave and move forward faster than that.

Katherine Devlin: Andrew Thomson raised several points, for which I thank him.

First, child resistance is required by law—or that is what people thought until July, when we found out that it is not required for products that have nicotine concentrations of under 2.5 per cent. However, in our code and our standard, we still insist on child resistance. No product should be out there that contains nicotine and is not child resistant. We verify that with a Government expert, for our members.

There is a significant difference between quitting smoking and quitting nicotine use. As I am sure Professor Britton agrees, nicotine is similar to caffeine in its dependence potential and its effect on the body. Quitting smoking is essential to securing health benefits; quitting nicotine is not such a big issue, in our view.

On the notion of continuing tobacco use, using electronic cigarettes is not tobacco use, of course. Tobacco use has potential health risks, but the continued use of e-cigarettes removes the harms that are associated with smoking tobacco. The issues are not quite the same.

On the point about behavioural support, Louise Ross at the Leicester stop smoking service has seen significant success after recommending electronic cigarettes—or perhaps not so much recommending them as educating her clients about them and making it possible for her clients to access products.

I absolutely agree with Andrew Thomson that we need more research and that we need to move fast on that.

Professor Britton: May I make a point of clarification? I agree that nicotine is about as hazardous as caffeine in terms of harm to the body—it is in the same order of magnitude. However, I suspect that nicotine addiction is harder to break.

I will pick up on two points that Andrew Thomson made. On dual use, the argument that has been advanced widely against electronic

cigarettes is that they encourage people to continue to smoke and just to use electronic cigarettes when it is difficult to smoke. However, we actively recommend and encourage dual use of licensed nicotine products in exactly the same way. The National Institute for Health and Care Excellence guidelines PH45 on tobacco harm reduction, which I think came out at the beginning of last year, do the same.

The argument is that, although cutting down on smoking probably has a trivial impact on health outcomes, because it is the first cigarette of the day that does the most damage—the situation is more complex than that, but there is a certain truth in that—we know that people who smoke and use electronic cigarettes are far more likely to quit smoking than people who do not. That is about the learning process. People say, "If I can go through a four-hour meeting without smoking by using an electronic cigarette, why shouldn't I go all day?" We encourage such an approach through nicotine replacement therapy, so it seems completely wrong to say that that is a bad thing in relation to electronic cigarettes.

Andrew Thomson mentioned behavioural support. I entirely agree with him that someone who wants to give up smoking is most likely to succeed if they use proper pharmacological support—which in my view can include electronic cigarettes; as a clinician I recommend them for people who have not found medicinal nicotine products satisfactory—plus behavioural support. However, the fact is that each year only about 8 or 9 per cent of our smokers go into behavioural support services. The other 90 per cent struggle on their own. Electronic cigarettes make the first step towards substituting cigarettes possible for people who are not engaging with medical services.

I agree that the more people we can persuade to go through the full monty of national health service support, the better. However, if smokers are not going to engage with NHS support, I would much rather that they tried an electronic cigarette and realised that maybe there is a way out of smoking than that they did nothing at all.

Robert West has described smoking as like being in a nightclub when a fire breaks out: people just need a way out—it does not matter what it is. Electronic cigarettes could well be a way out for many smokers who would not otherwise find an exit.

Dr Thomson: John Britton has clarified my point about dual use. Perhaps there was a misunderstanding about the point that I made. I absolutely recognise that we promote dual use and that it is promoted in the NICE recommendations for nicotine replacement therapies. However, that is in conjunction with behavioural therapy, with the aim of reaching a tobacco cessation date. That is far more of a pathway to quitting any use of tobacco, whereas such a pathway is less in place for e-cigarette use.

It is a learning process, as Professor Britton said—he mentioned people managing to go four hours without tobacco then thinking that they can go a bit longer without it and perhaps move to e-cigarettes. However, as he would agree, part of that process is the behavioural support that is built in to help people to gain that learning as opposed to it happening by default.

As for me as a clinician recommending e-cigarettes, I very much believe in the phrase "First, do no harm," and I still lack confidence about the absolute safety of e-cigarettes. I need that confidence before I can recommend that my patients use e-cigarettes. Of course, if a patient comes to me and says that they are using an e-cigarette because they have found no other way to give up smoking, I will not turn round and say, "No, you should stop that and start increasing your tobacco use again." However, it is a step further for me as a GP to recommend to my patients that they should use e-cigarettes, because there is a lack of evidence and I need to be absolutely sure that e-cigarettes are not causing any harm.

Jeremy Mean: On the point about harm and how to proceed—whether to take a cautious approach or to act urgently—the evidence base is not as clear as we would like. If there was clear evidence, the situation would be easy and we would be able to take decisions rapidly. However, we do not know enough about the safety of the products or their long-term impact, and we do not know whether dual use is the same as with nicotine replacement therapy.

That is why we have taken a cautious approach to regulation. We have defined areas where we think that it is important to take action—in relation to the age of sale and advertising restrictions. The committees of advertising practice have just brought in a new regime to ensure that advertising of e-cigarettes is targeted at adult smokers and not at bringing young people into the use of the products.

We need to proceed with caution. It might be worth flagging up that the tobacco products directive, which is due to be implemented across the UK in 2016, will put in place a range of measures that will give greater reassurance about the variability in the range of products that are on the market. It will have standards for the contents of the products, for notification, for labelling, for packaging, for electrical safety and for enforcement arrangements. We hope that that regime will allow healthcare professionals to be able to recommend trying the products.

An important point is that, with the smoking population still at about 8 million people in the UK, one size does not fit all and we need a range of measures to help people out of smoking, so that we can look forward to a tobacco-free generation.

Sheila Duffy: One of the harmful forces in the debate is the tobacco industry, which has been buying up the companies and technologies involved as if they were sweeties. We have Boots retailing an Imperial Tobacco brand; Lloyds Pharmacy retailing a British American Tobacco brand; and Rangers and Celtic being sponsored by E-Lites, which was bought out by Japan Tobacco International. With 98 per cent of its profits coming from lit smoked tobacco in the foreseeable future, we have to be conscious of how this deceitful and manipulative industry operates and watch closely its long-term strategy for the products.

Katherine Devlin: We have been watching big tobacco's involvement in our sector closely and with a certain amount of trepidation. However, it is important to remember that a handful of e-cigarette brands are owned by big tobacco companies at the moment, while hundreds and hundreds of brands—approaching 500—are totally independent of the tobacco industry. This is the tobacco industry's Kodak moment. The tobacco companies have recognised the threat, but they are the few and we are the many in the sector, and I think that it is highly unlikely that the tobacco industry will have control over the sector in the future.

What we can all hope for as part of a move towards a tobacco-free generation—which we hope will go a bit further than Scotland and the UK—is that big tobacco will recognise the need to move away from selling combustible products at all and move fully into harm-reduction products and nicotine delivery in a clean way, so that it can change its business model for the future and stop doing so much harm.

10:15

The Convener: What share of the e-cigarette market—as opposed to the number of companies—does the tobacco industry have?

Katherine Devlin: I do not have data on that, but I will see whether I can find that out for you and submit information to the committee.

Sheila Duffy: There is a good page on the website tobaccotactics.org that makes clear which tobacco companies own which brands. The guy who is in charge of the Scottish arm—which was Skycig but was bought over by Lorillard, the US tobacco giant, and is being taken over by Imperial Tobacco UK—has made it clear that he intends to reduce the number of brands to about 10 in the foreseeable future and that he intends his brand, as he put it in *The Guardian,* to be the Starbucks.

Professor Britton: In a market so big—and if electronic cigarettes are effective products, as many clearly are—it is inevitable that the market will consolidate into far fewer brands. It is clear that the tobacco industry will own many—if not, ultimately, all—of them.

It is important to note that, irrespective of what we think of the tobacco industry—I am certainly not here to stand up for it—what we need to prevent is people smoking tobacco. Our target is that, and not the tobacco industry.

Dr Simpson: I am interested in the Trading Standards Institute research involving children that is mentioned in the Scottish Parliament information centre briefing. It states that between 23 and 80 per cent of retailers are selling e-cigarettes to children. The industry may say that the self-regulation rules are working, but the retailers are not following them.

It is questionable that Boots and Lloyds Pharmacy are selling the products when we do not yet know their effects. Can I take it that everybody agrees that we need an effective Europe-wide programme to be funded to research the potential for short-term harm? The product is addictive. I slightly disagree with John Britton, as I think that nicotine is substantially more addictive than caffeine, and we do not know what long-term harm it may cause. It has been suggested that there is the potential for it to cause dementia.

