The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 26 May 2015

Session 4

Tuesday 26 May 2015

CONTENTS

HEALTH AND SPORT COMMITTEE
17th 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:

Tam Baillie (Scotland’s Commissioner for Children and Young People)
Jackie Baillie (Dumbarton) (Lab)
Fred Beckett (Glasgow City Council)
David Formstone (Social Work Scotland)
Beth Hall (Convention of Scottish Local Authorities)
Trisha Hall (Scottish Association of Social Workers)
Paul Henderson (Perth and Kinross Council)
Jamie Hepburn (Minister for Sport, Health Improvement and Mental Health)
Adam Ingram (Carrick, Cumnock and Doon Valley) (SNP)
Alison Jarvis (NHS Lothian)
Penny Nowell (Dumfries and Galloway Council)
Councillor David O’Neill (Convention of Scottish Local Authorities)

CLERK TO THE COMMITTEE

Steve Farrell

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Health and Sport Committee

Tuesday 26 May 2015

[The Convener opened the meeting at 09:15]

Mental Health (Scotland) Bill: Stage 2

The Convener (Duncan McNeil): Good morning and welcome to the 17th meeting in 2015 of the Health and Sport Committee. We welcome to the committee Adam Ingram MSP, and we expect Jackie Baillie MSP to attend.

At this point, I usually ask everyone in the room to switch off mobile phones, as they can interfere with the sound system. I remind people that committee members and our support staff are using tablet devices instead of hard copies of our papers.

The first item on the agenda is day 2 of stage 2 consideration of the Mental Health (Scotland) Bill. I again welcome the Minister for Sport, Health Improvement and Mental Health and his officials. For the record, I remind members that the minister's officials are here in a strictly supportive capacity and cannot speak during proceedings or be questioned by members. Everyone should have a copy of the bill as introduced, the second marshalled list of amendments and the second groupings of amendments.

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 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, but I will not specifically invite other members to do so. If no one moves the amendment, I will call the next one.

After section 22

Amendments 48 and 49 moved—[Jamie Hepburn]—and agreed to.

Section 23—Services and accommodation for mothers

The Convener: Amendment 50, in the name of the minister, is grouped with amendment 51.

The Minister for Sport, Health Improvement and Mental Health (Jamie Hepburn): In the development of my position on these issues, my policy intention has centred on the particular benefit for mothers and babies of maintaining and supporting that relationship in the first year of life. As part of that, it is important that our approach in the area is consistent with the Children and Young People (Scotland) Act 2014 in recognising the rights of the child and promoting, supporting and safeguarding a child's wellbeing.

Amendment 51 amends the Mental Health (Care and Treatment) (Scotland) Act 2003 to provide that

> "a Health Board is required to provide services and accommodation ... only if it is satisfied that doing so would be beneficial to the wellbeing of the child."

That would not preclude health boards from offering those services in other circumstances, without it being an express duty, for example in cases where the impact on the child may be judged to be neutral. I believe that that strikes the right balance, requiring that accommodation and services are provided where it is beneficial to the child, while providing flexibility for health boards to consider other circumstances.

Amendment 50 is a technical amendment, which restructures provisions in the 2003 act to accommodate the new provisions that are set out in amendment 51.

I move amendment 50.

Rhoda Grant (Highlands and Islands) (Lab): I have some concerns about amendment 51. I recognise that it is good and to be encouraged for mothers to have their babies with them. However, I wonder whether the catch-all of that being beneficial to the wellbeing of the child could give health boards an opt-out. I am wondering when it would not be beneficial to its wellbeing for a child to be with its mother. The provision is quite broad, but it seems to me that the range of situations in which a child would be away from its mother should be really narrow. I am a bit concerned that the amendment is very broadly drawn, which could give health boards the opportunity to opt out if they did not think that the facility was right, for instance. In what circumstances do you envisage that a parent and a child would be separated?

Jamie Hepburn: Rhoda Grant's points are well made. The bill already improves circumstances for mothers with respect to the right to have their child with them at the early stages. I think that I am right in recalling that, at the moment, under the 2003 act, the only circumstances that apply are those of postnatal depression. We are widening those circumstances to cover other forms of mental health disorder. In that sense, we are taking on board concerns about ensuring that children are with their mother where that is appropriate. Of course, the bottom line is that the measures must be appropriate for the circumstances of the child, too.

I hear Rhoda Grant's concern about a health board interpreting the circumstances as not being appropriate because of the structure of the facility and so on. That is certainly not the intention. I am happy to consider whether we need to finesse the provisions further, but I think that the principle that we have set out is the appropriate one. I believe that the committee should support amendment 51 at stage 2, and we will consider the matter further in advance of stage 3.

