The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 19 May 2015

Session 4

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HEALTH AND SPORT COMMITTEE
16th Meeting 2015, 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)
*Mike MacKenzie (Highlands and Islands) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Dennis Robertson (Aberdeenshire West) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jackie Baillie (Dumbarton) (Lab)
Jamie Hepburn (Minister for Sport, Health Improvement and Mental Health)
Adam Ingram (Carrick, Cumnock and Doon Valley) (SNP)

CLERK TO THE COMMITTEE

Steve Farrell

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 19 May 2015

[The Convener opened the meeting at 09:47]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the 16th meeting in 2015 of the Health and Sport Committee. I ask everyone to switch off mobile phones, as we know that they can interfere with the sound system. As I normally do, I point out that some members and clerks will use tablet devices instead of hard copies of papers.

The first item on the agenda is a decision on taking business in private. Do members agree to take item 3 in private?

Members *indicated agreement.*

Mental Health (Scotland) Bill: Stage 2

09:48

The Convener: Agenda item 2 is stage 2 consideration of the Mental Health (Scotland) Bill. Members should have a copy of the first groupings of amendments, the first marshalled list of amendments and the bill as introduced. I assume that everyone has those.

I remind members that the minister's officials are here in a strictly supportive capacity and that they cannot speak during proceedings or be questioned by members.

There will be one debate on each group of amendments. I will call the member who lodged the first amendment in the group to speak to and move that amendment and to speak to all the other amendments in the group. I will then call the other members who have amendments in the group. Finally, the member who lodged the first amendment in the group will be asked to wind up the debate and to press or withdraw the amendment. Members who have not lodged an amendment in the group but who wish to speak should catch my attention and make the request in the usual way.

If a member wishes to withdraw their amendment after it has been moved, I must check whether any member objects to its being withdrawn. If any member objects, the committee will immediately move to the vote on the amendment. Any member who does not want to move their amendment when it is called should say, "Not moved." Any other MSP can move the amendment, of course, but I will not specifically invite other members to do so. If no one moves the amendment, I will call the next one.

Section 1—Measures until application determined

The Convener: Amendment 1, in the name of Bob Doris, is grouped with amendments 2, 3, 66, 4 and 64. I point out that if amendment 3 is agreed to, I cannot call amendment 66, as it will have been pre-empted.

Bob Doris (Glasgow) (SNP): I thank the Government for the dialogue that it had with me as I was preparing these amendments.

On amendments 1 and 2, concerns were expressed to the committee that the changes in the bill that would deduct a period of time from the end of a compulsory treatment order under sections 1, 2 and 3 could be unclear and, indeed, could be inequitable as they do not take the extension certificate into account. In its stage 1

report, the committee asked the Scottish Government to respond to the concerns that had been raised and to provide further clarification on

"how this provision would operate in conjunction with certain detention orders."

The amendments that I have lodged seek to deduct from the end of the CTO or interim CTO any period of detention between the expiry of the original short-term detention certificate and the first tribunal hearing. I hope that they meet the concerns that were expressed by committee members and which were highlighted in our stage 1 report.

Amendment 3 seeks to remove from the bill the provision to extend from five to 10 days the period of short-term detention possible under section 68(2)(a) of the Mental Health (Care and Treatment) (Scotland) Act 2003 to allow the tribunal to arrange the first hearing in relation to a CTO application, and the consequential amendments to section 39 of the 2003 act. That will mean that the existing arrangements in the 2003 act that limit the period authorised to five days are retained. Although we were all keen for the period to be increased from five to 10 days, the evidence to the committee suggests that the problem that the bill sought to solve seems to have receded in recent years. As a result, amendment 3 seeks to take us back to the status quo position.

I move amendment 1.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I welcome amendments 1, 2 and 3 in the name of Bob Doris. As you have indicated, convener, if amendment 3 is agreed to, amendment 66, in my name, will fall.

The justification for the proposed extension in the period of short-term detention from five to 10 days was that it was in the patient's interest to reduce the number of repeat hearings. There was a firm denial that the rationale behind the proposal was administrative convenience; instead, it was made clear that the focus was on protecting the patient. However, as Mr Doris has indicated, many witnesses suggested that such an extension might become the norm rather than the exception and that increasing flexibility would lower the pressure to reduce the number of repeat hearings, which, as was acknowledged, has been significantly reduced under the tribunal's current president.

That said, Karen Kirk of the Legal Services Agency suggested that a further reduction in hearings might not be an entirely appropriate ambition and expressed concern that the provision as drafted might not be compliant with article 5 of the European convention on human rights, which relates to liberty and security. That view was partly supported by the witnesses from the Scottish Human Rights Commission.

Despite the reservations that have been expressed, I and, I think, the rest of the committee supported the extension of the period from five to 10 days. In the event that amendment 3 is not agreed to, amendment 66 would ensure that such a move would occur only in specific circumstances. In essence, I propose that an extension be granted only on application by the patient or the patient's representative because they need more time, or, in cases where an application is made by health professionals, with the consent of the patient or the patient's representative. As a result, the extension to 10 days would happen only if the patient or the patient's representative had consented or if the tribunal made a clear statement of the reasons for the extension. I expect those exceptional circumstances to be spelt out more clearly, if not fully defined, in regulations or guidance.

I believe that the amendments are broadly in line with the committee's report and will allow for flexibility. I ask Mr Doris, in his summing up, and perhaps the minister, when he addresses the amendments, to clarify whether the tribunal is now happy for the extension to 10 days to be completely removed. If that is the case, my amendment will clearly not be necessary.

The Convener: I formally welcome the minister to the committee and invite him to speak to amendment 4 and other amendments in the group.

The Minister for Sport, Health Improvement and Mental Health (Jamie Hepburn): I thank Bob Doris and Dr Simpson for lodging their amendments. In the Scottish Government's response to the committee's stage 1 report, I recognised the concerns about the extension of a short-term detention certificate applying in all cases. On the other side of the argument are the views of the Mental Health Tribunal for Scotland that there could be benefits in allowing service users more time to prepare. The response committed us to an exploration of whether an amendment could be made that would mean that the extension would not apply automatically in all cases.

We explored several solutions, including giving the patient and their representatives the option to request more time as part of the interview with a mental health officer when an application for a compulsory treatment order is being considered, or the option to make such a request after the application has been made. The latter option seems to be most like what Dr Simpson has proposed.

Another solution was to have a procedural or paper hearing of the tribunal to consider whether it would be appropriate for there to be an additional five days before the hearing. However, although that might take account of some of the issues that Dr Simpson mentioned, I understand that the tribunal has expressed some reservations about pursuing that approach. On balance, it did not seem practical to ask an unwell patient, who may not yet have seen the application in full or who may not yet have appointed legal representation, to make a decision as to whether they would like to be detained for a longer period when they may be distressed by detention in the first place.

Allowing a hearing to be arranged and then postponed on request at short notice as it becomes clear that the patient is not ready is likely to be expensive and to cause last-minute issues for all involved, including panel members, responsible medical officers and mental health officers, let alone the patient and named person.

I understand that the tribunal also gave views on whether it could make a judgment as to whether more time was required. Our view, having reflected on that, is that it would not be fair to expect the tribunal to make such a judgment without significant information from the patient, but that it would also be an unfair additional request of an unwell patient.

Overall, having taken the tribunal's views into account, our concern is that amendments to that effect, including that proposed by Dr Simpson, could add a cumbersome process to the tight time period that ensures that a patient has a hearing promptly.

I thank Dr Simpson for applying some thought to seeking a resolution to the issue, but I ask members to support amendment 3 in preference to amendment 66.

On amendments 1 and 2, on reducing the overall period of detention, I agree that the result will be a fairer and more equitable system. I ask members to support those amendments.

When I appeared before the committee at stage 1, I gave a commitment to propose amendments along the lines of amendments 4 and 64. The amendments relate to the new duties brought in by the bill, whereby a mental health officer must provide a report to the tribunal in relation to a determination to extend a compulsory treatment order or compulsion order. The amendments mean that the report will be required only where there has been a change in diagnosis, where the mental health officer disagrees with the determination, or where the mental health officer has failed to comply with their duty to express a view. They remove the requirement to provide a report to the tribunal for all two-year reviews of compulsory treatment orders and compulsion orders.

I ask members to support amendments 4 and 64.

Bob Doris: I thank Dr Simpson for his comments and for elaborating further on my reasons for lodging amendment 3. The driving force behind amendment 3 was the reduction in multiple hearings over the years since the initial recommendation to allow an extension from five to 10 days. I note that amendment 66, in the name of Dr Simpson, could in theory provide an alternative solution, but I tend to agree with the minister that it could create unnecessary complexity and bureaucracy and could put additional burdens on patients.

Other policy solutions could have given the practical effect that amendments 1 and 2 achieve, but in drafting the amendments I was minded to keep things as simple, straightforward, unbureaucratic and uncomplicated as possible, so that the provisions can be used effectively in practice if they are agreed to today.

I therefore press amendment 1.

10:00

Amendment 1 agreed to.

Amendment 2 moved—[Bob Doris]—and agreed to.

Amendment 3 moved—[Bob Doris].

The Convener: I remind members that if amendment 3 is agreed to, I will not be able to call amendment 66.

Amendment 3 agreed to.

Section 1, as amended, agreed to.

Section 2—Information where order extended

Amendment 4 moved—[Jamie Hepburn]—and agreed to.

Section 2, as amended, agreed to.

After section 2

The Convener: Amendment 93, in the name of the minister, is grouped with amendments 22, 23, 96, 112 and 61 to 63.

Jamie Hepburn: The main policy driver behind this group of amendments is our wish to clarify that a patient could be detained in a specific unit of a hospital rather than a hospital at large. The amendments make it clear that detention orders that are made in a civil context and those that are made in a criminal context may set out a specific hospital unit in which the patient is to be detained.

That will support the movement of patients within as well as between hospitals. Related to that is the need to address the fact that there is currently no procedure for transferring patients who are subject to interim compulsory treatment orders. The amendments are a response to concerns that were expressed by the Mental Welfare Commission for Scotland. As it is a complex group of amendments, it will take me some time to go through them, so I hope that members will bear with me.

On the civil side is amendment 22, which will mean that references to a "hospital" in sections 36, 44 and 62 to 68 of the Mental Health (Care and Treatment) (Scotland) Act 2003 may be read as references to a "hospital unit". It will allow emergency detention orders, short-term detention orders, interim compulsory treatment orders and compulsory treatment orders to authorise detention in a specified hospital unit, and a mental health officer's proposed care plan to propose that a patient is detained in a specified hospital unit. Amendment 22 will also enable the removal of patients who are subject to emergency or short-term detention certificates to a particular hospital unit or to a different unit within the same hospital.

On the criminal side, amendment 112 proposes the introduction of a new section in part VI of the Criminal Procedure (Scotland) Act 1995, on the specification of hospital units. The provisions in part VI of the 1995 act deal with mentally disordered people in the criminal justice system in Scotland. The purpose of amendment 112 is, first, to provide that any reference to a "hospital" in that part of the 1995 act may be read as a reference to a "hospital unit", where a "hospital unit" means any part of a hospital that is treated as a separate unit. That means that any order or direction that may already be made under part VI of the 1995 act authorising the detention of a person or patient in a specified hospital may authorise their detention in a specified hospital unit. The provision relates to assessment orders and treatment orders relating to remand patients as well as the following orders relating to mentally disordered offenders: interim compulsion orders; temporary compulsion orders; compulsion orders; compulsion orders and restriction orders; hospital directions; and transfer for treatment directions.

That goes further than the effect that would have been achieved by sections 36 to 38 of the bill, which are consequentially to be removed by amendments 61 to 63. Sections 36 to 38 related only to compulsion orders made with a restriction order, hospital directions and transfer for treatment directions.