Do we also need research on the pathways—in other words, whether the products lead people on to smoking or take them away from it? We might also need long-term research.

Does everyone agree that we need research into those things? That is my first question.

The Convener: That is your question. Can we have some responses, please?

Katherine Devlin: Research is always good and we always want more of it, but it has to be carefully constructed, especially if it is a Europe-wide research programme, because what we have seen so far from the European institutions has not been terribly impressive, to be fair. We need to make sure that the research is shaped properly.

Professor Britton: I am primarily a researcher, so I will not disagree with anybody who says that we need more money for research. I fully agree that we need to watch patterns of use carefully. If we see disturbing trends in the way in which young people are using the products, we will need to act on that, but unless we have regular—monthly or certainly three-monthly—monitoring in place, that will be missed.

We know a great deal about the long-term effects of nicotine from the long-term effects of oral tobacco use in Scandinavia, where people have used oral tobacco for many decades. It still delivers nitrosamines to the body and is not a harmless product by any stretch of the imagination but, because of the decades of use, we know a lot about the risk potential or the pattern of risk in lifetime users as opposed to non-lifetime users, and although I cannot say that there is no risk, it is very low.

Sheila Duffy: I agree that we need research. There are a lot of long-term unknowns. We also need to be clear about the funding for the research, because there is a long, well-documented history of research funded by the tobacco industry that does not hold to the body of general science when tested.

Claire McDermott: I have a word of caution. We considered quite a lot of evidence when developing the consultation document. While more research would be great, the question is what can be achieved in a short time. Some of the research that is required into cessation and health impacts cannot deliver anything robust in the short term; it will take a number of years.

Dr Thomson: I support an increase in Europe-wide research, which would be very welcome, even with all the caveats that others have included. I also support on-going monitoring and not selling ourselves down a European research line that will take a long time to do. If we can mobilise good-quality research in the UK and Scotland faster, we should get behind that, in parallel with wishing for Europe-wide research.

We need to seize quickly on and stop any trend towards seeing e-cigarettes as a gateway product. The evidence for that is weak at the moment, but it is a potential risk that they are a gateway product or that they normalise the image of smoking.

Professor Britton: On monitoring and research in the UK, Stan Glantz—an outspoken public health specialist from California—once described the UK, with the intention of disparaging it, as allowing itself to become a natural experiment in tobacco harm reduction. He meant that to be an insult, but it is a great tribute to the fact that we have a much more open mind about electronic cigarettes than most countries have. We are therefore in a position to do research that cannot be done anywhere else, because we are far advanced down the line of realising the potential of the products. I endorse the priority for research, which is national.

Robert West runs an excellent rolling survey of smokers, which covers electronic cigarette use. It is called smoking in England and, of course, it relates only to England. Such survey work can show us patterns of use quickly and it is vital that all components of the United Kingdom do that.

The Convener: Richard Simpson may have a brief question—we did agree a timetable.

Dr Simpson: I understand from an ASH survey that 50 per cent of 15-year-olds have tried e-cigarettes. Does the Scottish schools adolescent lifestyle and substance use survey include a question about e-cigarettes? How soon will we get information on that?

Sheila Duffy: That question is probably more for Claire McDermott, but the survey includes a question on e-cigarette use. I believe that the results will come out shortly.

Claire McDermott: In the next few weeks.

Dr Simpson: That is helpful.

Nanette Milne: I am a little worried about the flavourings in these things. I remember being put off cigarettes for life by one puff when I was a child because the taste was awful. If something that has a pleasant taste is being produced, I foresee children wanting to dabble in it and find out which flavour they like best, thereby developing the habit. Does anyone have any comments about that and what we can do about it?

Sheila Duffy: E-cigarettes are perfectly set up to be a starter product for children because they are smooth, the flavourings in some of them seem to be tailor-made for children and they are high-tech and glitzy. That raises concerns and we have not solved the question whether they could be a gateway into smoked tobacco, particularly if higher-strength nicotine e-cigarettes are more restricted.

We must not forget the tobacco epidemic, which is claiming 13,000 lives in Scotland every year. The committee should not be distracted from that epidemic and e-cigarettes should not be allowed to be a distraction from tackling the availability and supply of the more harmful product.

The Convener: There you go—now we have a few hands up. E-cigarettes are a distraction.

Katherine Devlin: John Britton is far better qualified than me to discuss the relative merits of flavourings. Adult smokers who switch to using electronic cigarettes and away from tobacco flavoured e-liquids find that it is much harder to relapse to smoking.

Relapse is one of the biggest drivers of the tenaciously stubborn smoking prevalence figures that we continue to see. It is all too easy for people to relapse into smoking, whereas someone who has made the switch away from tobacco flavours to something that is fruity or sweet—or totally different, once they get their taste buds back—cannot go back to smoking. I tried to do that and it

does not work—it is revolting. Such people stay off smoking, which is the ultimate goal.

Professor Britton: I do not know what the best approach to flavours is. I have heard from some of my patients the same sort of comments as Katherine Devlin made but, at the same time, I agree with Sheila Duffy that e-cigarettes seem set up to be attractive to young kids. None of us wants primary school children to use electronic cigarettes—indeed, I would be interested to know where such a child got the cigarette from. That is why we need monitoring in place—an annual survey is not enough.

We would be treading a difficult path unless we prohibited all advertising, which is not the case at present. On the advertising that has recently been allowed, does the committees of advertising practice guidance apply in Scotland?

Jeremy Mean: Yes.

Professor Britton: So the same thing happened here last week as happened in England.

Will the advertising appeal to young people? We will find out only by monitoring carefully and frequently people's behaviour in relation to the products and their use. I do not know about the flavouring question, but the answer in general is to measure who is using the product and at what age.

The Convener: I have a couple of questions. We have in place cessation policies to help people to stop smoking. The support that supposedly goes with that help is all based on nicotine replacement. What is the difference between nicotine getting into someone's body through a patch and someone vaporising nicotine? Is there a difference?

Professor Britton: I think that I can answer that. If someone swallows nicotine, it is absorbed into the bloodstream and passes through the liver, and most of the substance is destroyed. It might give the person heartburn and make them feel a bit queasy, but it does not get into the blood at high levels. If someone inhales nicotine, however, it is absorbed across the lung surfaces directly into the bloodstream and straight to the brain, so they get a hit very quickly.

We do not have a medicinal inhalation product—yet. To avoid its breakdown in the liver, medicinal nicotine must be given through routes that involve absorption into the blood supply or blood circulation that does not track through the liver. That usually means through the skin, nose or mouth or the other end of the gastrointestinal tract. All of those areas absorb nicotine very slowly, and much more slowly than through inhalation.

The Convener: So, irrespective of the speed of absorption, it is the entry system that matters. The nicotine levels that would be reached by vaporising or by using patches are very similar.

Professor Britton: Cigarettes do two key things: they deliver nicotine to the brain extremely quickly; and they deliver very high doses—

The Convener: But if you take away the cigarette, and compare vaporising with nicotine patches—

Professor Britton: The early-generation e-cigarettes were all pretty hopeless and delivered fairly low amounts of nicotine. At best, they were on a par with the Nicorette inhalator, which is an oral device. It is supposedly an inhalation device, but it works by delivering nicotine into the mouth.

The second-generation electronic cigarettes—the vaporisers, which look not at all like cigarettes—deliver higher doses through a mixture of mouth, upper-airway and, probably, some lung absorption. I have not yet seen evidence to show that electronic cigarettes—any of them—have achieved the sort of lung absorption that a cigarette achieves. There is still a long way to go, but the products will get a lot better.

Jeremy Mean: Sheila Duffy mentioned the potential for the products to be a distraction. I would put that slightly differently. My responsibility in the Department of Health relates to tobacco control. There is a range of things that we can do to impact on smoking. Some relate to nicotine replacement therapy and some relate to other central nervous system drugs that have been, or are currently being, developed. There is also cognitive behavioural therapy, and there is the environment, which includes standardised packaging of tobacco products, advertising and availability. All those things impact on the smoking epidemic, and they are tools that help us reduce the size of the population that still smokes.

10:30

We could think of electronic cigarettes as a distraction, or we could think of them as presenting an opportunity. Different levers will work for different people. We need as many tools as possible in the toolkit to help us. That is why we have taken a cautious approach in England, recognising that the opportunity and the risks of e-cigarettes need to be managed—but still recognising that they present an opportunity, rather than something that we should not focus on.