My instinct is that the concerns could be addressed by the guidance that we issue, but it is of course not the case that we want health boards to interpret the provisions on the basis of the facilities—this is a duty that they will have to adhere to.

Amendment 50 agreed to.

Amendment 51 moved—[Jamie Hepburn]—and agreed to.

Section 23, as amended, agreed to.

Section 24—Cross-border transfer of patients

Amendment 108 not moved.

Section 24 agreed to.

Section 25—Dealing with absconding patients

The Convener: Amendment 52, in the name of Bob Doris, is grouped with amendments 89 to 91 and 53. If amendment 52 is agreed to, I cannot call amendment 89, as amendment 52 will have pre-empted it.

Bob Doris (Glasgow) (SNP): Amendment 52 relates to section 25 of the bill, which amends section 309 of the 2003 act to allow regulations to be made

"applying some or all of Part 16"

of the 2003 act, relating to medical treatment, to patients who have absconded from jurisdictions outwith Scotland while they are held pending removal to their home jurisdiction. That section would allow medical treatment to be given to those patients in accordance with those regulations. The purpose of amendment 52 is to amend section 309 of the 2003 act so that, instead of allowing regulations to be made that apply

"some or all of Part 16"

to absconding patients, regulations would apply only

"specific provisions in"

that part of the act to such patients. The effect of the amendment is that the regulations would have to specify the particular provisions of that part of the act that are to apply to such patients, thereby authorising only specified treatments to be given in accordance with the provisions of that part only, rather than applying the part in its entirety.

Amendment 53 also relates to the regulation-making powers that are introduced in section 25 of the bill. The purpose of amendment 53 is to introduce a new exception to the power to make regulations applying the provisions of part 16 of the 2003 act to patients who have absconded to Scotland.

Amendment 53 would ensure that the regulations would not authorise medical treatment of the types mentioned in section 234(2) and section 237(3) of the 2003 act. The effect would be that no regulations could be made that would permit those treatments being given. It would—this comes to the nub of both amendments—preclude treatments such as surgical operations, other treatment specified in regulations made under section 234 and electroconvulsive therapy from being given to patients who have absconded to Scotland from other jurisdictions. The amendment would specifically preclude those forms of treatments, with other forms of treatments to be outlined in the regulations.

I have worked with the Scottish Association for Mental Health to look at alternative amendments, but we considered that the alternative proposals might preclude routine treatment that may be necessary for on-going medication to be given.

I hope that the two amendments reassure stakeholder groups that the rights of absconding patients will be protected, while allowing essential treatment to be given when it is needed. I hope that the committee will support amendments 52 and 53.

I move amendment 52.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I have listened very carefully to Bob Doris. I welcome the fact that he has lodged amendments to section 25. The amendments in my name would go somewhat further than his proposals. He is proposing that certain treatments under part 16 of the 2003 act would still be allowed, subject to regulations, whereas I am proposing that all treatment other than under section 243 of the 2003 act—that is, all treatment other than emergency treatment—should be precluded.

The bill as drafted will allow ECT and any surgical operations intended to destroy brain tissue, as well as treatments to reduce sex drive and to force nutrition. However, section 243 of the 2003 act, which is what the bill would refer to under my amendments, specifically authorises urgent treatment for the purposes of saving life, preventing serious deterioration, alleviating suffering and preventing violent behaviour. That fairly broad area protects patients. The question to the minister is whether, under the regulations under part 16 of the 2003 act, those other treatments would be excluded. Treatments should be excluded unless they are there to save life or prevent serious deterioration.

The Government has argued against the amendment. It has said that that is not the Government's policy and that more invasive treatments should be permitted in accordance with part 16 of the 2003 and should be given to patients who have absconded to Scotland. However, the amendments in my name would strengthen the situation. I will wait to hear the minister's reply and Bob Doris's summing up to see whether we will get guarantees on the regulations before I decide whether to move amendments 89 to 91.

Jamie Hepburn: I thank Bob Doris and Richard Simpson for lodging their amendments. I know that a range of stakeholders have particular interests in this area, such as the Scottish Association for Mental Health, as Mr Doris mentioned.

As I said in the response to the stage 1 report, it has never been the Government's policy that certain treatments for which part 16 of the 2003 act requires additional safeguards would be given to patients who have absconded to Scotland. However, it is important that we strike the right balance to allow absconding patients to receive the treatment that they need.