Amendment 23 seeks to amend section 136 of the 2003 act, which provides for the Scottish ministers to authorise the transfer of prisoners to hospital for treatment for mental disorder. It will allow references to a "hospital" to be read as references to a "hospital unit", and it provides a definition of "hospital unit" as meaning any part of a hospital that is treated as a separate unit.

Amendment 112 makes provision as to how proposed new section 61A of the 1995 act, which section 35 of the bill will insert, is to apply in relation to a transfer from one hospital unit to another within the same hospital.

As far as the secondary driver that I referred to is concerned, amendment 93 amends section 124 of the 2003 act to include reference to interim compulsory treatment orders, which are orders made under section 65(2) of the 2003 act that authorise the detention of a patient in hospital.

That measure will enable the transfer between hospitals of patients who are subject to interim compulsory treatment orders, as well as patients who are subject to compulsory treatment orders, providing a formal process to authorise a transfer from one hospital to another for a patient who has been detained under an interim compulsory treatment order.

Amendment 96 proposes the insertion of a new section—section 124A—into the 2003 act to make new provision on transfers between hospital units. Proposed new section 124A will apply to patients who are subject to compulsory treatment orders and interim compulsory treatment orders where the order specifies the particular hospital unit in which the patient is to be detained. New section 124A will enable the managers of the hospital in which the patient is detained to transfer the patient to another unit within the same hospital or hospital unit.

The effect of both amendments 93 and 96 will be that patients under interim compulsory treatment orders can also be transferred from one hospital unit to another where the interim compulsory treatment order has authorised detention in a specified hospital.

I move amendment 93.

Dr Simpson: I have one question for the minister. A concern has been expressed to me that we do not now have accommodation in the state hospital for female prisoners—or rather, for those who have been charged. Will the amendments in this group, or the amendments that we will consider later, on cross-border issues, allow ministers to transfer individuals south of the border?

I want to get that point straight because, at the moment, I am not sure where female individuals who are charged and who have an interim order made against them because of criminal acts will be detained. Will they be detained in a medium-

secure unit or in a unit in England? We do not have top-security units for female prisoners any longer.

Jamie Hepburn: We will probably come back to Dr Simpson with greater detail in writing on that point, but my instinct is that the court could direct them either to a medium-secure unit or to a place furth of Scotland. It could be the case that the amendments that come down the line for debate later will be relevant here.

I observe, however, that there is great merit in the amendments in this group. It seems somewhat onerous that, at present, it is not possible to move people from one part of a hospital to another. I hope that the committee will support the amendments.

Amendment 93 agreed to.

Section 3—Emergency detention in hospital

The Convener: Amendment 67, in the name of Dr Richard Simpson, is grouped with amendments 68 and 69.

Dr Simpson: These three amendments arose partly from my feeling that the bill as introduced was, to a great extent, a diminution of patient rights. It was a fairly administrative bill, or a provider bill, and many of the changes that are being proposed by the Government today roll back on some of the reductions in patient rights that concerned me.

With amendment 67, I highlight a particular place in the bill where I felt rather worried about the language, and I would like to have the Government's reply on record when I decide whether to press it. The amendment relates to section 3 of the bill which, at page 3, line 20, sets out proposed new section 38(3A) of the 2003 act:

"The managers of the hospital may, so far as they consider it appropriate, give notice of the matters notified to them under section 37 of this Act to the persons mentioned in subsection (4) below."

When managers have a "may" instruction, that simply allows them to do something. The further caveat that they can decide whether that is "appropriate" or not really worries me. Amendment 67 changes that to "must", and adds the words:

"unless it is impracticable to do so".

That allows a get-out for managers if it is not possible for them to notify people, but I think that they should notify people of things that are going on.

The other main amendment in the group, amendment 68, is simply to include advocates among those who are notified of the matters concerned. Amendment 69 is merely a consequential amendment.

I look forward to hearing the Government's response. I move amendment 67.

Jamie Hepburn: I understand Dr Simpson's rationale in lodging amendment 67, but I hope to be able to reassure him. The rationale for allowing hospital managers to share information only where they consider it appropriate is to give them discretion on sharing information with, for example, the person's nearest relative or someone who resides with them. Currently, the hospital manager is required to provide a copy of an emergency detention certificate to those people, even if contains very sensitive information that the patient may not want them to have. The provision in section 3 was not introduced to allow hospital managers to exercise discretion about whether it is practicable to inform relatives, carers or named persons. The discretion would not be available if amendment 67 were agreed to.

I hope that it will be possible to address Dr Simpson's concerns through the code of practice, which could set out in further detail the circumstances when and how the discretion should be used. Therefore, I would be very happy to have further discussions with Dr Simpson to see whether an alternative approach can be agreed. On that basis, I invite Dr Simpson not to press amendment 67.

Amendment 68 and consequential amendment 69 seem to go beyond the role of the independent advocate under the act and to be dependent on the changes in amendment 67 that I have argued against, noting that the discretion is not over the practicability of informing the nearest relative or person who resides with the patient. I request that Dr Simpson not press amendments 68 and 69.

The Convener: I call Dr Simpson to wind up and press or withdraw his amendment.

Dr Simpson: I do not need to wind up. I will move us on and not press amendment 67.

Amendment 67, by agreement, withdrawn.

Amendments 68 and 69 not moved.

Section 3 agreed to.

Sections 4 to 7 agreed to.

Section 8—Suspension of detention for certain purposes

The Convener: Amendment 5, in the name of the minister, is grouped with amendments 6 to 8, 94, 95, 9 to 13, 70, 14 to 18, 18A, 19, 19A, 20, 71, 21 and 21A.

If amendment 8 is agreed to, I cannot call amendment 94 because of pre-emption. If amendment 95 is agreed to, I cannot call

amendments 9 to 13 and 70 because of pre-emption.

Jamie Hepburn: Our overall policy aims on suspension of detention have been to realise best the suggestions that were made in the McManus report. Those recommendations included removing brief periods of suspension of detention from the cumulative total and aiding calculation of total periods by converting them to days rather than months. The report also recommended a total cumulative permissible period of suspension of 200 days, which could be extended by the tribunal in the small number of cases in which a patient has reached the limit but, because of the patient's individual mental state and care circumstances, it is not yet appropriate to apply to vary the order.

Our proposals will provide a sensible and workable framework for suspension of detention that suits the patient's individual requirements. It will also provide safeguards to ensure that it is used in the most appropriate way.

Amendments 5 to 7 will provide for more effective legislation on suspension of detention to complement the changes the bill introduces.

Amendment 5 makes changes for compulsory treatment orders in the interim. For compulsory treatment orders, it allows a single certificate to authorise either a single period of suspension of detention or a series of periods of suspension of detention. For compulsory treatment orders, any single continuous period of suspension and detention cannot exceed 200 days. The change is to express the period in days rather than months, in common with other changes in the bill relating to suspension of detention.

For compulsory treatment orders, the amendment states that the maximum duration for any certificate authorising multiple periods of suspension of detention is six months. The aim of the amendment is to produce a consistent and administratively sensible system of suspension of detention that is not burdensome to responsible medical officers and can be used in patients' best interests. The changes will also carry across to compulsion orders by virtue of section 179 of the 2003 act.

Amendment 6 allows a single certificate to specify either a single period of suspension of detention or a series of periods of suspension of detention in respect of assessment orders.

10:15

Amendment 7 relates to treatment orders, interim compulsion orders, compulsion orders and restriction orders—COROs—hospital directions, transfer for treatment directions and temporary compulsion orders. The amendment allows a single certificate to specify either a single period of suspension of detention or a series of periods of suspension of detention. Any single period cannot exceed 90 days. The change addresses an anomaly in the bill in that it expresses certain timescales in relation to suspension of detention in months rather than days. The amendment also states that the maximum period of time for any certificate authorising multiple periods of suspension of detention is three months.

The main changes to policy brought about by amendments 8 and 15 have the effect that any period of suspension authorised for up to eight hours does not count towards the total of 200 days. The bill as introduced did not count periods of up to 12 hours towards the total. We listened to concerns from stakeholders that 12 hours might not quite reflect the brief periods that the McManus report suggested should not be counted towards the cumulative total.

Broadly speaking, suspension of detention is used in two different ways. The first is for short trips out of hospital, usually escorted, during the working day. The second is for "testing out", in which the patient has an overnight stay out of hospital and eventually several nights out at a time. Testing out helps the patient and their care team to see how the patient will cope with being out of hospital when their order is revoked or varied to a community order.

By changing the time period to eight hours—roughly the standard working day—we are ensuring that the first type of suspension of detention, in which the patient is escorted, does not count towards the cumulative total but testing-out periods do. We believe that that best reflects the McManus report's recommendations on the subject.

The amendments also make provision for how periods of more than eight hours and less than 24 hours are counted towards the cumulative total, how the maximum cumulative period of 200 days is calculated and the manner of granting certificates.

Amendment 8 relates to compulsory treatment orders. Amendment 15 relates to treatment orders, interim compulsion orders, compulsion orders and restriction orders, hospital directions, transfer for treatment orders and temporary compulsion orders.

Amendments 9 and 16 make clear that, when the tribunal approves an additional 100 days of suspension of detention, it does so by an order.

Amendments 10 and 17 remove certain text from section 9 of the bill on how the additional 100 days of suspension of detention could be authorised by the tribunal. They are a consequence of other amendments.

Amendments 11 and 18 clarify requirements in the small number of cases in which a responsible medical officer applies for an extra 100 days of suspension of detention in relation to a patient's treatment. They ensure that the Mental Welfare Commission receives notification that that has occurred, in order to help with the commission's wider monitoring of the 2003 act.

Amendments 12 and 19 give patients and their named person the opportunity to make representations to the tribunal in relation to a hearing to extend the maximum total period of cumulative detention or to vary an order to a community-based order. They also ensure that the patient and named person will be informed of the result of the application. That adds to safeguards for the patient in relation to any application to extend the total period of cumulative detention.

Amendment 13 is introduced in response to concerns that an extension of 100 days to the cumulative total of suspension of detention might be granted by the tribunal when it would be more appropriate to vary the order to a community-based order. The amendment gives the tribunal the ability to reject the additional 100 days and instead vary the order to a community-based order. That should ensure that suspension of detention is not used on a long-term basis when a community-based order would be more appropriate. It should also avoid unnecessary extra hearings being held when the tribunal judges that a community-based order is more suitable.

At the same time, by retaining the additional 100 days, we have kept the flexibility for the very small number of patients the McManus report identified as needing further testing out before a community-based order would be appropriate. That disposal will be available in relation to a compulsory treatment order or a compulsion order.

Amendment 14 relates to suspension of measures other than detention for compulsory treatment orders. It changes the maximum period of suspension of measures other than detention to 90 days from three months. That change is made to be consistent with other changes made by the bill that convert time in months to time in days to facilitate calculation of those periods.

Amendment 21 provides an additional safeguard for patients. It will apply only for the small number of patients for whom an application is made to extend the maximum cumulative limit by a further 100 days. It will allow certain persons, including the patient and named person, to appeal the decision of the tribunal on whether to vary the order to a community-based order.

I will not move amendment 20; I thank the committee for its understanding. The intention behind the amendment was to provide a consistent approach in line with amendment 13 but for certain other orders and directions. However, on further reflection, I am not satisfied that it is appropriate to confer powers on the tribunal to vary those orders and directions to remove the detention requirement. The tribunal does not elsewhere in the act have powers to remove the detention element of those orders, and we do not want to introduce that power only in relation to where an application to the tribunal has been made to increase the total period of suspension of detention. Suspension of detention in relation to these orders is for rehabilitative purposes; conversion to a community-based order is a formal decision in relation to the order.

For a compulsion order and restriction order, the compulsion order would be varied only when the restriction order has been lifted. If a patient who is subject to a hospital direction or a transfer for treatment direction no longer requires to be detained in hospital, the mechanism would be for them to return to prison to serve the remainder of their sentence.