Katherine Devlin: I will add to what Professor Britton said about the comparison between nicotine in licensed medicinal products for NRT and nicotine in electronic cigarettes. It is important for the committee to recognise that the nicotine is

of the same grade: it is pharmaceutical-grade nicotine that is used in both electronic cigarettes and NRT products. That is built into our standard, but it is already pretty much standardised across the industry anyway.

The Convener: I am going to invite MSPs who have not already spoken to ask questions. Then, if there is time, I will let other members in again.

I have a question of my own on something that we have not yet covered. What justifies the ban on the use of e-cigarettes in public places? If people have to leave a public place—a pub for example—in order to go outside and smoke an e-cigarette, why would they not just go out and have a cigarette?

Professor Britton: The legislation that we have on cigarette smoking in enclosed public places was brought in primarily to protect people who work in those environments. The evidence on electronic cigarette use in indoor public places is that it releases nicotine into the atmosphere. It may well release other substances into the atmosphere, some of which may be toxic. Therefore, it is not a completely clean, innocuous product, although the levels of those things are extremely low.

Personally, I think that it is a matter of courtesy not to use electronic cigarettes indoors—for example, in this room as we speak. However, using the law to say that people cannot use an electronic cigarette indoors engenders exactly the process that you have just described: if people are treated like smokers, they might as well be smokers.

What about controversial circumstances, such as in-patient settings in general hospitals? Some of my patients smoke electronic cigarettes under the sheets, because they are not allowed to use them openly. In mental health settings, the prevalence of smoking is incredibly high, and it has not shifted over the past 20 years. In prisons, too, the prevalence of smoking is extremely high, and it is very difficult to control, although I am sure that going smoke-free can be done, and electronic cigarettes may be part of the solution.

I would be very cautious about a legislative prohibition of electronic cigarette use in enclosed public places, although I accept that the courteous thing for all electronic cigarette users to do is not to use them indoors.

Katherine Devlin: I could not agree more with John Britton—hence, my e-cigarette is in my bag and not in use. The prison population example is a very good one. We have a working example of that at Guernsey prison, where arrangements were rolled out to make e-cigarettes available to prisoners there, alongside NRT and behavioural support. That has been very successful, and the prison has gone completely smoke free.

When it comes to mental health institutions, there is a significant body of evidence to support the fact that mental health patients—particularly schizophrenics, but all those with mental health disorders—find nicotine enormously helpful, and that is why the prevalence of smoking tends to be much higher among mental health patients. I am sure that there are doctors present who could attest to that better than I can.

When it comes to bans in public spaces, however, we need to be very careful about our obligations in relation to every citizen's human rights. If we say to someone who wants to use an electronic cigarette, "You can't use it in the building; you'll need to go outside to the smoking shelter," we are putting them in harm's way, because we are telling them to stand with the smokers, and we know about the risks of passive smoking.

I agree with John Britton that the matter should not be mandated and should be left to courtesy and public policy decisions by each business, building owner or whoever. If people decide that vaping should not be allowed in their building, they will need to offer separate spaces for smokers and vapers.

Dr Thomson: The BMA was keen for electronic cigarettes to be included in the legislation on smoke-free public places. There is currently no evidence that they are not harmful, and there is an issue to do with the normalisation of the image of someone puffing.

Albeit that it is a vapour that is produced, as more and more people use e-cigarettes, the vapour is more and more visible, and there is an issue to do with whether you can tell the difference between smoke and vapour. That is partly why companies such as JD Wetherspoon have banned e-cigarettes. It is difficult for staff to ascertain whether someone is breaching the smoke-free legislation or using an e-cigarette, and when staff challenge people they are potentially put in harm's way.

We absolutely understand Katherine Devlin's point about the potential for putting someone in harm's way by exposing them to passive smoking, but we are not suggesting that solution—people can have a space in which they can use e-cigarettes away from the risks of passive smoking. However, we very much think that having a dual standard for tobacco use and e-cigarette use potentially undermines the current legislation on smoking in enclosed public places, so we are keen for e-cigarettes to come within the scope of the legislation.

The industry purports to say that it is promoting e-cigarettes only as tools to help to decrease tobacco use, so it should not be afraid of e-cigarettes and tobacco being treated in a similar way. We talked about flavourings, but there are even e-cigarettes with Bluetooth connectivity, so that people can use them to play music and so on. Such things are clearly designed to capture a young audience and not as a tool to reduce the impact of tobacco on society.

The Convener: Most scientists say that there are risks, but the BMA came off the fence and said, "We cannot prove that e-cigarettes are bad but we cannot prove that they are good." Why did you come down on that side of the fence?

Dr Thomson: Because we always come down on the side of the "first do no harm" principle. As doctors, that is our prime directive. We cannot prove that electronic cigarettes are safe to users and to those around them, for example in environments in which there might well be a lot of people using e-cigarettes. Therefore, we do not want to sit on the side where there is potential harm; the benefit is in taking the safest option, which in our view is to include e-cigarettes in the legislation on smoking in enclosed public places.

Jeremy Mean: The converse of that argument is that the riskiest thing to do is to continue to smoke, so anything that can help to bring people away from continuing to smoke tobacco is potentially helpful.

In England there are no plans to extend the ban on smoking in public places to electronic cigarettes. The products are different. The risks that are associated with second-hand smoking are clear; there is an evidence base in that regard. There is no evidence to support treating the two products the same, in the context of the level of risk in exposure to them.

However, we support the right of companies to take action on their premises. There are a range of reasons why people might want to do that, including for ease of enforcement of the smoke-free legislation.

I have heard the argument that the risks are different in different places. We heard about prisons and mental health institutions, which are examples of places where the normalisation argument—for example, the idea that children will see products that look like cigarettes being used—does not apply. There might well be different arguments for different settings.

Gil Paterson: The one thing that has come across clearly to me is that no one, so far, has said that the products are safe. Nobody knows. For me, the idea of not putting in place a ban similar to the ban on smoking sends the signal that e-cigarettes are safe and that we know that they are okay, rather than being proactive on the matter—particularly regarding children.

As regards the question whether the practice will become commonplace, I have never smoked in my life and I have never really worried about someone else smoking, other than encouraging them not to because I know that they are damaging their health. I have a weird attitude about what people do, whether it is drinking or smoking. Signals are very important to me. If the message is, "Don't go there," I will not go there; if there is no such message, I am allowed to go there.

Jeremy Mean: I stress the point that the Department of Health in England is not recommending the use of e-cigarettes. In fact, the chief medical officer for England has expressed concern, particularly about children and young people and the idea of a potential gateway. We have taken a cautious approach because tobacco is so harmful. It kills 80,000 people a year in the UK, which is something like 200 people each and every day. It is more harmful than alcohol, obesity or lack of exercise—it is more harmful than any other public health issue; it is the single biggest killer. For that reason, we need to do all that we can to support tobacco control. If the use of e-cigarettes is potentially helpful, we need to take a cautious approach to enable it, rather than banning something without sufficient evidence.

Gil Paterson: I wish to clear something up.

The Convener: I call Claire McDermott.

Gil Paterson: Convener, before anyone—

The Convener: I am calling Claire McDermott next.

Claire McDermott: These are very much the debates that we considered in developing our consultation paper. However, I echo Jeremy Mean's point that the smoke-free legislation was brought in on the grounds of really robust evidence on the significant harm of second-hand smoke. That is why our consultation focuses on the points that Mr Paterson makes about protecting young people and non-smokers and trying to achieve a balance through reducing young people's access to e-cigarettes and reducing the appeal of e-cigarettes for young people and non-smokers. We ask questions about how the products are marketed to those groups.

Gil Paterson: I would like to make a point of clarification. I am sorry: I misrepresented what I meant to say. I was not talking about a ban of these products; I was talking about a ban on their use in public places. I do not think that it is logical to have a separation in that respect. It is not about banning the products, but they should be treated

in the same way as cigarettes when it comes to their use in public places.

The Convener: Has any cost benefit analysis been done in relation to health—for example, on reduced deaths? There is an indirect claim that tobacco causes 80,000 deaths a year and e-cigarettes will reduce the level of harm, but by what extent? What health benefits are being claimed, if any?