Amendments 89 to 91, in the name of Richard Simpson, would restrict treatment to urgent situations for the purposes of saving the patient's life, preventing serious deterioration in the patient's condition, and alleviating serious suffering and preventing the patient from behaving violently or being a danger to the patient or to others. Although I recognise and understand the sentiments, the amendments extend too widely. As Dr Simpson said, they are fairly broad and, as Bob Doris suggests, could restrict appropriate treatment for absconding patients, as they potentially do not allow for on-going or routine treatment that may be of benefit to the patient.

09:30

As Bob Doris set out, amendments 52 and 53 rule out certain treatments that require additional safeguards—electroconvulsive therapy, surgical operations and other treatments specified in regulations under section 234 of the 2003 act.

Turning to Dr Simpson's question about what would be contained in the regulations, I note that the amendments will allow detailed consultation before the making of regulations to make specific provisions relating to other treatment for absconding patients. My commitment to Dr Simpson and the committee is that that will be a genuine consultation. It is important that we undertake such consultation to make sure that we get the right balance before we determine what would be in the regulations. The points by Dr Simpson are well made.

The amendments that have been lodged by Bob Doris strike the right balance, in advance of further consultation. I ask members to support amendments 52 and 53 and Dr Simpson not to move amendments 89 to 91.

The Convener: I call Bob Doris to wind up and press or withdraw his amendments.

Bob Doris: I will be very brief. I had written down three words in the course of that short debate: proportionality, balance and safeguards. The safeguards are for the patient in terms of when they would need treatment and when treatment should be precluded from being given to them. The amendments that I have lodged provide that balance, on the basis that the minister has agreed today to an open consultation in relation to what future regulations will be. I am sure that there will be such consultation. I press amendment 52 and will move amendment 53.

Amendment 52 agreed to.

Amendments 90 and 91 not moved.

Amendment 53 moved—[Bob Doris]—and agreed to.

Section 25, as amended, agreed to.

Section 26—Agreement to transfer of prisoners

The Convener: Amendment 54, in the name of the minister, is in a group on its own.

Jamie Hepburn: Section 26 amends section 136 of the 2003 act to provide that a prisoner may be transferred to a hospital for treatment under a transfer for treatment direction only when a mental health officer has agreed to that.

A number of stakeholders including the Mental Welfare Commission for Scotland, the Scottish Prison Service, and the Royal College of Psychiatrists do not believe that the requirement for mental health officer agreement should be mandatory in all cases, as that could lead to delays in transfer and treatment. In particular, the Royal College of Psychiatrists noted that

> "It would be inequitable for an ill prisoner to have a delay in necessary urgent treatment because their need is to do with their mental health and not physical."

Amendment 54 therefore amends section 26 to allow a transfer for treatment direction to be made if it has been impracticable to obtain the agreement of a mental health officer.

Appropriate guidance will be provided in the statutory code of practice to make clear that the presumption is that agreement should be received from a mental health officer before a transfer for treatment direction is made and that a mental health officer should be involved promptly after the transfer, where that has not been possible beforehand. That maintains the right balance of requiring mental health officer involvement while avoiding any delays in treating acutely unwell prisoners.

I move amendment 54.

Dr Simpson: I welcome amendment 54 because the practical situation is that we have fewer mental health officers than we had 10 years ago. Recruiting them is proving extremely difficult and, therefore, the absolute requirement that a mental health officer should be involved in transfer from prison would be impracticable on a number of occasions. That needs to be addressed, because their engagement and involvement is important in both the short and long term. Getting this right is important.

My experience of working in a prison is that trying to get a mental health officer caused delays that were not in the best interests of the prison, the prisoner, other prisoners or the prison staff. I very much welcome the amendment.

Dennis Robertson (Aberdeenshire West) (SNP): Can the minister tell us whether there is a timeline in the guidance to ensure that a mental health officer will be involved after transfer?

Jamie Hepburn: I thank Dr Simpson for his comments. In response to Dennis Robertson's question, I say that there is not a timeline because the guidance has not been written yet, but we can certainly consider that when we draft the guidance. We want to strike a balance between having a reasonable timescale and taking account of the other concerns that have been raised in comments. The general principle is one that we hope will be backed by the committee, for the reasons that Dr Simpson has set out.

Amendment 54 agreed to.

Section 26, as amended, agreed to.

Section 27 agreed to.

After section 27

The Convener: Amendment 55, in the name of Richard Simpson, is grouped with amendment 56.