Amendments 18A, 19A and 21A make changes to those amendments as a consequence of the intention not to move amendment 20. They remove references to subsection (12B), which would have been inserted by that amendment. I am grateful to the convener for accepting those manuscript amendments.

I thank Dr Simpson for lodging amendments 94, 95, 70 and 71, which look to alter or remove the ability of the tribunal to extend the 200-day cumulative limit of suspension of detention by a further 100 days. As I have now described, we have responded to concerns that the cumulative total may be extended where a conversion to a community-based order would be more appropriate and we have brought in safeguards for the patient. Amendments 94 and 95 would remove the ability to increase the total period of suspension of detention by up to 100 days, although only in relation to compulsory treatment orders, and amendments 70 and 71 would allow an extension by only a further 30 days. I do not believe that that provides as much flexibility for the individual circumstances of the patient as the Government's suggested way forward does. I believe that our proposals provide the best balance between a flexible system that meets individual needs and protection for patients and I ask that those amendments are not pressed.

I move amendment 5.

Dr Simpson: First, I thank the minister for addressing some of the concerns that were expressed to the committee. There is a view that the community orders, which were one of the new things that came in with the 2003 act, have been successful. My only concern about what the

minister has just said is that he talked about a small number of patients, but we have no indication of what that means. Is the number in single digits? Is it 30 or 40? What number is likely to apply in relation to the community treatment orders? However, I recognise that the minister has gone some way towards reinforcing the patient's right to say that the order should not be extended, and the tribunal will be given powers to ensure that it is not.

The amendments in my name are based on the written evidence from the Mental Welfare Commission. I believe that the 200-day or nine-month period that is in the act is sufficient. A number of witnesses have said that it would be inappropriate if, after 200 days, no decision has been made about whether the patient should continue under a restrictive order—it is better than being in hospital, but it is still a restrictive order—and we should therefore leave the act as it is, with the requirement for decisions to be made within the 200-day period. We should remember that the period of time could be much longer, because there could be a series of periods that amount in total to 200 days but which have suspensions in between.

The second set of amendments in the group, which will come into play only if the first set is not passed, offers an alternative. The amendments in the second set would allow a short period of extension of 30 days beyond the original period, rather than another 100 days. A hundred days is 50 per cent of the original period, which seems excessive. I am not sure why a 100-day period was decided on instead of a shorter period that would enable those who are concerned with the patient's health to determine whether a continuation of the compulsory order was appropriate, whether some other order should be put in place or whether treatment should continue on an entirely voluntary basis. For example, if, after 200 days, the patient is seen to be not taking their medicine to a sufficient extent to prevent them from relapsing, I can understand that it might be a good idea to extend the order for a further period of time.

I welcome the fact that the minister has gone some way towards addressing my concerns. I am not sure that he has gone far enough, but I will wait to see what he says in his summing up before deciding how to proceed.

The Convener: As no other member wishes to speak at this time, I ask the minister to wind up and respond.

Jamie Hepburn: Taking on board some of what has been raised by Dr Simpson, I should say that, at this stage, it has not been possible to get exact figures on how many patients reach the current nine-month limit. However, the snapshot figures that we have received from the commission suggest that very few do—the number is likely to be in single figures.

Although I recognise that there is validity to what Dr Simpson says, the Government's approach is that there is merit in having a more flexible system, which our amendments would allow for. That is more in line with what was recommended in the McManus report. On that basis, I urge the committee to support the amendments presented by the Government.

Amendment 5 agreed to.

Amendments 6 and 7 moved—[Jamie Hepburn]—and agreed to.

Section 8, as amended, agreed to.

Section 9—Maximum suspension of detention measures

Amendment 8 moved—[Jamie Hepburn].

The Convener: I remind members that if amendment 8 is agreed to, I cannot call amendment 94. The question is, that amendment 8 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Milne, Nanette (North East Scotland) (Con)
Robertson, Dennis (Aberdeenshire West) (SNP)

Abstentions

Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

The Convener: The result of the division is: For 6, Against 0, Abstentions 3.

Amendment 8 agreed to.

Amendment 95 not moved.

Amendments 9 to 13 moved—[Jamie Hepburn]—and agreed to.

Amendment 70 moved—[Richard Simpson].

The Convener: The question is, that amendment 70 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

Against

Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)

10:30

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 70 disagreed to.

Amendments 14 to 17 moved—[Jamie Hepburn]—and agreed to.

Amendment 18 moved—[Jamie Hepburn].

Amendment 18A moved—[Jamie Hepburn]—and agreed to.

Amendment 18, as amended, agreed to.

Amendment 19 moved—[Jamie Hepburn].

Amendment 19A moved—[Jamie Hepburn]—and agreed to.

Amendment 19, as amended, agreed to.

Amendments 20 and 71 not moved.

Amendment 21 moved—[Jamie Hepburn].

Amendment 21A moved—[Jamie Hepburn]—and agreed to.

Amendment 21, as amended, agreed to.

Section 9, as amended, agreed to.

After section 9

Amendments 22, 23 and 96 moved—[Jamie Hepburn]—and agreed to.

Before section 10

The Convener: Amendment 24, in the name of the minister, is grouped with amendments 25, 72, 26, 73 to 77, 27, 78, 79, 28 to 31, 80, 32 and 33. If amendment 26 is agreed to, amendment 73 will be pre-empted.

Jamie Hepburn: The amendments in the group relate to an important issue, so I hope that the committee will understand if I take some time to talk about the Government's position on it. The Government's stated intention was set out in the draft amendments, draft regulations and draft timetable for the introduction of the right of appeal outwith the state hospital that were provided to the committee on 24 April. I hope that the committee found them helpful in clearly setting out our position and demonstrating our commitment to bringing effective regulations into force as soon as possible after royal assent.

The amendments in the group relate to sections 10 to 12 of the bill, which amend the sections of the 2003 act that relate to appeals against being detained in conditions of excessive security in the state hospital and in hospitals other than the state hospital. I will focus first on amendments 26 to 31, which relate only to hospitals other than the state hospital, as they go to the heart of the differences between the Government's approach and the alternative approach that Dr Simpson appears to propose.

It is clear from the debate on the relevant provisions when the bill that became the 2003 act was considered that the intention in introducing them was to enable patients in the state hospital—and, in the future, those in medium-secure units—to seek to move to a lower level of security. That was the Millan recommendation.

The bill will fulfil that intention, and amendment 24 and the amendments grouped with it build on that intention. What the Government considers is needed is to ensure that the scheme that was provided for in 2003 can operate effectively in the present secure estate. We do not seek to extend that scheme to persons or purposes that it was never intended to cover.

It is clear that the scheme has always been about a move from one place to another. It is not about challenging the imposition of particular security measures in the place that a patient is in. That is clear when we consider that the only available remedy under the scheme is a move to another hospital or unit and not, for example, an order for certain measures to be lifted.

If there were a wish to change the appeal in a way that meant that it could sensibly be extended to all patients, that would require a more fundamental reworking of the scheme set out in the 2003 act than has been consulted on. As far as I am aware, there is no consensus in favour of that.

In its stage 1 report, the committee asked for consideration to be given to whether an individual in a low-secure setting could appeal so that they could move from one level of security to another and still remain in low-secure accommodation and asked whether that would appropriately merit the inclusion of a right to appeal for individuals in low-secure settings.

My response is that, as I have explained, the scheme that the 2003 act provided for is not about challenging particular security measures, including that of being locked. I do not consider the scenario of being locked while in low-secure accommodation to be one where the level of security is excessive. That is what we are talking about—levels of security that go beyond the proper limit or degree.

In general, patients in low-security accommodation are initially cared for in a ward for a period. They then have gradually increasing periods outwith the ward in the wider hospital environment, either escorted or unescorted, and then community access, progressing to overnight passes. Finally, they are discharged.

The committee has already considered amendments that allow patients being treated in hospital to have access to the community for up to 200 days—possibly even up to 300 days with tribunal agreement—in every 365 days. Other applications that might be made under the 2003 act would allow such patients to seek to vary or revoke their detention orders. We should also be mindful that everyone discharging functions under the 2003 act has a legal duty to do so in a manner that appears to them to involve the minimum restriction on the patient's freedom that is necessary in the circumstances.

I am interested to hear Dr Simpson's explanation of his amendments. I say with respect that, if they are intended to lay the groundwork for regulations that do not limit the right of appeal to patients in medium-secure units, I will be unable to support them. The Government's clear position is that the right to make an application under section 268 of the 2003 act should be made available only to patients in medium-secure units. We cannot support amendments that seek to provide otherwise.

If what I described is not the intention, I nonetheless prefer my proposed approach, which seeks to build on what is in the 2003 act by providing additional powers to make regulations in relation to the test to be applied by the tribunal, as well as providing for supportive medical reports. I will discuss my amendments and, I hope, persuade the committee that my proposed approach is the better option.

Amendments 26 to 29 ensure that the core of the test that is set out in the 2003 act remains unaltered while allowing flexibility for the test to be refined through regulations that would add extra limbs to it, should experience of the tribunal's operation indicate a need for the test to be refined. Amendments 26 and 27 do that by replacing the requirement for the tribunal to be satisfied, before making an order, that detention of the patient in the qualifying hospital involves the patient being subject to a level of security that is excessive in their case with a requirement that the tribunal may make an order only if it is satisfied that the test specified in regulations under new section 271A of the 2003 act, introduced by amendment 29, is met in relation to that patient. Amendment 28 is similar, but it will require the tribunal to be satisfied that the test specified in regulations is not met in relation to the patient before an order can be recalled.

Amendment 29 introduces new section 271A of the 2003 act, which sets out the regulation-making powers relating to detention in conditions of excessive security. It allows for a definition of a qualifying hospital so that the scheme that was provided for in 2003 can operate effectively in the present secure estate by allowing those in medium-secure units to seek a move to accommodation with a lower level of security.

Proposed new section 271A provides a regulatory framework for the test that must be met if the tribunal is to make an order that a patient is being detained in conditions of excessive security. That framework includes a requirement that the tribunal is satisfied that detention of the patient in the hospital where they are being detained involves the patient being subject to a level of security that is excessive in their case.

Section 271A also allows regulations to provide for the test to include further requirements in relation to a patient. Those could include factors such as the impact on a patient's care and treatment if they were to be moved, if that was felt to be an important consideration.

The proposal allows for flexibility for the test in the light of changes in practice or the tribunal's experience of hearing appeals and the subsequent effect on patients. Anything that was included in regulations would be subject to scrutiny by the committee and Parliament.

Amendment 31 makes regulations under proposed new section 271A of the 2003 act subject to the affirmative procedure.

Amendment 30 is a minor technical amendment to reorder the words in the first line of the definition of a relevant patient so that, instead of saying "is authorised in hospital", it reads "in hospital is authorised". That has no impact on the provision's effect.

Amendments 24, 25, 32 and 33 relate to appeals under sections 10 to 12 of the bill, whether they relate to the state hospital or hospitals other than the state hospital.

On amendment 24, we know that appeals that have a medical practitioner's support are significantly more likely to succeed. Of the first 100 state hospital patients to make an application, 93 per cent of those who were successful had responsible medical officer support and, of those whose applications were unsuccessful, 91 per cent did not have responsible medical officer support. Research into the first 100 state hospital patients to appeal found that 23 per cent of appeals were rejected and a further 23 per cent were withdrawn. A number of reasons may be in

play, but it is not unreasonable to assume that, in the majority of those 46 per cent of cases, there was no supportive report from a medical practitioner.

Amendment 24 allows a medical practitioner to consider a patient's case and assess whether, in their opinion, the test that is intended to be set out in regulations is met. It will not prevent any appeals that would have succeeded without the new requirement for a supportive report by a medical practitioner. Additional criteria that a medical practitioner might be required to meet could be set out in the regulations that are introduced under amendment 29.