Professor Britton: The best or closest analogy that I can use to answer that question relates to the pattern of health harms that arise from oral tobacco use in Sweden. Sweden has the lowest lung cancer rates in Europe, alongside the lowest smoking rates. Tobacco use is the same in Sweden as it is elsewhere, however; it is just that many more tobacco users there use oral tobacco. That is partly because smokers in Sweden have switched to oral tobacco—as smokers have switched to electronic cigarettes in this country—and partly because a whole cohort of young people who were going to become smokers have instead become oral tobacco users and are growing through without the risk.

We know from that experience that whereas lifelong use of smoked tobacco takes about 10 years off life expectancy, lifelong use of oral tobacco probably takes off a couple of months or so—it is of that order of magnitude; it is a fairly trivial risk.

Richard Lyle: On that point, convener—

The Convener: No, no—I always take the panel members first.

Richard Lyle: I would like to ask one last question.

The Convener: You might get in with it later if you do not delay the committee's proceedings now.

10:45

Sheila Duffy: The health gains and savings from people stopping using lit-smoke tobacco are huge. We do not yet know, for the whole body of smokers, whether dual use of e-cigarettes with lit-smoke tobacco will perpetuate or whether people will switch to e-cigarettes completely. We just do not know that yet.

Professor Britton: I will clarify my point about oral tobacco. An electronic cigarette is an inhalation product and we do not know the long-term risks of propylene glycol, glycerine or any of the other by-products. There are theoretical risks in that regard, but to my eye those risks are of a similar order of magnitude to those that relate to the use of oral tobacco, which causes other hazards that electronic cigarettes do not.

I entirely agree with Sheila Duffy that we do not know what the long-term pattern of use will be. That is why we must monitor use carefully, repeatedly and frequently. We should be able to get those figures in days, rather than in a year or two, as happens in England with many Government surveys.

Katherine Devlin: I completely agree with Sheila Duffy and John Britton that we do not know the long-term effects yet: we cannot, because e-cigarettes have not been used for long enough. We know that the use of e-cigarettes, like the use of the oral tobacco products that John Britton described, completely removes the by-products of combustion. There is no combustion, so there is no tar or carbon monoxide: all of that sort of stuff is completely absent.

Professor West, who presented at a summit that was held last week, has said that the residual risks will be of such a tiny order in comparison with the massive risks of continued smoking that they will be almost negligible.

Rhoda Grant: Professor Britton talked about harm and the differences in Sweden. Were you comparing figures for lung cancer or all cancers? Some argue that nicotine can enhance tumour growth and the like.

Professor Britton: There is evidence that nicotine can promote tumour growth but there is no evidence that nicotine causes tumours. If you are a nicotine user and you develop cancer, it could progress quicker than it would in someone who is not a nicotine user. I have never argued that nicotine is safe; I have argued that it is not the cause of most of the harm from smoking. In terms of safety, it is probably on a par with caffeine, which causes heart arrhythmias and other problems.

I can only speak to the Swedish cancer figures. From memory, for men in the 25 to 45 group, which is a very good marker of future mortality, the figure is about half—it is certainly the lowest in Europe. For heart disease risk, things are slightly different in Sweden, but there are many more influences on heart disease than just smoking, whereas smoking accounts for nearly all the influences on lung cancer.

I do not know whether that answers your question.

Rhoda Grant: Lung cancer is obviously a by-product of smoking tobacco, but I was keen to know whether the figures for other cancers were the same.

Professor Britton: I cannot answer that except to say the other known potential risks from oral tobacco are oesophageal cancer and pancreatic cancer, the figures for both of which—this certainly

applies to pancreatic cancer—are slightly higher for oral tobacco users than never users, but less high than for smokers. The risks are all relatively low. I appreciate that that is slightly tangential to your question.

The Convener: Richard Lyle may now come back in.

Richard Lyle: Professor Britton spoke about damage to lungs. At the European Respiratory Society's annual congress in Vienna in September 2012, researchers from the University of Athens, in Greece, presented a report that said:

"Electronic cigarettes could 'damage your lungs' as they cause less oxygen to be absorbed by the blood."

Do any panel members have any comments on that report?

Professor Britton: I specialise in lung disease. The lung is a fascinating and very complex organ. It is also extremely delicate, so inhaling things that you should not inhale probably does not make sense. What matters is the relative perspective against inhaling tobacco smoke. I take with a huge pinch of salt any study—and there are such studies out there—that argues that electronic cigarette inhalation generates as much damage to certain in vitro or laboratory-based cellular measures as cigarette smoking. There is no question but that inhaling toxins into the lung causes the lung to object, but whether that will translate into lung cancer or chronic obstructive pulmonary disease—which smoking certainly leads to—we just do not know. My suspicion is that it will a little bit—but it will be trivial.

Katherine Devlin: I have a fairly intimate working knowledge of that particular set of studies and headlines, having been around at the time and having had to deal with them on behalf of my industry. The reporting was egregious, to be fair. What the study found was that there was an acute effect on the lungs and the respiratory system that is almost certainly attributable to propylene glycol, which is an irritant. That is why we enjoy it—it gives us the throat hit that makes using an e-cigarette feel like smoking. It is an acute effect, but it is very transitory. Within about 10 minutes of stopping, the effect is gone. Unfortunately, the way that the study was reported transmuted those fairly ordinary findings into *Daily Mail* headlines of magnificent proportions that suggested that e-cigarettes can damage your lungs and cause permanent damage and all sorts of nonsense. Those conclusions simply were not in the findings of the study.

Dr Simpson: I have one quick comment. I do not think that England has registration of tobacco outlets, but Scotland does. It was one of the moves that were made to control illicit sales. It seems to me that it is only a matter of time before the criminal fraternity get into this area and supply tobacco material to go into these products in some way. Do other people feel that that is likely to happen, and pretty quickly? If so, should we limit sales to registered outlets so that we can make sure that children are not sold e-cigarettes? That is clearly happening everywhere, with the figures ranging from 80 per cent at car boot sales down to 25 per cent—which is the best figure—at supermarkets, according to the Trading Standards Institute report. Should we limit sales? I do not know whether that issue is addressed in the Government's consultation, although I expect that it is.

Dr Thomson: I agree that sales should be limited to enable us to control the supply of e-cigarettes and avoid the very thing that I have experienced: a child coming into the surgery with an e-cigarette. To answer John Britton's question, the child got it by accident—they went into a newsagent and bought it thinking that it was a toy. That was how that seven-year-old child got it.

Claire McDermott: Sales restrictions are addressed in the Scottish Government's consultation, which contains a proposal to introduce age restrictions for e-cigarettes, which will help trading standards with its enforcement role.

At the moment, there is no record of who is selling e-cigarettes, so identifying who is selling e-cigarettes would also help trading standards with enforcement and with its educational role. Much of the work that trading standards does is about educating retailers to help them not make illegal sales.

Jeremy Mean: I can confirm that England does not currently have a registration scheme and there are no plans to introduce one. However, we have been working closely with our colleagues in the Trading Standards Institute and locally to ensure that age-restricted sales are controlled carefully and that these products—once they are restricted by the regulations that we will publish shortly—will be well controlled under local arrangements.

The question of illicit trade has been raised. Recognising the potential role that registration can play in controlling illicit sales, Her Majesty's Revenue and Customs recently consulted on a range of measures in England to help control illicit trade.

We have seen that illicit trade tends to fall as prevalence falls. The lower the smoking rates, the more illicit trade tends to come down. Our action on tobacco control should impact on illicit trade. That is certainly a priority for the Government in London.

Sheila Duffy: It is clear that smugglers will shift anything that makes money, whether it is tobacco,

fish or e-cigarettes, so we can expect the issue to come up. The retail register in Scotland has been tremendously helpful, in that it has allowed the enforcement community to engage with retailers, to offer them education and to counter the misinformation that they have had from the tobacco industry. I would certainly support those who sell e-cigarettes and vaping devices being part of the register. However, we need to go beyond that for tobacco. I think that we need to start looking at putting it further out of sight, out of mind and out of fashion.

The Convener: That brings an end to this session. I am sure that the debate will go on. As a committee, we look forward to following that debate and to working with the Scottish Government to address the issue.

Thank you all for your attendance this morning and for the evidence that you have provided.

10:56

Meeting suspended.

11:02

On resuming—

Mental Health (Scotland) Bill: Stage 1

The Convener: Agenda item 2 is continuation of our scrutiny of the Mental Health (Scotland) Bill at stage 1. This week, we have another round-table evidence-taking session. We normally all introduce ourselves at the beginning of such a session. My name is Duncan McNeil. I am the MSP for Greenock and Inverclyde, and the convener of the Health and Sport Committee.