Dr Simpson: The inclusion of learning disabilities and autism spectrum disorder in mental health legislation was raised by a number of witnesses and in written submissions to the committee. Autism Rights and Psychiatric Rights Scotland called for the removal of people with learning disabilities and ASD from mental health law.

Inclusion Scotland commented that people with learning disabilities are concerned that they could be subject to compulsory treatment as a result of their learning disability alone. The committee received powerful testimony from Steve Robertson of People First, who questioned the appropriateness of the way in which people with learning difficulties are considered under mental health legislation. He said:

> "We honestly believe that the time has come for a new piece of legislation that is just about people with learning disabilities. We think that it is only right and fair that learning disability is properly defined as an intellectual impairment rather than a mental disorder. With that definition, we would want recognition that additional time to learn and support to understand things, together with easy-read documents and support to make some decisions, are what we need. We need those things to help us take part in our communities, rather than restrictions, detentions and efforts to keep us apart from the world that we want to live in."—[*Official Report*, *Health and Sport Committee*, 11 November 2014; c 39-40.]

I recognise that the Government's document "The keys to life", which came on top of the iconic and groundbreaking document "The same as you?" produced under Labour in 2000, moves things on for learning disability. However, we should recognise that, in 1999, recommendation 2 from the Millan committee said:

> "In due course, mental health and incapacity legislation should be consolidated into a single Act."

In 2009—six years ago—the McManus commission said that there was a need to review the Adults with Incapacity (Scotland) Act 2000 along with the Mental Health (Care and Treatment) (Scotland) Act 2003.

Northern Ireland has already begun the process of aligning incapacity and mental health legislation. In discussing previous amendments, I have raised my concern about the difference between SIDMA—significantly impaired decision-making ability—and lack of capacity, which must be looked at again. The need for alignment was echoed by a raft of witnesses who called for a wholesale review of mental health and incapacity legislation for a further reason—because of new information on, and knowledge about, neurodevelopmental disorders.

I concur with the Mental Welfare Commission for Scotland, which said that while the 2003 act and the 2000 act

> "for a time ... genuinely led the world",—[*Official Report*, *Health and Sport Committee*, 30 September 2014; c 27.]

there is a need to start thinking about the next wave and particularly about supported decision making in future plans.

Such views apply not just to amendment 55 but to other amendments that I have lodged. By continuing to include learning disability in the definition of mental illness, we are harking back to a bygone era. The inclusion of learning disability as a mental illness goes to the heart of issues of capacity.

The journey that we have taken from the lunacy acts of the 19th century, when we had idiot schools, through the asylum movement, the growth of huge institutions such as the Royal Scottish National hospital, Gogarburn house and Lennox Castle hospital, the shift to the community—which happened in my professional lifetime and was an excellent move with transitional and double funding—to the groundbreaking "The same as you?" report in 2000 and "The keys to life" in 2013 must now or in the very near future be matched by and fully reflected in our laws.

Colleagues, the simple truth is that, although people with learning disabilities are much more likely to have mental illness than the one in four of the general population who will have it, learning disability is not in and of itself a mental illness, and to continue to include it in the definition is an infringement of the human rights of those with such disabilities. Of course they need protection in law, but not in a law that could remove their human rights. As the Government's second response to the committee's stage 1 report said, a review would not be simple, but that should not prevent us from immediately commencing one.

In April 2014, the Committee on the Rights of Persons with Disabilities made a general comment on article 12 of the Convention on the Rights of Persons with Disabilities. Paragraph 38 of that general comment states:

> "forced treatment by psychiatric and other health and medical professionals … denies the legal capacity of a person to choose medical treatment and is therefore a violation of article 12 of the Convention."

Learning disability is such a disability. Accordingly, it follows that states parties

> "must abolish policies and legislative provisions that allow or perpetrate forced treatment".

We cannot ignore the fact that there have been occasions when patients have been deprived of their right to refuse treatment although they did not lack capacity and when the treatment and what those who were in power considered to be in the patient's best interests might not, in fact, have been in their best interests. If necessary, a speedy application to the court should occur when there is a dispute.

The Government said in its initial response to our stage 1 report that it was not considering removing learning disabilities or autism spectrum disorder from the 2003 act or having a wider review. Its more recent, fuller response to the report was much more accommodating but still said that such an approach would be difficult.

I believe that the minister is sympathetic. I ask him to make a firm commitment on the record to an early review and to discussing with other parties and stakeholders the chair, membership and remit for such a review in the near future. Amendment 56 goes further than my amendment 55 in specifying that such a review must occur within a year. For me, a year is too long but, nevertheless, I will support Jackie Baillie's amendment 56 if my amendment is disagreed to or if I do not press it.