Amendment 25 takes out section 10(9) of the bill, which was included to allow an application to be made even if one had previously been made and then withdrawn. On further reflection, we are not persuaded of the need for that provision. We are not aware from the 10 years of operation of appeals from the state hospital that the 2003 act's provisions to allow for only one application per 12 months in respect of the same patient have been an issue. There have not been calls for change. Following discussions with the tribunal, we have also considered the possibility of applications being made and withdrawn multiple times from any of the people with the right to make an application, which could have the impact of an increase in tribunal hearings. On balance, it was felt that we should maintain the considered position as set out in the 2003 act, but we are open to considering the matter again if there is evidence of a practical issue.

Amendment 32 inserts a new subsection that provides that, in chapter 3 of part 17 of the 2003 act,

"a reference to a hospital may be read as a reference to a hospital unit"

and that, for the purposes of that chapter,

"'hospital unit' means any part of a hospital which is treated as a separate unit."

That will, for example, mean that the duty on a health board under proposed new section 268(3) of the 2003 act to identify a hospital can be fulfilled by identifying a hospital unit, whether or not that is in the hospital in which the patient is currently detained.

Amendment 33 removes section 12 of the bill, which would insert proposed new section 272A in the 2003 act, as its terms are now included in other provisions. Powers to make regulations on the definition of a qualifying hospital and the question whether a patient's detention in hospital involves the patient being subject to excessive security are instead addressed in proposed new section 271A, as introduced by amendment 29. Provision in relation to hospital units that extends to all of chapter 3 of part 17 of the 2003 act and not just provisions that relate to patients not in the state hospital is in proposed section 273(2) of the 2003 act, as introduced by amendment 32.

I move amendment 24.

Dr Simpson: I welcome the proposals in the bill and the minister's amendments. The ability to appeal against an overly restrictive level of detention being applied in a medium-secure unit is welcome.

As the minister said, one of the major principles of the Millan committee, which was incorporated into the 2003 act, was that restrictions should be at the minimum level that is compatible with the safety of the patient and of others. Hitherto, that has meant that appeals could be made against continued excessive security in the state hospital. When we passed the 2003 act, there was only one medium-secure unit—the Orchard clinic in Edinburgh—and the number who were held in the state hospital was more than twice the number who are currently held. We now have additional medium-secure units at Stobhill and the new unit at Murray royal hospital in Perth, which is in my constituency.

10:45

I very much welcome the fact that the minister published the regulations early. That allowed us to be clear that the proposal is about appeals against restriction in medium-secure units, which is to be very much welcomed.

The purpose of my amendments is to take us further. If we look back to 2003, there was the state hospital and one medium-secure unit, so the possibilities for transfer were not particularly numerous, but there are now low-secure units. There are units at the state hospital level, medium-secure units and low-secure units, but they are not discrete. Increasingly, there will be different levels of security within low-secure units.

In line with the Millan committee requirement that restriction should be at a minimum level, I believe that the time has come to consider whether people should have a right of appeal without having to appeal against the detention order. They should be able to appeal against being held in a particular low-secure unit and should be able to move to another low-secure unit, which may have a different approach. The amendments in my name deal with that.

Having had discussions with mental health professionals, I recognise that, although they are ready for the changes that the Government has proposed in respect of medium-secure units, they are not yet ready to tackle low-secure units. It would therefore be more sensible to include the

proposal in regulations, which can be put through when the service is ready to deal with the matter.

Does the minister agree in principle that we should now look at transfer between low-secure units or does he believe that the time is not right? If he believes that the time is not right and therefore does not accept the principle at this time, I take it that he would not be prepared to work with me to produce suitable amendments at stage 3. However, I hope that he will undertake that, if he agrees to a major review of the 2003 act at a future date—I hope that he will do that later when we come to other amendments—the issue will be an element of that, because we have to give patients greater rights to appeal against detention in a particular type of secure unit. That point is reinforced by the fact that the minister is making the change from an appeal against a hospital to an appeal against a unit. The issue is the differentiation between units, which will become increasingly supported. My amendments would future proof the bill.

Bob Doris: I have listened carefully to the arguments that the minister and Dr Simpson made. I also considered whether to lodge amendments.

Some of the minister's comments were quite interesting and got me thinking about whether an appeal against low security is an appeal against excessive security or against security itself. He made the point well that the various low-secure settings may be part of a continuum and may be preparation for a community disposal. I would like more information about whether there are, for example, various levels of security in medium-secure settings. I understand that the bill will allow someone to appeal against detention in a medium-secure setting but not against detention in the various types of setting within medium secure.

I am more content with the minister's proposals if we view the low-secure setting as a continuum towards a potential community disposal. We heard that it is possible to suspend a CTO for 200 days. Does the minister agree that more work needs to be done to get a greater understanding of precisely what happens in a low-secure setting to prepare those who have had their liberty withdrawn from them for a return to the community?

I am minded to support the minister's position, but the interesting points that Dr Simpson made about how we look at various security settings in low-secure and medium-secure units and the state hospital require further discussion at a later date.

Rhoda Grant (Highlands and Islands) (Lab): The Scottish Association for Mental Health has raised some concerns about amendments in the group. First, it raises a concern about amendment 29, which defines a qualifying hospital and states that a patient must be in a qualifying hospital to appeal against detention on the ground of excessive security. SAMH's concern is that the issue should be the conditions in which a patient is held rather than the hospital that they are held in. I look forward to hearing the minister's comments on that.

SAMH has also flagged up concerns about amendments 24 and 25. On amendment 24, which requires an appeal to be accompanied by a medical practitioner's report, I believe that I heard the minister correctly when he said that 91 per cent of appeals were rejected if they were not accompanied by a medical practitioner's report. What would happen to the 9 per cent that go through without such support if amendment 24 were agreed to?

On amendment 25, which relates to the withdrawal of appeals, I acknowledge the minister's comment that he would consider the matter again if any evidence emerged of such a move creating any barriers, but 12 months seems a long time between an individual withdrawing an appeal and their being able to lodge another if, say, their circumstances changed. I would therefore welcome hearing his comments about that.

Jamie Hepburn: A number of issues have been raised, and I will try to pick everything up as well as I can.

Mr Doris is correct to say that we are talking about appeals against the level of security and not the specific circumstances of medium-secure settings in the estate. As for Rhoda Grant's point about SAMH's concern over our reference to "qualifying hospital" and the comment that the issue is the conditions in which the patient is held, I suggest that that is a bit of a moot point, given that the conditions in which the individual is held are defined as medium secure. However, I am always happy to consider concerns that have been expressed.

As for the other concerns that Rhoda Grant raised, she is right that I mentioned that 91 per cent of unsuccessful applications did not come with the support of a responsible medical officer, but I point out that I was referring to a sample of the first 100 state hospital patients to make an application. She asked what would happen to the 9 per cent of applications that were successful, and I pointed out that they would still be successful; the difference is that, under these provisions, they would have to get the report in the first instance. Those individuals did not need to get the report before, but I expect that, under these provisions, that 9 per cent will get a report in support of their applications and will still be successful.

Dr Simpson set out a different approach in his amendments. I entirely understand his perspective, but I note his point that professionals in the field do not feel that they are ready at this stage for what he proposes. I agree that we should always seek to reinforce patients' rights—that is why we have lodged the amendments—but I am not convinced that we should go forward in his preferred way. He asked whether we can discuss the matter; I am always happy to have such dialogue and I commit myself to having the discussion that he seeks, but I suspect that, if we were to consider the move that he proposes, it would be a longer-term thing rather than something that would be achieved through the bill.

Amendment 24 agreed to.

Section 10—Process for enforcement of orders

Amendment 25 moved—[Jamie Hepburn]—and agreed to.

Section 10, as amended, agreed to.

Section 11—Orders relating to non-state hospitals

Amendment 72 not moved.

Amendment 26 moved—[Jamie Hepburn].

The Convener: I remind members that, if amendment 26 is agreed to, I cannot call amendment 73. The question is, that amendment 26 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)

Abstentions

Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

The Convener: The result of the division is: For 5, Against 0, Abstentions 4.

Amendment 26 agreed to.

Amendments 74 to 77 not moved.

Amendment 27 moved—[Jamie Hepburn]—and agreed to.

Amendments 78 and 79 not moved.

Amendments 28 to 31 moved—[Jamie Hepburn]—and agreed to.

Amendment 80 not moved.

Section 11, as amended, agreed to.

After section 11

Amendment 32 moved—[Jamie Hepburn]—and agreed to.

Section 12—Qualifying non-state hospitals and units

Amendment 33 moved—[Jamie Hepburn]—and agreed to.

Section 12, as amended, agreed to.

Section 13 agreed to.

The Convener: I propose at this point, with the committee's agreement, to have a 10-minute comfort break. We will resume at 10 past 11 for approximately another hour.

10:59

Meeting suspended.

11:09

On resuming—

The Convener: We welcome Adam Ingram to the meeting. He has amendments coming up in a wee while—we hope.

Section 14—Detention pending medical examination

The Convener: Amendment 34, in the name of the minister, is grouped with amendments 97, 98, 35 and 81.

Jamie Hepburn: The Scottish Government's key reason for amending the existing provisions is to make the maximum period of detention and the purposes of that detention clearer for everyone involved, particularly in respect of detention being for the purposes of medical examination.

I am very clear that the provisions that will be introduced by the bill will not extend the period of detention. The maximum period of detention under the provisions will remain as it is now, at three hours. The only difference is that the maximum period of detention under the 2003 act is currently two hours, extendable to three, and under the bill, the maximum period will be three hours from the outset. I consider that that added clarity will be beneficial to service users and will not result in patients being detained for any longer than is the case under the current legislation.

It is important to note that the three hours is an upper limit, not a fixed period. The provision will be accompanied by clear updated guidance in the code of practice, which will confirm that the provision should be used in line with the principle

of least restriction. A working group that includes a range of stakeholders has been set up to advise the Government on updates to the code.

Aside from the issue of the maximum period of detention, I am aware that a number of stakeholders have concerns that the proposals could result in restriction of service users' liberty. Amendment 35 responds to those concerns by seeking to remove the provision that would have allowed the nurse's holding power to be used for the purpose of detaining the patient to ensure that he or she did not leave the hospital before the granting of an EDC or STDC. On reflection, I do not believe that that would be in line with the principle of least restriction. Amendment 34 will simply remove from section 14 text that is no longer required because of the changes that will be made by amendment 35.

I turn to amendments 97 and 98, in the name of Nanette Milne. Amendment 98 is intended to remove any suggestion that patients must actively leave the hospital before nurses can exercise the holding power. I am not convinced that that addresses a significant practical problem. The Mental Welfare Commission's guidance covers the fine line between encouraging a patient to stay in hospital, which does not require use of the nurse's power to detain under section 299 of the 2003 act, and telling the patient that they cannot leave and will be restrained the moment that they try to do so, which could amount to de facto detention and should normally trigger use of the power.

Amendment 97 is a structural amendment that would be necessary to allow amendment 98 to work.

I ask Nanette Milne not to move her two amendments.

Amendment 81 would remove the entirety of section 14. I believe that it is right to remove the provision which would have allowed the nurse's holding power to be used for the purpose of detaining the patient to ensure that they did not leave the hospital before the granting of an emergency detention certificate or short-term detention certificate, as covered by amendments 34 and 35. However, I believe that the nurse's holding power will benefit from it being made more clear in terms that its purpose is for arranging a medical examination, and from it being made clear to the patient from the outset that the power can last for up three hours.

I therefore ask Dr Simpson not to move amendment 81.

I move amendment 34.

Nanette Milne (North East Scotland) (Con): I appreciate the minister's comments. What he has said probably makes my amendments more or less redundant. The reason for lodging them, however, was basically that section 299(3)(b) of the 2003 act says that the nurse's power to detain is required only where

"it is necessary for the protection of ... the health, safety or welfare of the patient; or ... the safety of any other person, that the patient be immediately restrained from leaving the hospital".