Sarah Crombie (Victim Support Scotland): I am the acting director of corporate services at Victim Support Scotland.

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

Karen Kirk (Legal Services Agency): I am a solicitor advocate and partner at the Legal Services Agency, a mental health project that acts for people with mental ill health.

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

Kenneth Campbell QC (Faculty of Advocates): I am from the Faculty of Advocates.

Richard Lyle: I am an MSP for Central Scotland.

Cathy Asante (Scottish Human Rights Commission): I am a legal officer at the Scottish Human Rights Commission.

Colin Keir: I am the MSP for Edinburgh West.

Dr Jill Stavert (Edinburgh Napier University): I am director of the centre for mental health and incapacity law, rights and policy at Edinburgh Napier University. I am also a member of the Law Society of Scotland's sub-committee on mental health and disability, but I am not representing it today.

Gil Paterson: I am the MSP for Clydebank and Milngavie.

Jan Todd (Law Society of Scotland): I am a solicitor, and I am here representing the Law Society of Scotland's sub-committee on mental health and disability.

Rhoda Grant: I am an MSP for the Highlands and Islands.

The Convener: I invite Rhoda Grant to open up the discussion.

Rhoda Grant: Do the witnesses think that the victim notification scheme gets the balance right between the needs of the victim and the needs of someone who was mentally ill at the time that they committed the crime?

Sarah Crombie: Striking a fair balance between victims, witnesses and patients is a complex and complicated matter. Victim Support Scotland welcomes the provision of information to victims of mentally disordered offenders. We believe that every victim should be heard and should have a voice throughout the assessment process, and that information should be proactively provided to victims in an appropriate and timely manner, whether that is by letter, telephone call or email, and in plain English.

From victims whom we have supported through the process, we have found that there can be duplications and gaps. It would be good for the system to be streamlined under one scheme, so that victims of mentally disordered offenders receive the proactive information that is crucial if they are to understand the system.

The Convener: Would anyone else like to speak? Jill Stavert? You do not need to press the request-to-speak button. The sound will come on automatically.

Dr Stavert: Although I think that the supplying of information is a good thing, and the amendments that have been made to the bill as a result of Scottish Government consultation are welcome, we must be careful that mentally disordered offenders are not discriminated against, relative to the rest of the offender population.

Obviously, the sharing of information is a matter that impacts on people's private lives, and personal information about them should be shared only in a proportionate and legitimate way.

Rhoda Grant: What do you mean by "personal information"? Victim notification schemes tend to be about when someone will be released, so that a victim knows where they are likely to be released to and can prepare themselves for that event. What other sort of information do you envisage being shared? Is the balance right in the bill? Does the bill suggest that information should be shared that you do not think should be shared?

Dr Stavert: It is a matter of discernment in each individual case. I think that, sometimes, informing a person where the offender lives in a situation that involves a minor crime would not be a proportionate response.

Sarah Crombie: I acknowledge the concerns that have been expressed, but victims and witnesses require information that will allow them to put in place safety plans, if they choose to, and ensure that they do not bump into the offender when the offender is on temporary release in the community or whatever. That is the type of information that should be proactively supplied to victims and witnesses, who have a choice about what they do with that information.

Kenneth Campbell: On the point about discrimination that was raised by Jill Stavert, my view is that the scheme should operate in the same useful way, irrespective of the character of the offender. In other words, we should not stigmatise people who are offenders and who were mentally disordered at the time of offending. Subject to that, I think that the balance that is proposed in the bill is appropriate.

Jan Todd: I agree with what my colleague has said. The Law Society was concerned that the victim notification arrangements should be the same in relation to offenders with mental health as they are in relation to other types of offender.

We note that the bill is going to consider guidance on exceptional circumstances in which the notification would not be made. It is important to discuss what would be included in those exceptional circumstances. Further guidance on that is probably needed.

The Convener: What would be appropriate—or inappropriate—in that regard? What would you be concerned about?

Jan Todd: I suppose that personal circumstances would have to be taken into account. If giving out information was going to endanger someone, that might outweigh the need to give victims information. Guidance will have to be designed on what would or would not be exceptional circumstances.

Karen Kirk: We agree that there needs to be a proportionate response, on the basis that the tribunal will be looking at a care plan for the patient's care and treatment. If there were concerns about releasing information that might have a negative impact on the care plan and treatment, there should be an opportunity to try to stop the release of the information.

Cathy Asante: I want to pick up on the comment about the need for parity between mentally disordered offenders and non-mentally disordered offenders. We agree, and we were pleased to see that a change has been made since the draft bill was published, so that the proposal applies to offenders who are on compulsion orders with restriction orders.

However, the bill will give the Scottish ministers the power to amend the provision so that it applies to people who are not on restriction orders but are on only compulsion orders. A person on a compulsion order might have committed only a

minor offence, so we are not certain why that power is needed.

The Convener: Does anyone else have concerns about that? Gil Paterson has a question.

Gil Paterson: My question is about the rights of the patient. Managers currently have the power to move a patient from one hospital to another, or from hospital to the state hospital. Currently a patient has 12 weeks in which to lodge an appeal, but the proposal in the bill is that that period be cut to 28 days. What are the pros and cons of the measure?

Cathy Asante: We are concerned about what is quite a dramatic reduction in the timescale. A transfer to the state hospital has a significant impact on an individual's autonomy and right to a private and family life, so a restriction of the appeal period needs to be justified.

In the policy memorandum, one of the justifications is the need to bring the timeline into line with the timeline for other appeals. However, there are reasons for the longer timescale for such appeals. The longer timescale reflects the serious consequences of a move to the state hospital and the complexity of cases in which the person is very unwell.

Another justification is the need not to delay treatment for someone who is unwell during the appeal process. However, the Mental Health (Care and Treatment) (Scotland) Act 2003 has provision for a person to be transferred pending a decision on an appeal, if that is necessary, so we do not regard the delay argument as adequate justification, either.

Karen Kirk: We agree with Cathy Asante. There are provisions throughout the 2003 act that relate only to state hospital patients. I can see the rationale for bringing the appeal period into line with other appeal periods, but the state hospital is unusual, to an extent, and is treated as such in the 2003 act. There are concerns about patients who are subject to detention in the state hospital that are not relevant to other patient detention.

A transfer for treatment direction can be appealed only after the first six-month period, so sometimes the patient's right to challenge has to be exercised when the transfer takes place. A solicitor might need to do a lot of work, given the complexities of state hospital transfer, so we regard 12 weeks as an appropriate appeal period.

11:15

Nanette Milne: A number of witnesses have highlighted matters that are not in the bill, but which they think merit inclusion in primary legislation. One such matter, which also struck me, is the use of forced covert medication and restraint, about which there is little in the code of practice under the 2003 act. Representations have been made to Parliament by people who feel strongly about the use of covert medication. What are the witnesses' views on that?

Jan Todd: The Law Society has said that it would like use of covert medication and restraint to be included, if possible. We think that there is not sufficient guidance out there, so anything would be useful.

Cathy Asante: I echo that. The SHRC also raised the issue in our written evidence. There is quite a lot of confusion about use of covert medication and restraint in practice, and more guidance would be beneficial to patients, in that it would protect their rights. Guidance would also be beneficial to staff, who would know where they stand.

Dr Stavert: I echo what Jan Todd and Cathy Asante said. Edinburgh Napier University, too, raised the issue in our response to the call for written evidence.

Dr Simpson: I am interested in a comment that I read in one of the submissions, which relates to the United Nations Convention on the Rights of Persons with Disabilities. The SHRC said:

> "The recent radical interpretation of Article 12(4) CRPD by several human rights experts advocates that legal capacity cannot be denied on the basis of disability ... that decision-making be supported not substituted (and the removal, therefore, of guardianship) and the abolition of laws providing for the compulsory treatment of mental disorder."

That is clearly a pretty radical view, but it is out there. I understand that the United Nations has published a general comment on article 12, to that effect.

I should have said that I am a psychiatrist and a fellow of the Royal College of Psychiatrists. I do not know whether the witnesses have read the powerful evidence on people with learning disabilities that we heard from Steve Robertson last week. I cannot see us abolishing compulsory detention in certain circumstances, which is provided for by law. However, given the radical views that are out there, will the amendment to the 2003 act, for which the bill provides, move us in the wrong direction?

Dr Stavert: I appreciate that the view is extremely radical and I think that most jurisdictions would struggle with completely abolishing non-consensual treatment for mental disorder.