On 19 May, the General Assembly of the Church of Scotland approved a report prepared by its church and society council that includes a section on human rights and mental health. That report strongly urges the Government to undertake the wider review for which I call. It also urges that the review should consider the issues that are raised in that report, which include matters relating to legal capacity and consent to treatment.

I seek from the minister an unequivocal commitment to an early review with a full commission similar to the Millan committee to examine the relevant acts: the Criminal Procedure (Scotland) Act 1995, the Adults with Incapacity (Scotland) Act 2000, the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adult Support and Protection (Scotland) Act 2007.

I will listen carefully to the minister's response before deciding whether to press my amendment, because I realise that it might remove protections in the 2003 act for individuals with learning difficulties or autism spectrum disorder. Nevertheless, it is an important amendment that requires debate.

I move amendment 55.

Jackie Baillie (Dumbarton) (Lab): I thank the committee for allowing me the opportunity to speak to amendment 56. I support amendment 55, but I am conscious that it seeks to remove learning disability and autism from the definition of mental disorder in the 2003 act. Amendment 56 calls for a review in the event that amendment 55 is lost. It reflects lengthy discussions held by the cross-party group on learning disability and would give effect to the group's view that the inclusion of people with learning disabilities in the definition of mental disorder should be reviewed.

I absolutely acknowledge that unpicking complex legislation, much of which provides a passport to services and rights, is difficult to do. That is why I believe that amendment 56 is proportionate, because it calls for a review. Let us face it—a review is nothing new. The Millan committee first recommended it in 2001 and the McManus review recommended it in 2009. Both supported the idea of removing learning disability from the definition of mental disorder in existing legislation. I might be called a patient person but, 14 years on, it has still not happened, and it is now time to make that review happen.

Amendment 56 does not presuppose the outcome of any review. It would simply ensure that a review happened, that we got a chance to look at complex issues away from the urgency, if you like, and the process of a bill, and that we could consider the matter properly.

I hope that the minister will support amendment 56. Like Richard Simpson, I detect a change to a more welcoming tone. The previous comments from the Scottish Government were more negative. I hope that we will gain support for the amendment from the Scottish Government.

09:45

Dennis Robertson: I have a great deal of sympathy for Dr Simpson's amendment 55 and, to some extent, for the patient Jackie Baillie. I echo the sentiments that they expressed. I hope that the Government can provide us with details as to when a review will take place, because the organisations and agencies that provide services for people with learning disabilities are asking for that. I will listen to the minister's comments.

Rhoda Grant: I support amendments 55 and 56. We have had powerful evidence about the difficulties that the current situation causes. It is time that we moved on and came to a better settlement with people with learning disabilities and other conditions that are not mental illnesses.

Jamie Hepburn: I recognise the issues that Richard Simpson and Jackie Baillie raise in their amendments and the passion with which they argue their case. I have heard the concerns that a number of people and organisations have raised about the inclusion of learning disability and autism under the mental health legislation. I met representatives of People First just last week, when the issue was discussed.

The 2003 act provides people with learning disabilities and autism spectrum disorders with important protections, safeguards and access to care and treatment. In anything that we seek to do, we must ensure that that continues.

In the Scottish Government's response to the committee's stage 1 report, I indicated that we intend to review the inclusion of learning disability and autism in the mental health legislation. It is important that we undertake that review to ensure that the range of views is heard—the views of those who have been making the case that learning disability and autism should not be included and the views of those who make the case for the benefit of the protections, safeguards and access that the legislation provides. We also need to consider carefully the practicality and the implications of any review that concludes that learning disability and autism spectrum disorder should be removed from the 2003 act. The review process would clearly allow for that.

I do not support Richard Simpson's amendment 55 as it would remove the protections and safeguards that exist for people with learning disability and autism who are treated under the 2003 act and would not replace them with anything. Dr Simpson referred to the request for new legislation specifically on learning disability, but his amendment would not achieve that in and of itself. I urge him to withdraw his amendment in the light of the Government's commitment to carrying out a review.

I understand why Jackie Baillie's amendment 56 requires ministers to carry out a review within a year of royal assent. There has been an expectation that a review will take place for a considerable time—since the 2003 act came into effect, and again following the McManus report. I note that Richard Simpson believes the timescale in Jackie Baillie's amendment to be too long.