My amendments sought to address the words "leaving the hospital". The Law Society of Scotland highlighted the fact that those words have caused confusion, which has left the question whether detention under section 299 of the 2003 act is lawful when a patient has not made an overt attempt to leave the hospital. I will leave it at that.

Dr Simpson: I welcome amendments 34 and 35 because they will clarify aspects of the nurse's power to detain. My amendment 81 was formulated before those Government amendments were lodged, however, so I might have approached it slightly differently.

Amendment 81, to delete the whole of section 14, which would return the situation to the status quo ante, was lodged because both SAMH and the Royal College of Nursing representative who spoke at the Health and Sport Committee, who is the chair of the mental health nursing forum Scotland, were of the view that the proposed amendment to the 2003 act that is contained in section 14 of the bill—to make a change from two hours with an extension to three hours, to three hours—is unnecessary.

11:15

Section 14 appears to be a tidying-up amendment to the 2003 act. The minister said that the period will be a maximum, but knowing as I do the way things go, I think that people are likely to drift towards the maximum just because it is there. The ability to extend from two hours to three was a deliberate inclusion in the 2003 act. If the minister and the Government had produced a justification for the proposal based on statistical analysis or data collection, I would have been happier to support it, but as Mr Barron said—I quote from our report—

"We do not even know where the proposal came from; it certainly did not come from nursing".

That seems to me to be a real problem. I remain confused about where the proposal came from.

Furthermore, without considerable enhancement of both the numbers and availability of mental health officers, it appears that it is unlikely that the proposal—if this is what it is about—will lead to greater involvement of MHOs. We know that they are already under pressure, and I do not think that the proposed change is going to increase their involvement.

Psychiatry is also facing significant challenges, particularly in view of the fact that—as the latest report from the Royal College of Psychiatrists indicates—42 per cent of psychiatrists in training are emigrating after completing their foundation exams. A failure in workforce planning should not be a basis for changing a provision and extending it to allow that fewer psychiatrists need attend medical examinations. Overall, what is proposed would be an unnecessary diminution of patients' rights, so it should be deleted. However, had I seen amendments 34 and 35 before I lodged my amendment 81, I would have proposed simply to return the situation to the status quo ante with the enhanced power that people could be detained only for the purposes of a medical examination. I will probably look at that at stage 3.

Jamie Hepburn: I thank Nanette Milne for her comments. I am glad that what we propose takes care of her concerns: I think that that is what she said.

Turning to Dr Simpson's amendment 81, I note that we could have run around and sought to bring statistical justification for the position that we are taking. I should not call it a change, because I do not perceive it to be that. I believe that what is in the bill is far clearer for patients than the current position. They will know at the outset that the maximum time for which they can be held is three hours, whereas at present it is two hours extendable to three. I do not consider that to be a great diminution of patients' rights—especially when we consider the other safeguards that we are putting in place. It will enhance patients' rights because it offers greater clarity for the patient.

I hear that the RCN has another position; indeed, it has made a submission to the Scottish Government in which it sets out its position. It has not sought to meet me directly, although I will be meeting it later today in relation to another matter, so the subject might be something that we will discuss. However, I am comfortable with the provision that we have included in the bill.

I urge members to support the Government amendments and to reject Richard Simpson's amendment and the amendments in the name of Dr Milne, if she chooses to move them.

Amendment 34 agreed to.

Amendments 97 and 98 not moved.

Amendment 35 moved—[Jamie Hepburn]—and agreed to.

Amendment 81 moved—[Richard Simpson].

The Convener: The question is, that amendment 81 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

Against

Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 81 disagreed to.

Section 14, as amended, agreed to.

Section 15—Appeal on hospital transfer

The Convener: Amendment 36, in the name of the minister, is in a group on its own.

Jamie Hepburn: Amendment 36 will remove section 15, which would have shortened the period of appeal against transfer to the state hospital from 12 weeks to 28 days. The amendment means that patients will continue to have 12 weeks to appeal against their transfer under section 220 of the 2003 act.

The provision was intended to ensure that potential treatment was not delayed. However, we have listened to stakeholders' views, including those of the committee, about the potential difficulties for patients in having to appeal in the proposed 28-day timescale. I accept that the concerns outweigh the potential benefits.

I move amendment 36.

Amendment 36 agreed to.

Section 16—Periodical referral of cases

The Convener: Amendment 37, in the name of the minister, is grouped with amendments 38 and 99.

Jamie Hepburn: Amendment 37 will amend section 16 to make it clear that, on compulsory treatment orders, the periodical referral by the tribunal is to take place where no application has been "determined by" it, rather than "made to" it, in the preceding two years. That will avoid the situation where a review is not triggered because an application has been made to the tribunal and then withdrawn by the patient. The amendment will ensure consistency with the changes that are made under section 16, for compulsion orders and restriction orders to be reviewed every two years.

Amendment 38 is consequential to amendment 37 and will ensure that paragraph 13A of schedule 2 to the 2003 act is repealed in its entirety because it will no longer be necessary. Section 16

is intended to solve a genuine problem that has led to reviews under section 189 of that act being delayed. The need for a section 189 reference is calculated by whether reference was made in the two years prior to the relevant day, which is the anniversary of the order, as I have described in relation to amendment 37.

Section 16 of the bill relates particularly to when a review is not triggered because an application that is made to the tribunal is then withdrawn by the patient. That can lead to substantial delays to the two-year review. Therefore, I invite Dr Simpson not to move amendment 99, given the benefits that will result from section 16.

I move amendment 37.

Dr Simpson: The issue in amendment 99 was raised with me by the Law Society of Scotland, which considers that any reference should be dealt with efficiently and effectively by the tribunal, thus avoiding any unnecessary delay in determining the reference. Patients should not be disadvantaged by delays in the tribunal process. They also should have a right to have their orders reviewed by reference every two years from the date on which the reference is made, in order to maintain consistency and to avoid confusion. To ensure that patients are not disadvantaged, reviews of all orders should be timetabled every two years in the same way.

If I am hearing the minister correctly, his amendments will deal with the issue. Subject to that, I will be content.

The Convener: I ask the minister to wind up and press or withdraw.

Jamie Hepburn: I have nothing to add, convener.

Amendment 37 agreed to.

Amendment 38 moved—[Jamie Hepburn]—and agreed to.

Amendment 99 not moved.

Section 16, as amended, agreed to.

Section 17—Recording where late disposal

The Convener: Amendment 100, in the name of Dr Richard Simpson, is in a group on its own.

Dr Simpson: Amendment 100, which, again, has arisen from discussions with the Law Society, seeks to delete section 17. As the section seems to depend on the Scottish Government introducing statutory timescales that do not appear in the bill, it does not make sense, as things stand. Accordingly, the Law Society believes that it should be deleted.

I move amendment 100.

Jamie Hepburn: On amendment 100, Dr Simpson argues that the bill contains no statutory timescales, but that is not quite right. The 2003 act contains, in section 69, at least one timescale for the tribunal, which relates to the extension of short-term detention pending determination of application. It is also possible for timescales to be set by tribunal rules, and the provisions leave open the question of where the timescales come from. However, although I argue that section 17 still has a purpose, I am, having reflected on changes to the bill since it was originally consulted on, content to accept amendment 100, so I urge members to vote for it.

Amendment 100 agreed to.

After section 17

The Convener: Amendment 101, in the name of Adam Ingram, is grouped with amendment 102.

Adam Ingram (Carrick, Cumnock and Doon Valley) (SNP): Although there are few people who would challenge the powers to keep mentally ill patients in a place of safety or place of care, I believe that psychiatric drugs should not be the sole means of treating mental illness. However, that seems to be the prevailing situation in Scotland.

Many contend that, too often, physical health conditions that might underlie mental illness go untreated in mental hospitals. For example, 25 per cent of long-stay patients have no record of health checks. Similarly, people with behavioural issues such as those on the autism spectrum can be doubly disadvantaged, as treating people with autism spectrum disorders with psychiatric drugs has serious consequences that have been outlined and detailed by Autism Rights in its written evidence to the committee.

None of the current practice takes account of individual tolerance of such drugs, and little is known of the effects of polypharmacy. Let me give the committee one example: it is not current practice to record the prescription of drugs for epilepsy in mental health institutions. Many people with autism also have epilepsy, and it is not well known that seizure activity, even at sub-clinical level, can induce hallucinations, with the obvious dangers of misdiagnosis. As psychiatrists are not considered to be knowledgeable about autism, access to other professional expertise is essential, particularly for people who are on the autism spectrum.

Far greater care should be taken with psychotropic drugs, and amendment 101, in my name, seeks to promote that. Given that some people cannot tolerate such drugs at all or can tolerate them only in tiny doses over a short period of time, there must be a real choice of treatment

options for them. I note that the National Institute for Health and Care Excellence guidance on ASD states that psychotropic drugs should be used only for six weeks and discontinued if there is no significant improvement. That is a major change from current psychiatric practice, and it needs to be applied and respected.

Amendments 101 and 102 are designed to address what appears to be the default position of psychotropic drug use in the treatment of mental illness in favour of a more holistic approach.

I move amendment 101.

11:30

Dr Simpson: I support Adam Ingram's amendments on a very important matter. I would take issue with some of the things that he said about my psychiatric colleagues, and I remind members of my declaration of interests as a fellow of the Royal College of Psychiatrists. Nevertheless, the issues that Adam Ingram raises are important.

One of my major concerns at the moment is about the treatment with psychotropic drugs of people with dementia in acute hospitals. That is unacceptable, but it is not being ordered by psychiatrists; it is being ordered by those serving in acute hospitals, often without the use of liaison psychiatry. It is a matter of grave concern to me that that is happening.

In addition, there is the question of the use of psychotropic drugs in care homes, which the committee has looked at previously. Again, although the Care Inspectorate has looked at the matter, I do not believe that it has been examined as effectively as it might have been, despite the excellent reports by the Mental Welfare Commission for Scotland on such issues.

The general purpose of Mr Ingram's amendments is extremely welcome and they are worthy of consideration.

Nanette Milne: I, too, speak in favour of Adam Ingram's amendments. This is an opportunity to address something that has been a running sore for quite a long time. A lot of concerns have been expressed about the use of psychotropic drugs, both in acute hospitals and, as Richard Simpson said, in care homes, so I would happily support the amendments.

Jamie Hepburn: I recognise that Adam Ingram lodged amendments 101 and 102 to highlight strongly held concerns that have been raised by some individuals and organisations, and I am willing to meet Mr Ingram, Dr Simpson and other members to discuss specific concerns in greater detail. Let me say at the outset that the bill is very focused, and that the issue that Mr Ingram seeks to address goes slightly wider than the proposed legislation that we have before us.

The 2003 act is designed to improve the safeguards for patients. All medical practitioners who are giving treatment for a mental disorder must have regard to the principles that are set out in section 1 of the 2003 act, and to any advance statement that a patient makes. In particular, the code of practice already highlights the responsibilities that medical practitioners have, including that the views of the patient should be taken into account and that the patient should be given information and assisted to understand the treatment and its aims and effect. My view is that the 2003 act already makes adequate provision that treatment, including the use of psychoactive substances, has appropriate safeguards in place including that patients have the information that they need to understand the treatment and to make their views known.

It might be helpful if I highlight provisions from the Patient Rights (Scotland) Act 2011, which states:

"Health care is to—

(a) be patient focused: that is to say, anything done in relation to the patient must take into account the patient's needs,

(b) have regard to the importance of providing the optimum benefit to the patient's health and wellbeing,

(c) allow and encourage the patient to participate as fully as possible in decisions relating to the patient's health and wellbeing,

(d) have regard to the importance of providing such information and support as is necessary to enable the patient to participate in accordance with paragraph (c) and in relation to any related processes, taking all reasonable steps to ensure that the patient is supplied with information and support in a form that is appropriate to the patient's needs."

I reiterate my willingness to meet Mr Ingram and others, if they request such a meeting, to discuss the issues, but I urge him not to press his amendments. If he does, I urge members to vote against them.