However, the general comment provides an opportunity for us to revisit what we understand by capacity and the extent of capacity, in the context of the exercise of legal capacity. The UN's general comment very much promotes supported decision making, so it provides an opportunity to look at

existing and other forms of supported decision making, in order to enable patients to be full partners in a shared decision-making process.

As it stands, the 2003 act promotes shared decision making—that is an underlying principle. However, if patients are additionally supported, they will be more equal players, so the debate presents an opportunity in that regard.

Advance directives are an important form of supported decision making, so advance statements should be promoted more. The 2003 act should be amended to place a duty on medical staff to encourage patients to make advance statements.

In addition, independent advocacy is an important aspect of supported decision making, but it is not, we note, covered in the bill. The issue should be reinforced, particularly given the provisions in section 259 of the 2003 act.

Cathy Asante: There is a wider challenge out there in terms of responding to the UN's general comment. The recent interpretation is radical and we will need to consider it carefully if we are to make broader changes to our system of compulsory detention.

In the meantime, the issues that Jill Stavert mentioned are important if we are to show that we are taking steps to advance supported decision making as much as possible. There are opportunities in the bill to make provision on advance statements and advocacy. We can also look carefully at the named person provisions in order to ensure that they do what they set out to do. Those are the three real opportunities in the bill to begin, at least, to respond to the UN's general comment.

Kenneth Campbell: I broadly agree with Cathy Asante. The structure of the bill and the existing provisions in the 2003 act to do with support for advocacy, and the general trend towards patient involvement in decision making, are not wholly incompatible with the UN's general comment, which certainly takes a radical approach.

The question is about the extent to which further primary legislation is the appropriate way forward, and whether there is a case for revisiting the code of practice, which was issued when the 2003 act was originally passed. The time might be right for revisiting some of these important issues in a systematic way, by those means.

Karen Kirk: The concern that I want to raise in regard to one of the principles of the UN declaration is about participation. The proposal to extend the short-term detention extension period from five days to 10 days is our main concern about the amendments. The concern that Dr Simpson raised is quite right. If we are looking for more participation, and more effective participation, by our patients, is it right that they would have to wait a longer time before they would be called before a mental health tribunal for a compulsory treatment order? We very much feel that that is not right and we think that it would affect their ability to participate in the process itself.

The proposal is to increase the detention extension period from five days to 10 days, which would mean, as things currently stand, 10 working days. If we add up the time of a short-term detention certificate, an emergency detention certificate and the extension of 10 working days, we could be looking at a person's being detained for more than seven weeks before appearing before a mental health tribunal. That potentially does not comply with European convention on human rights article 5, and it definitely does not promote participation of patients.

Bob Doris: My next question was going to be on the extension anyway, so maybe we can flesh the matter out a bit before we go on.

The Convener: There will be other opportunities to come in.

Bob Doris: It is perhaps worth saying that I am delighted that this Parliament is bound by the European convention on human rights, and that I hope that it will be on an on-going basis. It is no bad thing if it challenges the legislation that we scrutinise—that is why it exists.

Earlier, we heard evidence suggesting that the need in some cases—some people would debate whether there is a need—to extend detention from five to 10 working days is related to the need to prepare a variety of reports, including family reports and, if there is a named person, to get their details. It was also suggested that in some cases it may be beneficial to individuals because it might keep them from going through repeated tribunal disposals to decide what is best for them, although it would not be used as standard.

I am delighted that I am not a lawyer. I do not mean that flippantly. I am not a lawyer, but the word "proportionate" comes up in relation to the European convention on human rights. I suppose that my question is this: is there a balance to be struck in exceptional circumstances where there is a proportionate need to prepare all reports so that a tribunal can make an informed decision? Would that be compliant with the human rights of the individual? Some of the evidence seems to be quite black and white on whether extension of the time period would contravene human rights, but is it actually a grey area? Is not this about the checks and balances in the system, the policing of the system and making sure that advocacy groups

and the Mental Welfare Commission for Scotland are taking a view and checking on it?

Do witnesses have concerns about human rights as a matter of course, or is there a way of extending the detention extension period from five to 10 working days, in exceptional circumstances, that would be compliant with the human rights of vulnerable individuals, irrespective of what they have or have not done, and whose human rights need to be protected by the state?

Cathy Asante: Our issue with the proposal is that we are talking about a blanket, across-the-board extension from five to 10 days. We absolutely acknowledge that there can be exceptional circumstances and that there are lots of very good reasons for such a move, including the need to prepare for a hearing, but that is what the existing provision, under which a hearing can be postponed until such time as people are ready, is designed to achieve. That is entirely compliant with human rights and gives people the time to get ready to argue their case.

I am aware of the Mental Health Tribunal for Scotland's evidence that the number of repeated hearings has dropped and now happens in 20 to 30 per cent of cases, and we would query whether there is sufficient and proportionate justification for applying to everyone a blanket extension of the period of the short-term detention certificate. In certain circumstances, more time might be needed and a hearing might need to be postponed, but extending everyone's detention in this way is not the way to go.

Jan Todd: The Law Society agrees with Karen Kirk and Cathy Asante. Perhaps this was an issue five years ago, when the McManus report was drafted.

At this point, I should declare that I am convener of tribunals; I therefore have first-hand experience and have not found the matter to have been a big issue in recent times. Obviously the patient has a right of appeal during the 28-day period of the short-term detention period; if they wish, they can instruct a lawyer to make an appeal at that point. Indeed, many patients appeal during that period. They appeal again when they make their CTO application, but the tribunal does not always get told whether they have made a previous appeal.

I take on board the point that some patients can be so unwell at the start of the process that they might not be able to instruct a lawyer or seek an appeal, so it is important that they have an early opportunity to have their case brought to a tribunal. I have found that, if an application for a CTO is made by a mental health officer within the five-day period and the case is brought to a tribunal for a hearing, the patient and their solicitor are quite often ready to proceed. However, I do not know whether a blanket extension of five days will provide any significant benefit to a patient who has just instructed their lawyer, or who allows their lawyer to get an independent medical report. It usually takes longer than five working days to get a proper independent medical report before a full hearing can go ahead.

In the meantime, the patient's rights are protected, because they will get a full hearing. Even though the patient might not be able to make full representations based on the medical evidence that they have sought separately, the tribunal will still make it clear that it will need to be satisfied that all the tests have been met at that stage for the patient to be detained. The patient's human rights are being protected at that point, and any order that is issued will be an interim one to allow that representation to be fully explored and expanded on with the independent medical report.

The Law Society is of the opinion that there is, at the moment, no benefit in having a blanket extension to the five working days. First of all, we do not think that there is a particular need for it now. A secondary point that we have made in our written submission is that extending the period and then attempting to deduct that extension from any future detention period might give rise to more confusion and uncertainty in any potential review, if the length of the extension has to be worked out and then deducted from a certain period—say, the 56-day period for two interim CTOs or the six-month period for a full CTO.

Kenneth Campbell: It seems to me to be unlikely that a provision that made it clear that a greater period of time might be granted in exceptional circumstances would be disproportionate and not convention compliant. The committee should be reassured on that front. The whole aim of involving the tribunal in the procedure that is set out in the legislation is to ensure as far as possible that patients' convention rights are properly addressed. I do not think that truly exceptional circumstances would cause a problem in terms of the ECHR.

11:30

Karen Kirk: I agree with my fellow panel members. We very much think that the existing provisions provide the opportunity for a patient to participate and give them the time to prepare, which was what Mr Doris was asking about.

The benefits of an early tribunal are quite vast and depend on the individual circumstances of each case. For example, at a first hearing, a tribunal can direct certain matters to take place for the next hearing and can deal with named person issues and other preliminary issues such as the application's competence under the terms of the

2003 act. An early hearing can have a number of uses for a patient, not least the practical use of allowing people to focus on the issues in a patient's case. That is invaluable for a patient who is opposing a hospital-based, not a community-based order, and who is challenging at the very beginning the responsible medical officer's thoughts on the matter and why they believe hospital-based detention to be the least restrictive option under the general principles of the 2003 act. That early hearing can be effective in ensuring that such views are put across, and it very often means that, at the second hearing, a different case can be heard; for example, the patient might be better, and the focus might be on a community-based order.

We definitely feel that if there are two hearings for a case the patient is not necessarily being disadvantaged or caused upset, because they direct the proceedings and instruct their solicitor in both cases. We therefore think that the approach has benefits.