I understand the sentiment, but I observe that the timescale that amendment 56 would impose would mean carrying out the review at the same time as implementing the bill. The people who will be involved in implementation—in feeding into the secondary legislation, developing the code of practice and putting in place the required changes to services—will also be key to the carrying out of a review.

I want the review to be participative, to ensure that all voices have an opportunity to influence the process and to be heard. It is critical to include those who have learning disabilities and autism spectrum disorders. That takes time, and it sometimes means taking longer than expected for genuine reasons, as unexpected issues arise during the process. I do not want us to set out an expectation, least of all in legislation, that is not achievable.

I make a commitment to carrying out a review. I would be happy to speak in more detail about the issue to Jackie Baillie, Dr Simpson or any other member of the committee or Parliament. I urge Jackie Baillie not to move her amendment 56 and, if she moves it, I urge members not to support it.

My position is unequivocal. I support a review of the inclusion of learning disability and autism in mental health legislation and I am happy to discuss that further with Opposition members and the committee. In setting out that position, we have to be clear that the review must be genuine. I do not want us to set a timescale that could curb the review so that it is not full scale and proper.

Dr Simpson: I welcome the fact that the minister has committed to a review, although the time is uncertain. As I said when I moved amendment 55, the review has to commence pretty rapidly. The term “carry out” in Jackie Baillie’s amendment 56 might not be the right one, as it may imply that the review will be carried out and completed. My interpretation is that the review would at least have to commence within a year. As I said, it is reasonable to expect the Government to establish the review within months, rather than a year.

I am happy to seek to withdraw my amendment 55, which I lodged as a probing amendment to ensure that there would be a proper debate, as there has now been. I realised that it would remove certain protections from people with learning disability, which would not be appropriate, so I am happy to seek to withdraw it. However, I will support Jackie Baillie’s amendment 56, if she moves it, on the basis that the review must start within a reasonable period. At stage 3, we will have the opportunity to make minor modifications to ensure that the bill talks about starting the review, rather than completing it, which was the implication of the minister’s remarks.

Amendment 55, by agreement, withdrawn.

Jackie Baillie: I will not move amendment 56, on the basis that there will be a discussion with the minister about a firm timescale for a review. People expect that. However, I reserve my right to bring back the amendment at stage 3.

Amendment 56 not moved.

The Convener: Amendment 109, in the name of Adam Ingram, is in a group on its own.

Adam Ingram (Carrick, Cumnock and Doon Valley) (SNP): Amendment 109 was inspired by my constituent Fiona Sinclair of the Autism Rights group. Her research, using freedom of information requests, has established that there are no published statistics on deaths, suicides or adverse events such as assaults or restraints in the mental health system in Scotland. There is no collation of any data for any of those categories, apart from deaths.

There are national statistics for suicides, but there is no separate collation of data for those in mental institutions or those who are subject to compulsory treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003. Although pilot schemes are in place to collate some of that information, we as parliamentarians must ensure that scrutiny is thorough and systemic.

In addition, there appears to be little collation of evidence, other than randomised control trials that are funded by the pharmaceutical industry, on the efficacy and effectiveness of various drug treatments. It is therefore impossible to judge how those treatments compare with different forms of treatment.

Amendment 109 would assist the purposes of medical research as well as providing a useful check on human rights in the system.

I move amendment 109.

Jamie Hepburn: I thank Adam Ingram for lodging amendment 109, which raises the important issue of how we reduce harm to people who receive care and treatment and how information gathering can support such a reduction. Of course, that is an issue not just for mental health services but for all health services.

I absolutely recognise the importance of reducing harm to people who are subject to compulsory treatment, but I do not think that the amendment would deliver the improvements to services that it is intended to deliver. We have already put in place mechanisms to support improvements in patient safety in mental health services. Health boards already report the deaths of patients who are detained in hospital to the Mental Welfare Commission, which in 2014 produced a report entitled “Death in detention monitoring” that provides an analysis of the situation. Moreover, Healthcare Improvement Scotland runs a suicide reporting and learning system that shares learning from suicide reviews. I am sure that we will return to the matter when we debate amendment 110, in the name of Richard Simpson, on reviews of deaths in detention.

In 2012, we introduced the Scottish patient safety programme for mental health. That genuinely innovative work on mental health services, which is run by Healthcare Improvement Scotland and involves all health boards, aims to systematically reduce harm experienced by people receiving care from mental health services. It focuses on five areas: communication at transitions; leadership and culture; medicines management; restraint and seclusion; and risk assessment and safety planning. Some of those areas—restraint and seclusion; risk assessment and safety planning; and medicines management—are exactly those that Adam Ingram's amendment highlights.