Adam Ingram: I would be more than happy to engage with the minister on the issue. Indeed, it would be helpful if Dr Simpson were to accompany me, as I have no doubt that he would keep me right about his psychiatric colleagues.

As both Dr Simpson and Nanette Milne have said, the use of psychotropic drugs has been a long-running issue, and it needs to be addressed. I hear what the minister says about the scope of the bill, but perhaps we could have a discussion with a view to revisiting the matter at stage 3. I would be grateful for that opportunity. On that basis, I seek leave to withdraw amendment 101.

Amendment 101, by agreement, withdrawn.

Amendment 102 not moved.

Section 18—Opt-out from having named person

The Convener: Amendment 103, in the name of Nanette Milne, is grouped with amendments 39 to 43, 105 and 108.

Nanette Milne: Amendment 103 relates to a patient's ability to opt out of having a named person. It might seem odd that we are discussing opt-out provisions, as paragraph 90 of the policy memorandum states that

"an individual should only have a named person if they chose to have one".

However, the bill retains the default provisions that are in section 251 of the 2003 act.

The bill requires any opt-out from having a named person to be in writing but an opt-out should be able to be made by any means available. The Law Society states that amendment 103 would allow people to opt out, for example, by making an oral statement before the tribunal or by communicating that intention to an independent advocate.

I realise, of course, that had I lodged my amendment later, I would have seen that it was not relevant because the other amendments in the group remove my concerns by making it quite clear that a person does not have to have a named person unless they specifically say that they want one.

I move amendment 103.

Jamie Hepburn: The stage 1 debate highlighted the importance of ensuring that individuals have a named person only if they choose to have one. I noted that I was likely to lodge amendments to achieve that. The Government's response to the committee's stage 1 report recognised the need to provide protections for service users without capacity who have not been able to appoint a named person.

Amendment 39 works with amendment 40 to remove the default named person role. Specifically, amendment 39 removes section 18, which currently allows someone to opt out from having a named person but retains the default for those without capacity to make the decision. Amendment 40 removes the existing provisions for the default named person under the 2003 act.

The Government listened carefully to stakeholders' concerns about the default named person. We have taken their view that it can cause considerable distress to patients and to their carers and relatives.

Amendment 40 and its related consequential amendments will mean that a service user will have a named person only if they want one. Amendment 41 is consequential to amendment 40; it removes a reference to section 251 of the 2003 act from section 19 of the bill. Section 251 of the act is repealed by amendment 40.

Amendment 42 relates to the provisions in section 20 of the bill, which repeals the section of the 2003 act that gives powers to the tribunal to appoint a named person when the patient does not have one. That is a consequential amendment to remove the right to appeal that decision, an omission that was picked up during scrutiny of the bill.

As already noted, amendment 40 removes the default named person provisions. As colleagues will be aware, the Government did not remove the default named person role when we introduced the bill because we had some concerns about protections for the most vulnerable service users. It would not be right to remove the default named person role without bringing in some form of right of appeal for those without capacity to either nominate a named person or initiate an application or appeal to the tribunal. Without an alternative appeal right, the patient would, in effect, not be able to appeal when they have no named person. In the case of a short-term detention certificate, they could be detained for 28 days with no automatic review or right of appeal, which might be of concern in relation to their rights under the European convention on human rights.

We have therefore introduced a limited right to initiate certain appeals and applications for the patient's guardian, welfare attorney, primary carer or nearest relative. In the absence of a named person, they are the best-placed people to act. They are referred to in the amendments as "listed persons". It is important to emphasise that they can act only when the patient does not have the capacity to do so. The amendments will also allow a patient's guardian or welfare attorney to receive certain information or notifications that would otherwise have been given to a named person. In coming to that view, the Government has balanced a range of factors, including the need to protect vulnerable service users while also respecting patient autonomy and privacy. We believe that that solution best meets all those important considerations.

Certain provisions in amendment 43 are designed to address our policy of respecting patient autonomy and privacy. They include new section 257A(7) of the 2003 act, which will allow the patient to make a written declaration that they do not want their primary carer or nearest relative to be able to make applications and appeals on the patient's behalf when the patient does not have capacity to do so. A patient may, for example, make such a declaration if they had

made a decision that they did not want a named person.

New section 257A(6) of the 2003 act will protect privacy by ensuring that a guardian or welfare attorney will not automatically receive certain potentially sensitive information in the same way that a named person would at the sections referred to in subsection (6). For example, if a responsible medical officer determines that a compulsory treatment order is to be extended, the guardian or welfare attorney will receive notification of the determination, but not the full record setting out the reasons for the determination and any views expressed by the mental health officer.

It is important that I also put on record an additional provision, which is not covered by the bill. Our intention is that the listed person will only be able to initiate the application or appeal; a curator ad litem will take over at the hearing. With the agreement of the tribunal, we will also seek to amend tribunal rules so that the listed person will not automatically receive copies of papers, orders, records or certificates, as they could contain sensitive information.

We are continuing to work on the best solution to the issue, and I will be working closely with the tribunal and the commission. I am happy to take the views of committee members and stakeholders on the best way to do so, as this is a vital aspect of the bill that I am determined to get right.

In that regard, I refer back to what Dr Simpson said earlier about cross-border transfers. I am happy to look at anything that Dr Simpson would like the Government to consider in relation to that.

If, for any reason, we do not feel we can achieve a solution through the tribunal rules, I will look to lodge amendments at stage 3. I fully understand the concerns about sensitive information being received by carers and relatives who do not want to receive it and about breaching the service user's privacy. Our policy intention is that that will not happen.

Amendment 103 relates to how a person who does not wish to have a named person makes such a declaration. In particular, it seeks to remove the requirement that that be done in writing. If the Government amendments to remove the default named person are accepted, amendment 103 will be redundant, as Nanette Milne has noted, so I ask her not to press it.

Amendment 105 would give the Mental Health Tribunal powers to appoint a person to provide independent advocacy services when the service user has no named person. It would also give ministers powers to make regulations to prescribe the functions of the independent advocate, as long as those powers did not give them access to medical records. The role of an advocate is different from that of a named person, and it should remain so. Amendment 105 would blur the lines around the role of an advocate, which is to express the wishes of the person they advocate for and not to make decisions for them.

Although I accept that its intent is positive, I do not support amendment 105. It seems to envisage that the Mental Health Tribunal might appoint a person to provide advocacy services to a patient. However, advocacy services have to be accepted voluntarily. Also, independent advocates are not a replacement for a named person, who has the right to initiate proceedings and take part in proceedings independently of the patient. On that basis, I ask Rhoda Grant not to move amendment 105.

The intention of amendment 108 is to put a right of appeal for named persons against cross-border transfers into the 2003 act. I cannot accept the drafting of the amendment, as it refers to section 290(1)(f) of the 2003 act, which does not exist. However, I agree with the policy intention, and I am happy to say on the record that I will ensure that a right of appeal for named persons against cross-border transfers will be covered by regulations on cross-border transfers. I have already made that commitment to Dr Simpson. I hope that that reassures Nanette Milne, and I ask her not to move amendment 108.

Rhoda Grant: I have listened carefully to what the minister said and I welcome the removal of the default named person in the bill. However, I do not think that we are there yet. Amendment 105 seeks to provide additional support for people who may not have capacity and are having to undertake compulsory treatment.

I have listened to what the minister and others have said and will not move amendment 105. However, there are issues with amendment 43, which also seeks to provide additional support to people who do not have a named person. I have concerns about that because it still puts a carer or a relative in that position and does not give them the opportunity to refuse to take action on behalf of a patient. It might also give the next of kin stronger rights than the carer.

11:45

Jamie Hepburn: Will Rhoda Grant give way?

The Convener: That might be helpful to the discussion.

Jamie Hepburn: I want to clarify something. Rhoda Grant expresses concerns about amendment 43 putting requirements on carers and those with the power of attorney. It should be clear

that no such requirement will be placed on them. The amendment gives them the right to initiate proceedings; they do not have to do so.

Rhoda Grant: That is really helpful, but the minister will be aware that SAMH has concerns about amendment 43. With the ranking between the primary carer and next of kin, people are concerned that patients might have issues with the next of kin who are being given rights over them. We should have further discussions about that. We certainly welcome the minister's earlier discussions of the matter but we should ensure that we get it right because it is a crucial part of the bill. Although I welcome the steps that have been taken, we have a bit further to go before we satisfy everyone.

Dr Simpson: I welcome the Government's amendments, which help, but they do not remove the matter that Nanette Milne raised in relation to leaving out the words "in writing" and inserting

"by any means or in any way".

I understand that the Government suggests that amendment 103 should not be pursued because it relates to capacity. What constitutes capacity remains my problem.

In the amendment, "incapable" has the same meaning as in section 250 of the 2003 act. I take it that a significantly impaired decision-making ability—or SIDMA—is involved, not the total loss of capacity, as under the Adults with Incapacity (Scotland) Act 2000, "incapable" means incapable of

"acting; or ... making decisions; or ... communicating decisions; or .. understanding decisions; or ... retaining the memory of decisions".

The differentiation between SIDMA and the 2000 act is at the nub of discussions that are taking place in civic Scotland among health professionals and patients.

In summing up, will the minister say whether, in referring to section 250 of the 2003 act, he can confirm—actually, he is not going to sum up—

Jamie Hepburn: Will Dr Simpson therefore give way?

Dr Simpson: I would be happy to do so, if the convener will allow it.

The Convener: Yes. We might be breaking new territory here, but I am sure that taking an intervention will help the debate. We all want to get it right.

Dr Simpson: That would be helpful.

Jamie Hepburn: To clarify, the concerns that Nanette Milne has raised, which Dr Simpson seems to be echoing, are no longer a consideration, because we want to delete section 18. Therefore, it would no longer be a requirement that someone would have to apply in writing.

Dr Simpson: But—

Jamie Hepburn: The point is that no one would have to apply at all.

The Convener: I am not extending the intervention to a conversation.

Dr Simpson: Okay. That is fine.

The Convener: The minister has made his point, and you will need to weigh it in your consideration.

Dr Simpson: Okay. I will continue.

I have slight concerns about passing the responsible medical officer's report to the other listed persons. The responsible medical officer might or might not do that but it would depend on what they see as sensitive information. I am slightly concerned that, even if the patient's advance statement indicates that it should be given to the listed persons, it remains the responsibility of the responsible medical officer to decide; it is not the patient's decision even when that indication was given in full capacity in an advance statement. As I have said, I am slightly concerned about that. I realise that, as he is not summing up on this group of amendments, the minister cannot come back on the point, but I think that we might need to revisit the issue at stage 3.

On amendment 105, in the name of Rhoda Grant, which seeks to add advocacy, I know that we will be discussing this issue later and I fully understand that, although advocates should normally be notified and informed, they do not actually represent patients or make appeals on their behalf. I accept the minister's view that that distinction needs to be maintained. However, there will still be individuals who have no guardian, no welfare attorney, no primary carer, no near relative or, indeed, no named individual at all and who will have no one to operate on their behalf. I believe that, in those circumstances, the Scottish Independent Advocacy Alliance would be prepared to allow advocates to be nominated to carry out such actions and, as a result, Rhoda Grant's amendment might have some merit.

In short, although amendment 103 might not be pressed and amendment 105 not be moved, I believe that the issues that they raise require to be addressed before stage 3.

The Convener: I am going off-script here, I suppose, but I will give the minister a chance to respond to the discussion that we have just had before I ask Nanette Milne to wind up and indicate whether she wishes to press or withdraw amendment 103.

Jamie Hepburn: I will be very brief, convener. I have already intervened a couple of times to make clarifications—and I hope that they have been helpful—but I want to clarify one other point with regard to Dr Simpson's concern about a mental health officer's report being passed on to those identified as listed persons. As I made clear in my opening remarks, that is not quite the case: the mental health officer's determination will be passed on, but the content of their report will not.