The only other point that I would raise follows on from Jan Todd's comment about whether it is practical to expect that in every case an independent medical report can be instructed and received within 10 days. For this meeting, we did some research in which we looked at quite a few cases and found that it took about 30 days from an independent doctor being instructed until the written report was received. Those doctors do the work over and above their normal patient work in their local authority areas, and we rely on them to ensure that we have an effective system for the patient. The fact is that it takes time for an effective and appropriate report to be put together, and we would not want that time to be reduced and for an expectation to be placed on doctors to produce a report in an unreasonable amount of time.

I also point out that in some areas it can be difficult to identify someone to carry out an independent specialist psychiatric report such as a report on an adolescent or an eating disorder, so I think that, from a practical point of view, it would be quite unreasonable to say that that will happen in 10 days.

Bob Doris: I am probably more confused than I was at the start, but Mr Campbell has given me some ideas. I will also look at Ms Todd's comments in the *Official Report*, as there was clearly quite a lot to take in.

I thought that towards the end of her comments Ms Kirk was almost arguing that if clients or patients need to commission an independent report, that process would not start after the 28 days. Instead, it would start at the beginning of the process. Is that not the case?

Karen Kirk: No. We might not be instructed until an application for a CTO has been lodged. We must also bear in mind that these patients are unwell, and that quite often they might not become well enough to instruct a solicitor until 24 to 48 working days before a hearing.

I should also point out that as well as having to go and see people who are detained—and who therefore cannot come to one's office—we are also dealing with people with fluctuating mental health.

Bob Doris: Those comments are helpful to us in the committee as we tease our way forward on this matter, but I thought that that might be the reason why you would need additional time and why you were almost arguing for the extension.

It might help if we tease out and seek clarification on Mr Campbell's comments. Perhaps the issue is not whether there should be an increase in the blanket extension from five to 10 days but whether its use, if it is ever used, can be justified as proportionate and reasonable on a variety of grounds and might therefore be ECHR compliant. In other words, the increase in the blanket extension from five to 10 days becomes an issue only if it is applied inappropriately. I suppose that what I am asking is whether there is a breach of the ECHR if it is applied appropriately. If there is not, do we need guidance on when it should or should not be used, or do we leave that to the good judgment of those who are seeking to extend it? I hope that that is clear. I know what I am trying to say, Mr Campbell, but I am not sure that I am articulating it very well.

Kenneth Campbell: What I understand Mr Doris to be asking is whether a provision for an automatic extension for 10 days, as opposed to the existing five days, is problematic in itself or whether we look at the reason for which an extension might be given in an existing case. Perhaps I did not make myself sufficiently clear when I was answering the question earlier. If the existing text were to be changed in such a way as to say that the period of five days could be extended in exceptional circumstances, speaking for myself I do not see an ECHR difficulty with that. There is then a second question about whether an increase in the blanket extension from five days to 10 days would give rise to a convention problem. I suppose that, in that case, we are into the issue of proportionality.

In thinking about that, the committee, and, no doubt the Scottish Government, will be mindful of the evidence that the committee has already had from the Mental Health Tribunal for Scotland about the number of cases in which this is an issue and the reasons for that. I would have thought that, in working out whether a rule is disproportionate, one would have to have that in mind.

I am not sure that I can be drawn much further on the answer to whether it would be convention compliant to have a blanket extension. I suspect that it probably would not be unduly problematic from that point of view, but I certainly do not see a convention problem with the ability to extend in exceptional circumstances from the existing five days.

Dr Simpson: I have a question on this topic, which I think is very important. I am grateful for the evidence that we have had so far. As I understand it, the reason for increasing the extension period from five days to 10 days is to reduce the number of repeat hearings. That was the issue identified in the McManus report. As Jan Todd has said, the number of repeat hearings has reduced quite significantly already. The exceptionality rule seems to be very important here. If the extension is going to save a repeat hearing and the patient, their named person, the person advocating on their behalf or their legal representative seeks an extension of five or 10 days, that does not seem to me to be of critical importance, because the individual is seeking to avoid having more than one hearing. If that was laid down as exceptionality or if the whole 10-day period was considered exceptionality, would that be okay?

Karen Kirk's evidence is that if a specialist report or an independent report is required, there is going to be a repeat hearing anyway, because the period is 30 days and there is no way that that work can be undertaken within the period that we have been talking about today. That would be a quite different set-up. Can I just check that I am clear about that and can I have comments on the first bit of what I said?

Jan Todd: My concern with any change from the blanket extension, which we were opposed to anyway, to an extension in exceptional circumstances is how circumstances would be described and who would decide when to have a hearing within 10 days as opposed to five. As Karen Kirk said, if the patient needs further time to prepare his case by getting specialist evidence, a further hearing is going to be needed anyway. Would the extra five days make a difference? Are there going to be extra, multiple hearings that will not be helpful to the patient? I am not sure that I see a great need for the change, but that is just my view.

The Law Society was consulted on the proposed five-day extension. The consensus round our table was pretty much that we did not feel that it was necessary and that, from the patient's point of view, it would be less compliant with the ECHR to have a later hearing rather than an earlier one, and I am still of that view. I prefer the current situation, both for the patient's protection and from the point of view of not having multiple hearings. I do not think that the proposed change would save a lot.

However, I would be interested to hear what others believe exceptional circumstances would be and who would decide on them. Would it be left to the tribunal service? Would the applicant for a CTO have to make a request, saying, "Here are the exceptional circumstances, and this is why we want a hearing set within 10 days instead of within five days"?

The Convener: Does anyone want to respond to that?

Kenneth Campbell: In general, I would expect that the person who said that there are exceptional circumstances would have to show why that was the case.

Jan Todd: Would that be the applicant? With a CTO, that is generally the mental health officer. What if the patient or their solicitor said that they needed longer? We need to consider the practicalities of how that would work before we find out at a first hearing that has been set up that the patient wanted it to be a few days later because his mum, who is the named person, could not attend. I can see some practical difficulties.

Kenneth Campbell: As you know, there is already plenty of experience of applications for adjournments for exactly those sorts of reasons.

I suppose that we are drilling down into the conflict between the desirability of an early resolution and the desirability of avoiding multiple hearings. It may be that it is impossible to get a complete resolution and what is being sought is the most effective way of reducing to a minimum the number of cases in which there are multiple hearings. I am not sure whether the committee has a sense from the tribunal's evidence that it has reached that point or whether it believes that further work can be done. The Faculty of Advocates does not have a view about that.

Cathy Asante: Part of the discussion that is taking place is about how the determination of whether there are exceptional circumstances is going to be made. Essentially, the current system, which allows people to seek an adjournment and have a second hearing, allows them to argue at the first stage that there are exceptional circumstances that mean that they need to put it off until a second hearing. There is provision for a tribunal to decide that within the format of a hearing, where it hears evidence and discusses some of the things that Karen Kirk brought up.

The alternative is to have an exceptional circumstances clause of the type that we are discussing, in which case there would be, essentially, a paper hearing, where the tribunal

service would look at what the person was saying their exceptional circumstances were and make a determination. It is a question of the need to assess the evidence and the preferable way of determining that. In my view, the system that we have, in which people go to a hearing and the tribunal considers whether more time is needed, is appropriate.

11:45

Karen Kirk: At the time of the McManus review, almost 50 per cent of cases were being continued at the first hearing, but that has now been reduced to 20 to 30 per cent. A lot of cases that come before the tribunal will be opposed. How low can that figure go if we are to allow people to participate effectively in the system? Patients are going to oppose these applications by their very nature. At this stage, our view is that the system works.

As Cathy Asante has said, the first hearing allows the involvement and participation of the patient, but it also allows the involvement of the Mental Health Tribunal, which is able to consider the issues and to direct orders and so on that might be needed. There is a full set of rules for the Mental Health Tribunal, in addition to what is in legislation, and it has the flexibility to get involved at an earlier stage in the process, which we think benefits the patient.

At the time of the McManus report, the figure for repeat tribunals was around 50 per cent. Given that that has been reduced, is the proposal justified? We definitely think that it has reduced on a number of fronts. For example, the Mental Health Tribunal now uses video technology for evidence and doctors who are busy are able to give evidence by telephone. There have been many such developments since the McManus report, which we think will have reduced the numbers who go on from a first hearing. However, we should make no mistake about the fact that many cases will go on from a first hearing because, by their nature, they are contentious as they involve a patient who does not agree to be in hospital or to the care plan.