The approach under the Scottish patient safety programme is powerful, because it allows services and front-line staff to focus resources, including those for collecting and analysing information, on the areas that need most attention locally, which will certainly change over time. Introducing a legislative requirement to always collect certain information or data would result in a lack of flexibility to do such work effectively. I argue that what we have in place and are continuing to develop is a more effective way of improving safety and reducing harm to patients, and it is more effective than introducing a new layer of statutory reporting and information collection requirements that would have substantial resource implications for health boards and front-line staff.

I urge Adam Ingram not to press amendment 109.

Dr Simpson: I very much support what Adam Ingram is trying to do. It is essential that boards collect such information if they are to learn anything. I heard what the minister said about the patient safety programme, which is important, but it is a matter of regret that we have no clear data on these matters.

I think that the issue can be covered in regulations and that the Government should give an undertaking on that if amendment 109 is not agreed to. It is essential that we have an appropriate understanding of such things. As I will indicate when I speak to amendment 110, I think that the time has come for further reviews, but I note that Adam Ingram's amendment 109 goes further, as it deals with assaults, recorded adverse events and

"occasions on which restraints have been used in relation to a patient."

The public are concerned about such issues, and it is important that we have some understanding so that we can see variations between health boards, which I have gone on about at length in the Parliament. That information would allow us to understand when one board is performing well and another is not. Until that information is made available in a public and transparent way, we will not be serving the public in the way that we should be, despite all the excellent programmes that the Government has put in place.

Adam Ingram: To add to what Dr Simpson has just expounded, I think that we need to improve the level of information that is available. A couple of years ago, the Scottish Information Commissioner produced a report that criticised a health board's recording of significant adverse incidents in its mental health services. There is a deficiency in practice across the country, and I very much support Dr Simpson's suggestion of putting in place regulations to improve that practice.

I heard what the minister said about the level of bureaucracy that might be involved in the administration that would result from amendment 109, but I certainly want to pursue regulations. On that basis, I will seek to withdraw my amendment, but I want to return to the issue, perhaps with Dr Simpson and others. If the minister was willing to listen to us, I would appreciate that.

10:00

The Convener: I cannot speak on the minister's behalf but, throughout these days of considering the bill, he has been approachable and has been available to discuss any of the details.

Amendment 109, by agreement, withdrawn.

The Convener: Amendment 110, in the name of Richard Simpson, is in a group on its own.

Dr Simpson: Amendment 110 follows on from Adam Ingram's amendment 109. The wording of amendment 110 has been lifted and redrafted from Patricia Ferguson's proposal for a member's bill on fatal accident inquiries. The reason for lodging it as an amendment to the Mental Health (Scotland) Bill arose from a suggestion at a recent Justice Committee evidence session on the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Bill that scrutiny of deaths in mental health hospitals would be dealt with more suitably in a mental health bill.

At present, there are serious incident reviews, but families with whom I have corresponded are of the view that those are insufficiently regulated. Amendment 110 will not prevent a fatal accident inquiry from taking place if the procurator fiscal deems that an FAI is appropriate. However, there are reasons to believe that, notwithstanding any decision by the fiscal not to have a FAI, the Health and Safety Executive should conduct investigations. Roger Livermore, with whom I have had considerable correspondence, has extensive experience and expertise in this field and is scathing of the failure by the Health and Safety Executive, and, indeed, ministers to undertake detailed investigations.

The situation is further confused by the role of the Mental Welfare Commission, which also has a duty in the area. From time to time, it has produced valuable reports proposing improvements. In addition, as the minister mentioned in the debate on amendment 109, suicides in hospitals are reported to the confidential inquiry into homicides and suicides.

The fact that all those different organisations share responsibility for the situation is unsatisfactory. It is a complicated and confused area, which needs to be addressed. I will move amendment 110—as I will move an amendment on homicide later on—in the hope that it is accepted by the minister either in full or in principle. We need clarity of process, and families need transparency.

Amendment 110 would require the minister to establish a proper review of the arrangements for investigation of deaths, and it seeks to involve stakeholders in the process. If the minister opposes the amendment in principle, or supports the principle but opposes the amendment as it stands, I will seek to withdraw it and reconstruct it in order to lodge it at stage 3—with, I hope, the Government's help.

I move amendment 110.

Jamie Hepburn: Richard Simpson's amendment 110 is helpful in raising the issue. I am aware that in its report, "Death in detention monitoring", the most important issue that the Mental Welfare Commission identified was the higher death rate in general among individuals with a history of mental health admission. However, it was not compulsory treatment that was associated with death; it was the presence of mental illness, learning disability and related conditions.