I accept Dr Simpson's point about further safeguards for those who might not have anyone else to act on their behalf once the bill is passed. As Ms Grant has asked for further discussions, I commit to having further dialogue with her on the matter.

The Convener: I now ask Nanette Milne to wind up and indicate whether she wishes to press or withdraw amendment 103.

Nanette Milne: As I am happy to accept the minister's explanation as to why amendment 103 is no longer necessary, I will not press it.

Amendment 103, by agreement, withdrawn.

Amendment 39 moved—[Jamie Hepburn]—and agreed to.

After section 18

Amendment 40 moved—[Jamie Hepburn]—and agreed to.

Section 19—Consent to being named person

Amendment 41 moved—[Jamie Hepburn]—and agreed to.

Section 19, as amended, agreed to.

Section 20—Appointment of named person

Amendment 42 moved—[Jamie Hepburn]—and agreed to.

Section 20, as amended, agreed to.

After section 20

Amendment 43 moved—[Jamie Hepburn]—and agreed to.

Amendment 105 not moved.

The Convener: Amendment 104, in the name of Rhoda Grant, is in a group on its own.

Rhoda Grant: Amendment 104 is intended to reflect the rights of carers and gives ministers the power to draw up a code of practice that gives

"guidance on the role of carers and relatives".

However, it does not give them access to medical records, so it provides some balance against the next of kin not being involved but allows carers and relatives to have an input to a patient's treatment.

That is most important when it comes to discharge planning. Many people have told me that, when a patient is being discharged from hospital, carers seldom have any information. Some carers have told me that that has led them to be unprepared and unable to support the patient. As discharge is a time of big suicide risk, it is really important that carers be involved in that planning so that they can support—and, indeed, decide whether they are able to support—the person through that process.

Amendment 104 gives ministers powers to create a code of practice so that those measures can be put in place. Giving ministers those powers rather than putting the role of carers into the bill demonstrates an understanding that that role might change and move on, and enables the guidance to be adapted.

I move amendment 104.

Bob Doris: I was inspired to speak on the amendment by listening to Ms Grant's comments. Yesterday, the committee held an event in Glasgow at which we spoke to a variety of carers. One of the issues that was raised at that event—although not in relation to mental health—was carers not being routinely informed when patients are discharged from hospital, for example.

The issue might not be specific to mental health provision, but might be more connected to carers rights in general and communication with carers. I am open minded about whether the bill is the right place to address that, but it is important to put that point on the record.

Jamie Hepburn: The Government takes seriously the role of carers and our responsibility to support them better. That is why we have introduced the Carers (Scotland) Bill, which the committee is beginning to consider.

Involving carers and relatives in a patient's care and treatment is important. It is one of the strong themes that emerged from the consultation on the mental health strategy and is raised with me in correspondence. I welcome the fact that Rhoda Grant's amendment has allowed us to get the issue on the record.

The best care and treatment requires professionals to work with carers and patients collaboratively so that all are able to contribute. Making that work can be difficult and requires good professional judgment and skill about sharing information and involving carers while taking account of the patient's views, which are sometimes in conflict.

I recognise that Rhoda Grant's amendment is intended to reflect exactly that point—the concern

that patients might have about carers having access to information that they would not want shared—by emphasising that patient records cannot be shared. Indeed, other legislation already provides safeguards on the confidentiality of medical records.

In developing the revised code of practice, I intend to include guidance about the involvement of carers and relatives. I will ask the working group that is developing the revised code to do that and to reflect the good practice that exists. That does not need to be included in the bill, but I make a commitment on the record that it will be covered in the revised code of practice.

I would be happy to discuss with Rhoda Grant how we can do that. If she wants to pursue an amendment at stage 3 in the light of that discussion, I would be happy to work with her to try to develop a revised amendment that reflects how the code of practice supports good practice on involving carers and relatives.

On that basis, I urge Rhoda Grant not to press amendment 104.

Rhoda Grant: I welcome the minister's commitment to ensure that the matter is covered in the revised code of practice. Because of that, I will withdraw the amendment and might come back at stage 3 if that is required.

Amendment 104, by agreement, withdrawn.

The Convener: Amendment 82, in the name of Richard Simpson, is grouped with amendments 83 and 84.

Dr Simpson: During the evidence taking, it became clear that there was a strong desire among those who are engaged in mental health to strengthen the role of independent advocacy. The series of amendments that I have lodged do that.

The first intention is to ensure that in all situations in which the patient or the patient's named person, carer or other representative, such as a legal representative, is to be informed or notified, the independent advocate—if such a person is in place providing a service to the patient—should also be notified.

Matters of notification or informing aside, there are two roles that I propose the advocate may take on: they may make representations on behalf of a patient, or they may make an application on the patient's behalf. As I mentioned when we considered an earlier amendment, those are not usual roles for an advocate to play, but in the absence of someone else being willing to undertake either of those roles, it seems to me appropriate that advocates should at least be asked whether they would wish to make representations or applications on a patient's behalf, based on their knowledge of the patient. I recognise that those additional duties go beyond the more usual role of an advocate.

12:00

The purpose of amendment 84, which is supported more widely by the Scottish Independent Advocacy Alliance, SAMH and others, is to ensure that there is adequate monitoring of the availability and accessibility of advocacy services. There is considerable evidence that, despite the welcome advance in the deployment, availability and use of independent advocates, the picture is anything but uniform. I believe that we need to be aware of the situation, and I think that the monitoring and reporting that I suggest in amendment 84 would best be undertaken by the Mental Welfare Commission would help. Regular reports should be made by the local authorities and national health service boards that would allow the commission to determine the adequacy of independent advocacy services and to report to the Scottish ministers on that. I would expect that, thereafter, the Scottish ministers would wish to report from time to time to the Parliament or the Health and Sport Committee on the issue, which is certainly one that has concerned the committee over a number of years.

I move amendment 82.

The Convener: As no other members wish to speak on this group, I invite the minister to do so.

Jamie Hepburn: Some of my remarks will be similar to those that I made in relation to Rhoda Grant's amendment 105 in group 11.

As drafted, Richard Simpson's amendments 82 and 83 make provision for rights for advocates that are extensive and which go beyond the role that advocates normally play—advocates normally assist the patient to access their rights, rather than having rights to make representations, to have access to information and to lead and produce evidence at the tribunal.

However, I appreciate that the amendments might have been developed to fill the gap that is created by removing the default position of having a named person when a person has not appointed a named person and the person is not able to act on their own behalf. Our amendment 43, to which the committee has agreed, is intended to provide for that situation by including a limited list of people who, in limited circumstances, can act on behalf of a patient who does not have a named person and who is not able to act on their own behalf. I have committed to having dialogue with Ms Grant on the issue, and I would be happy to speak to Dr Simpson about it in advance of stage 3. On that basis, I urge members not to support amendments 82 and 83.

I recognise that ensuring that people can access advocacy is important to many of the people and organisations that offered their views to the committee during its consideration of the bill at stage 1; indeed, I met the Scottish Independent Advocacy Alliance to discuss some of these matters a couple of weeks ago. I understand, too, that some people have interpreted the fact that we did not include in the bill any specific provision on advocacy as an indication that it is not important. That is definitely not the case. My view is that the 2003 act already sets out duties to provide advocacy.

I accept that people's experience of accessing advocacy does not always meet their expectations. It is important that we understand that and ensure that people are able to access services and their rights. The Mental Welfare Commission has indicated that it would be possible to develop reporting that is not overly resource intensive. If that proves to be the case for NHS boards and local authorities as well as the commission, I would be prepared to work with Dr Simpson to lodge an amendment at stage 3. On that basis, I urge him not to move amendment 84.

Dr Simpson: As the minister has quite rightly said, the issue is that given the possibility of there being no named person, individuals might be unrepresented. I believe that the advocacy role could be extended reasonably in those rather limited circumstances.

For me, the situation is complicated by the difference between the Adults with Incapacity (Scotland) Act 2000's measurement of capacity and the bill's measurement of capacity. That is a fundamental problem, to which we will return in later amendments. In situations in which capacity is very seriously impaired, individual patients might be left totally unrepresented. In those circumstances, it seems reasonable that the advocate, if they have previous knowledge of the patient—which they might well do—should be able, on that basis, to make an application or representation on their behalf. At the moment, however, I accept the minister's view and will withdraw amendment 82 and not move amendments 83 and 84, on the basis that we will have further discussions and examine whether the role of the advocate needs to be enhanced either in the bill or in regulations to ensure that patients do not go unrepresented.

Amendment 82, by agreement, withdrawn.

Amendments 83 and 84 not moved.

Section 21—Registering of advance statements

The Convener: Amendment 44, in the name of the minister, is grouped with amendments 45, 46, 106 and 107. I point out that, if amendment 46 is agreed to, I cannot call amendments 106 or 107, because of pre-emption.

Jamie Hepburn: The Government's intention with section 21 is to increase the uptake of advance statements. We had hoped that a central register of statements could do that by giving reassurance that the statement could always be located there, but we have listened to stakeholder concerns that such a move could have an adverse effect and deter some service users from making an advance statement. I had also hoped that such a system would lead to advance statements being more readily available for relevant practitioners when they required them, but it is now clear that that might not be the case.

We have therefore worked with the Mental Welfare Commission to develop alternative proposals that will not require the statement to be sent but which will require certain information to be sent to the commission to help it monitor the numbers of advance statements made and to provide a central place where the existence and location of an advance statement are recorded but where the advance statement itself is not held.

Amendment 44 seeks to remove the provisions that required a health board to send a copy of the statement to the commission. Instead, it sets out the information that should be sent, which include that a statement or withdrawal document exists, where it is held, and any personal and administrative details that are essential to identify the record as the person's advance statement.

Amendment 45 seeks to ensure that the commission keeps a central register of information about advance statements to provide a source of information if there is any uncertainty as to whether a statement exists for a particular patient or where it is held. Requiring the commission to mark the date of entry will ensure that there is no confusion if a subsequent statement is made or if a statement is withdrawn.

Amendment 46, which is consequential on amendments 44 and 45, replaces the reference to

"anything kept in the register to be inspected at a reasonable time ... by the person to whom the thing relates"

with

"an entry in the register to be inspected at a reasonable time ... by the person whose medical records are referred to in the entry"

to reflect the changes to the information kept in the register. I think that that should take care of the concerns about legislative terminology that I believe Nanette Milne's amendments 106 and 107 are aimed at addressing.

Beyond that, there is a problem with amendments 106 and 107, as they would make

the provisions refer to only an "advance statement", not to a document withdrawing one. Both things need to be covered. Given that no "thing" remains in the text and given the omission of a reference to any withdrawal document, I respectfully invite Nanette Milne not to move her amendments.

I move amendment 44.

Nanette Milne: As has been said, amendments 106 and 107 in my name are largely technical and seek to amend the language in section 21, which amends proposed new section 276C of the 2003 act.

The commission will keep a register of advance statements. Although the wording of the bill as it stands would allow

"anything ... in the register to be inspected",

I think that the context is clear that that can refer only to advance statements. I believe that the alteration of the language in section 21 as proposed in amendments 106 and 107—in other words, the replacement of "anything" and "thing" with "advance statement"—will provide additional clarity.

I appreciate that the terminology that the minister has set out in his amendment is not exactly the same, but I think that the meaning is the same.

The Convener: Minister, do you wish to wind up?

Jamie Hepburn: I have nothing to add.

Amendment 44 agreed to.

Amendment 45 moved—[Jamie Hepburn]—and agreed to.

Amendment 46 moved—[Jamie Hepburn].

The Convener: I remind members that, if amendment 46 is agreed to, I cannot call amendments 106 and 107.

Amendment 46 agreed to.

The Convener: Amendment 85, in the name of Dr Richard Simpson, is grouped with amendments 86 and 87.