The Convener: I suppose that the objective is to reduce that figure below 20 per cent, but there does not seem to be a consensus among the people on today's panel that that will happen.

Bob Doris: I should briefly clarify what I said earlier—I should always be careful about the words that I use in front of lawyers or people with legal experience. When I asked about compliance with the ECHR, Ms Todd said that the legislation was likely to be less compliant, and Mr Campbell said that it would not be unduly problematic. There was no clear answer either way, which I thought was fantastic. However, when I said "exceptional circumstances" what I had in my head was the idea that I did not want an extension to be routinely used just to enable people to work to a longer deadline, which would unduly prolong the process. Let us not get hung up on the words "exceptional circumstances", as they were my words.

Having heard the evidence, I think that every case is clearly an individual case with its own unique circumstances, and I am more drawn to the need for there to be a general power to extend to 10 days. The question is whether it is used routinely or appropriately in an individual case.

I wanted to clarify the language that I had used. I set a hare running in relation to exceptional circumstances, but I have found the exchange helpful.

Karen Kirk: Just to defend lawyers, I should say that, obviously, there would not be a challenge. If someone is going to be detained, and it has not been challenged past seven weeks, certainly it could be stateable that there could be a challenge on the compliance of the provision. If that is what happens, watch this space. We feel that the act is compliant, currently. There is a question about whether it would continue to be so if there were a change to an automatic extension of 10 days.

The Convener: I see that Jill Stavert wants to come in. Far be it from me to stop this discussion.

Dr Stavert: I want to whole-heartedly reinforce what Karen Kirk has just said. If there is the potential for the legislation to violate article 5 of the ECHR, for example, there is the potential that that will indeed happen, so it is better to ensure that the legislation is watertight in the first place, in order to minimise the ability for that to happen.

Dr Simpson: This bill is a fairly limited one. We have heard that codes of conduct might need to be reviewed. Another of the submissions that we received suggested that we should consider the legislation's compatibility with the Adults with Incapacity (Scotland) Act 2000 and the 2003 act, and that a wider review was needed.

The topic is broad and I do not want to prolong our discussion unnecessarily, but the act is limited, and some people have said that we need to consider issues such as autism and learning disability and where they lie within the act—those are two issues in relation to which capacity is an important issue. I invite people to put on record whether there are any issues that they think we should recommend that the Government addresses as part of a broader review that goes beyond this act, and whether that should happen in the near future or is something that we do not need to go for at this point.

Cathy Asante: It is important that a wider review of our whole system in relation to capacity takes place so that the relationship between the bill, the Adults with Incapacity (Scotland) Act 2000 and the Adult Support and Protection (Scotland) Act 2007 can be properly understood. We need to look at that partly from the point of view of the general comment from the UN, which we discussed earlier. We need to have a more comprehensive system that ties everything together. I believe that Colin McKay from the Mental Welfare Commission mentioned that in his evidence, and I strongly endorse his comments. There is a bigger challenge to be addressed that we need to tackle in early course.

Jan Todd: I concur with that. We made written comments about incompatibility between the 2000 act and the powers that guardians and attorneys have to consent to medical treatment under the 2003 act. That is one area. In addition, there is the recent Scottish Law Commission report on deprivation of liberty, which makes certain recommendations. That is a whole different area of potential changes to the 2000 act, but the changes in question are extremely important. Local authorities are looking at how they are treating people, how they are moving them and whether they are being detained in deprivation-of-liberty situations. I think that it would be useful to have a wholesale look at that area, too, in the future.

Kenneth Campbell: I endorse what Jan Todd said. The Law Commission report on proposals to change the law in relation to adults with incapacity is potentially extremely important. If it were thought appropriate to have a wider review, the scale of that task should not be underestimated. A lot would require to be considered as part of that.

Karen Kirk: I agree with my colleagues. Major reform of the Adults with Incapacity (Scotland) Act 2000 is needed in light of the Cheshire West case. Deprivation of liberty was not looked at in the context of the 2000 act. We press for that to be looked at in relation to article 5 of ECHR. Patients and those who, in most cases, are in the community, in nursing homes and suchlike, need to have a mechanism to challenge that. Currently, the provisions in the 2000 act do not meet that need.

Dr Stavert: I do not have much to add. I fully endorse what Jan Todd said about the mismatch between section 50 of the 2000 act and section 242 of the 2003 act, which is on substitute decision makers giving consent on behalf of the person concerned. I also agree with what has been said about the deprivation of liberty. We need to have a major overhaul of all the legislation in that respect.

The Convener: I have not had any bids from members to ask further questions. We have received extensive written evidence. We have approximately 10 minutes left, so we are at the point at which I make an offer to the panel, to avoid you going home on the bus and thinking, "I wish I had said that," or, "I wish I had given a bit more emphasis to that." Cathy Asante wants to take up the opportunity. Is there anything that you want to emphasise from your written evidence or anything that you have heard this morning that you would like to comment on before we consider all the evidence that we have received?

Cathy Asante: I want to raise a specific point about appeals against conditions of excessive security. We are pleased that the bill seeks to address that issue by bringing in regulations so that people in conditions of medium security can appeal against those conditions on the ground that they are conditions of excessive security. However, that right appears to apply only to people who are on criminal orders. We think that the provision should be construed much more broadly, because conditions of excessive security have a significant impact on a person's private and family life and their ability to determine how they live their life.

Careful thought needs to be given to who is brought into the category of those who can bring an appeal. It is our opinion that at least those on civil orders in medium-secure settings should be entitled to bring an appeal. We also think that people in low-secure settings should be able to appeal against their conditions of security.

We know that the argument is that the move from a low-secure setting is into the community, but there are different conditions and levels of security in low-secure settings. For example, there is a difference between being on a locked ward and an open ward. It is worth noting that the individual in the case that has led to the provisions was in a low-secure setting but would still not be able to bring an appeal under the current provisions in the bill.

The other point to note is that the matter has been outstanding for a while. The Supreme Court case found that there was a failure by the Government to bring forward regulations, and the bill still requires regulations to be brought forward, so we encourage the committee to ask for a timetable for when those regulations are going to be introduced, so that it happens as soon as possible.

The Convener: Thank you. Does anyone else want to comment, either on Cathy Asante's statement or on any other issue?

Sarah Crombie: My point is on victims' rights to information. Victim Support Scotland hopes that

there will be no restrictions on eligibility to receive information on the release of an offender back into the community so, when it comes to compulsion orders, that would bring us into line with the European Union directive, as victims of crime would all receive information. Also, if people are being supervised in the community, victims would not be informed under the planned victim notification scheme covering mentally disordered offenders, so there is a risk of them meeting in the community. Whether an offender is supervised or non-supervised really bears no relation to the impact that such a meeting could have on the victim, so we believe that victims should be notified on all occasions.

Karen Kirk: I have just one point to make on what Cathy Asante said. Section 264 of the 2003 act includes patients subject to civil orders such as compulsory treatment orders and short-term detention certificates. The new section 273 proposed as an amendment to the 2003 act removes those persons on civil orders, so it just includes those on compulsion orders, restriction orders and transfer-for-treatment directions. We consider that discriminatory against those patients who may be in the state hospital for treatment but under a civil order, as they would have fewer rights than they currently have under the act. We wonder whether that was the intention of the bill. I take on board what Cathy Asante has said, but we think that that change could discriminate against some patients who are on civil orders rather than criminal procedure-type orders.

Jan Todd: I endorse what Cathy Asante said about rights of appeal against excessive security in low-secure units and hospital wards. I emphasise that we do not think that extending the rights of appeal to medium-secure units would be sufficient in itself.

The Convener: If no one else wants to comment on what Jan Todd, Karen Kirk, Sarah Crombie and Cathy Asante said, we shall leave it at that. I thank all the witnesses for their attendance and for giving us their valuable time, and for their written and oral evidence.

11:58

Meeting continued in private until 12:31.

Members who would like a printed copy of the *Official Report* to be forwarded to them should give notice to SPICe.

Available in e-format only. Printed Scottish Parliament documentation is published in Edinburgh by APS Group Scotland.

All documents are available on
the Scottish Parliament website at:

www.scottish.parliament.uk

For details of documents available to
order in hard copy format, please contact:
APS Scottish Parliament Publications on 0131 629 9941.

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@scottish.parliament.uk

e-format first available
ISBN 978-1-78534-334-6

Revised e-format available
ISBN 978-1-78534-350-6

Printed in Scotland by APS Group Scotland