Dr Simpson: I welcome the changes that the minister has made to the registration process. The issue of protecting confidentiality and privacy with regard to advance statements was raised in the evidence that the committee received.

I have lodged a number of amendments to seek to ensure that privacy and confidentiality is fully protected, and the provision for registration with the Mental Welfare Commission goes a long way towards addressing those concerns. However, the advance statement itself will now be held elsewhere.

My amendment 85 seeks to insert as section 276D in the 2003 act a requirement on ministers, by regulations, to set out the circumstances under which a person or persons may have access to advance statements. I believe that amendment 85 remains pertinent, although I am happy to hear from the minister whether or not that is the case.

Aside from my amendments 85 and 86, the other amendment in the group is amendment 87, in the name of Bob Doris, on promotion of advance statements, which I support.

I move amendment 85.

Bob Doris: I thank SAMH for its partnership work in drafting amendment 87, which would place a duty on health boards and local authorities to promote advance statements. The amendment has support from a wide range of stakeholders.

An advance statement is a powerful tool that allows people with mental health problems to state what treatment they do or do not wish to receive in the event that they are treated compulsorily under the 2003 act. Although those statements are not binding, medical staff must notify the person, that person's named person and the Mental Welfare Commission in writing if the statement is overridden, setting out the reason for doing so.

No information is available at present on the number of advance statements that have been made, but the Mental Welfare Commission was notified of 31 overrides in 2013-14. Given the other provisions in the bill, we will start to get more robust data on the matter. SAMH's research suggests that awareness of the right to make an advance statement is mixed. People feel that advance statements are often not well promoted, and, while there is strong support for the concept, people are sceptical about whether an advance statement will be taken seriously.

A duty to promote advance statements, coupled with stronger guidance in the code of practice about when and how promotion should take place, will potentially increase uptake and empower people to make it clear what they do and do not want to happen. The committee noted in its stage 1 report the Government's preference to raise awareness of advance statements "from the grass-roots". We asked the Government to consider placing a duty to promote statements in the bill, which is what my amendment seeks to do.

If the Government cannot support placing a duty in the text of the bill, I would need some additional assurance about how the four aims in the bill can be achieved by another means. I have worked in partnership with SAMH to ensure that advance statements are promoted.

Jamie Hepburn: I thank Dr Simpson for setting out his thinking on amendment 85. However, it remains unclear to me what he envisages might be set out in the proposed regulations beyond the requirement for access to an advance statement to relate to the exercise of functions under the 2003 act. The act already requires the designated medical practitioner to have regard to an advance statement before making a decision under sections 236(2)(c), 239(1)(c) or 241(1)(c) of the act.

I am mindful of the fact that, when an advance statement is lodged in a patient's medical records, it should be treated as a medical record in terms of patient confidentiality. We should also ensure that service users have as much control as possible over who accesses their advance statement without there being too much bureaucracy governing how they share their information.

I am not convinced of the need for amendment 85, so I invite Dr Simpson not to press amendment 85 and not to move its consequential amendment 86.

12:15

On amendment 87, I am conscious that the committee recommended in its stage 1 report that the Scottish Government consider placing on health boards and local authorities a statutory duty to promote advance statements. As I said during the stage 1 debate, I very much agree with the committee's belief that more can be done to promote advance statements. I was happy recently to meet SAMH, which Mr Doris mentioned, and the matter has been the subject of discussion between us.

I want to ensure that advance statements are promoted in the most meaningful way and a way that has the most impact, and I remain unconvinced that the use of legislation would necessarily achieve that. Given that there are other effective ways for service users to be supported and encouraged to make an advance statement, including peer support initiatives, and given the burden that such a duty might place on health boards and local authorities, I invite Mr Doris not to move his amendment 87. I will, of course, be happy to meet him to discuss the work that he has undertaken with SAMH thus far.

In asking Mr Doris not to move his amendment, I also make it clear that the Scottish Government will look to do more to promote advance statements as part of implementation of the bill, and we will of course be happy to have the committee's input as part of that work.

Dr Simpson: I am not totally convinced that amendments 44 to 46, to which we have already agreed, cover the situation adequately. I still think that there need to be regulations—beyond the bill's provisions—for the responsible medical officer to have regard to the advance statement and therefore to have access to it. There should be regulations that allow or do not allow other persons to have access.

My amendments 85 and 86 might not be perfect and the Government might wish to amend them further at the next stage but, if they were agreed to, it would make a statement about the need to ensure that there is clarity in the regulations about who should and should not access advance statements.

Amendment 87 also needs to be supported. Again, the Government could further amend it at stage 3 if it felt that that was necessary, but I feel that it should be moved and agreed to.

The Convener: The question is, that amendment 85 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

Against

Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 85 disagreed to.

Amendment 86 moved—[Dr Richard Simpson].

The Convener: The question is, that amendment 86 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

Against

Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 86 disagreed to.

The Convener: I ask Bob Doris whether he wishes to move amendment 87.

Bob Doris: In asking me not to move amendment 87, the minister raised the issue of the burden that it might place on health boards and local authorities. I am unconvinced about the extent of the burden that would be placed on them. Looking at the provisions in the bill, I cannot imagine why health boards and local authorities would not want to promote the existence and effectiveness of the provisions about advance statements, irrespective of whether there is a duty to do that in the bill. That said, I am happy to meet the minister to discuss what that burden may or may not be.

I am conscious that putting something in the bill does not necessarily mean that there will be good-quality and extensive promotion of advance statements. I intend to hold my position until stage 3 and the possibility of lodging a revised amendment, depending on the outcome of meetings with the minister.

I know that Richard Simpson is keen for me to move amendment 87; if he wishes to move it, it is his prerogative to do so. However, on the basis that the minister has agreed to meet me to consider the matter further, I will not move the amendment.

Amendment 87 moved—[Dr Richard Simpson].

The Convener: The question is, that amendment 87 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

Against

Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 87 disagreed to.

Section 21, as amended, agreed to.

After section 21

The Convener: Amendment 88, in the name of Richard Simpson, is in a group on its own.

Dr Simpson: The committee will probably realise that, throughout our consideration of the bill, I have been wrestling with the differentiation between the definition of "incapacity" in the Adults with Incapacity (Scotland) Act 2000 and the lower test of capacity commonly known as SIDMA.

The conclusion that we reached when we debated the matter in 2003 was that it was appropriate, while modernising the Mental Health Act 1983, that the SIDMA test, not the incapacity test under the 2000 act, should be applied.

However, the significant impairment of decision-making ability is a lesser test for adults than is required under the 2000 act. Although, in the overwhelming majority of cases, that test serves the interests of the patient well, I believe that there are circumstances in which the patient's right to refuse medical treatment, under the European convention on human rights, is being denied inappropriately.

Amendment 88 seeks in a very modest way to ensure that when a patient has made an advance statement while they have full capacity, their wishes are followed, and should be followed unless the patient's capacity is so impaired that they meet the more stringent requirements of the test of incapacity under the 2000 act.

We must recognise that underuse of advance statements may in part be because there is a feeling—realistic or not—that the wishes that are expressed in them will not be fully respected, despite the fact that there is already a requirement that where and at what time treatment is given must be on the orders of the tribunal. Variation must be reported to the Mental Welfare Commission if it does not reflect the advance statement. Amendment 88 is a rather modest proposal pending what I believe to be a necessary, much fuller review of the legislation governing the whole issue of mental health and capacity, including protection of vulnerable adults.

Since lodging my amendments I have been asked whether amendment 88 would do exactly what I intend: it may need to be modified for stage 3. However, I believe that the amendment should be agreed to now, then modified at stage 3, unless the minister agrees in principle that the amendment is appropriate, and is willing to discuss its inclusion in modified form at stage 3.

I move amendment 88.

Jamie Hepburn: I share the Mental Welfare Commission's concerns about the intended effect of proposed new subsection (3B) of section 276 of the 2003 act and what that proposal would mean for urgent cases. Tribunal hearings can take some time to arrange, and amendment 88 would mean that the patient could not be given treatment in the meantime—treatment that could be essential for their immediate wellbeing, long-term recovery and rehabilitation.

Furthermore, I am not sure of the need for amendment 88. Advance statements are written statements setting out how patients would wish to be treated, or not be treated, for their mental disorder should their ability to make decisions about treatment for it become significantly impaired as a result of that disorder. However, amendment 88 seems to relate to situations in which the patient is capable of consenting to treatment. In such situations—where a patient is judged to be capable in terms of the 2003 act—we would expect the patient's consent to the treatment to be the primary consideration. In addition, from what I understand there is not a significant issue that needs to be addressed; the number of instances each year in which advance statements are being overridden is relatively small.

The current framework ensures that doctors and tribunals take account of advance statements and it requires them to set out the reasons why they are overridden, whenever that occurs.

On that basis I invite Dr Simpson not to press amendment 88.

Dr Simpson: The fundamental point remains that it is the right of any individual to refuse treatment if they have the capacity to do so. My proposal is that "significantly impaired decision-making ability" is not a total loss of capacity. Therefore, in those circumstances, patients should be entitled to choose to review their treatment, which they are not entitled to do under the 2003 act as it stands. Amendment 88 would therefore apply the more severe test of the Adults with Incapacity (Scotland) Act 2000, under which only when there is complete loss of capacity would treatment be allowed to proceed.

Moving forward from the original act, which I very much supported at the time, I do not believe that we have got the balance right. I think that this very modest provision—which will allow the advance statement that is given at a time of full capacity to be fully respected, unless the patient has lost capacity—is reflected in the 2000 act and not the 2003 act.

I press amendment 88.

The Convener: The question is, that amendment 88 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Grant, Rhoda (Highlands and Islands) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

Against

Doris, Bob (Glasgow) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 88 disagreed to.

Section 22—Communication at medical examination etc

The Convener: Amendment 47, in the name of the minister, is grouped with amendments 48 and 49.

Jamie Hepburn: Amendment 47 seeks to amend an incorrect cross-reference that was inadvertently left in the version of the bill that was introduced to Parliament. A prior draft version of the bill had gone out to consultation. It contained a provision that would have inserted a new section 57A into the 2003 act. That related to a previous proposal on applications for compulsory treatment orders. However, the provision was removed following consideration of consultation responses. The amendment will therefore remove the reference to section 57A(2), which appears in proposed new section 261A(4) of the 2003 act.

Amendment 48 will insert a new section 291A into the Mental Health (Care and Treatment) (Scotland) Act 2003. It provides that there must be no conflict of interests in relation to certain medical examinations that are carried out for purposes that are covered in a variety of sections under the 2003 act. The amendment will also extend coverage of existing conflict of interests provisions in the 2003 act to include compulsion order and compulsion order with restriction order reviews. In addition, the proposed new section will confer on Scottish ministers a power to make regulations that may specify circumstances in which there is, or is not, taken to be a conflict of interests.

Amendment 48 has been lodged following concern among stakeholders that conflict rules apply in relation to, for example, the making of a compulsory treatment order but not to its extension. Stakeholders have also identified that such provision does not apply to reviews of compulsion orders, either. There is a strong feeling that conflict rules should apply and that, where a conflict exists, the responsible medical officer should be required to arrange for the examination to be carried out by an approved medical practitioner. That is something that can be considered under the proposed regulations.

Amendment 49 will amend section 245 of the Mental Health (Care and Treatment) (Scotland) Act 2003. It will add to the list of people who must be consulted in circumstances where certain certificates are granted in accordance with the 2003 act. It will provide additional protections for

patients in the light of removal of the default named person, which has already been discussed under amendment 40.

I move amendment 47.

Amendment 47 agreed to.

Section 22, as amended, agreed to.

The Convener: That ends day 1 of stage 2 consideration of amendments to the Mental Health (Scotland) Bill. Day 2 will be at the committee's meeting next Tuesday; we will start where we ended today. A further marshalled list and groupings will be issued on Wednesday.

Agenda item 3 will be held in private.

12:30

Meeting continued in private until 12:37.

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