I have reflected on the issues that the report raises and on the point that the commission identifies about ensuring a more consistent and streamlined approach to reviewing deaths of patients in hospital. That approach should be focused on ensuring that services are able to both learn from reviews that are carried out and improve, so that they are more effective and safer. The approach should also ensure that relatives or carers are able to participate fully in the process.

I propose to ask the Mental Welfare Commission and Healthcare Improvement Scotland to consider how a more effective and consistent approach to investigating deaths could be developed. I expect them to take account of the views of relatives who have been affected by deaths in hospital. I will provide an update to the committee on those proposals, which would allow the committee to provide its views before we determine the action that will follow.

On that basis, I invite Dr Simpson to consider withdrawing amendment 110.

Dr Simpson: I am happy to withdraw amendment 110 on the basis of the minister's helpful statement. However, I am concerned about the timeframe. If we do not see some strong progress soon, I expect to see, at stage 3, a requirement on ministers to produce regulations covering the issue, so that we have absolute clarity. I hope that the minister will make further comments on the developing discussions between the Mental Welfare Commission for Scotland and Healthcare Improvement Scotland.

Amendment 110, by agreement, withdrawn.

Section 28 agreed to.

After section 28

The Convener: Amendment 57, in the name of the minister, is in a group on its own.

Jamie Hepburn: Section 57(2) of the Criminal Procedure (Scotland) Act 1995 sets out the disposals available in cases where the accused has been acquitted on the ground of lack of criminal responsibility or where they have been found to be unfit for trial.

Section 57A of the 1995 act sets out equivalent provision for those who are convicted of an offence and meet the test for a compulsion order, and provides that a compulsion order may be made authorising treatment either in detention in hospital or in the community.

Amendment 57 is intended to clarify that a person who has been acquitted on the ground of lack of criminal responsibility or found to be unfit for trial may also be made subject to either a hospital-based compulsion order or a community-based compulsion order.

It is appropriate that such a person should be able to be treated in the community in the same way as someone who has been convicted of an offence, and the amendment achieves that intention, which is in keeping with the principles of the legislation in terms of being the least restrictive option. The amendment also allows the court to act on the recommendations of the psychiatrists and mental health officer who prepare the reports for the court.

Amendment 57 also makes a consequential amendment to make clear the current position, which is that a restriction order may be made only where a compulsion order authorising detention in hospital is also made.

I move amendment 57.

Rhoda Grant: In a case of a person who is found not fit to stand trial, what consideration is given to the victim of the crime that has been committed to ensure that they do not suffer any detriment and that the crime is not repeated? The minister will be aware of some quite high-profile cases.

Jamie Hepburn: We are introducing the victim notification scheme in the bill to notify victims of certain pieces of information that they are not currently privy to or able to request. We are making a significant advance in victims' rights, for the reasons that Rhoda Grant set out.

Having said that, it is important that we ensure that we give equal treatment to those who are treated in the mental health system, rather than sent through the criminal justice system. That is what amendment 57 seeks to achieve. Victims' rights will always be paramount, and that is why we have introduced the victim notification scheme in the bill.

Amendment 57 agreed to.

Section 29—Periods for assessment orders

The Convener: Amendment 111, in the name of Dr Richard Simpson, is in a group on its own.

Dr Simpson: The effect of amendment 111 is to delete paragraphs (b) and (c) of section 29(4).

I note that no provision is made for cross-border transfers in section 52D of the Criminal Procedure (Scotland) Act 1995. I anticipate that problems may be encountered with respect to female and child patients who are on remand, who should be detained in a high-security facility, given that Scotland's state hospital does not have provision for female or child patients.

Section 29(4)(c) allows the court to extend the assessment order to 14 days. I note that the consultation on the draft bill proposed extending the period to 21 days. Although I acknowledge that it is in the patient's interests that as full an assessment as possible is made, I do not support the increase from seven to 14 days. Articles 5(4) and 6(1) of the European convention on human rights require a timely hearing, and I am not convinced that such an extension is necessary or proportionate.

Amendment 111 is supported by the Law Society of Scotland.

I move amendment 111.

Jamie Hepburn: Amendment 111, in the name of Richard Simpson, is on an issue that has generated considerable debate not only during the passage of the bill but when the proposals for the bill were consulted on. The committee also highlighted the issue in its stage 1 report.

As Dr Simpson said, our original proposal was to allow the court to extend an assessment order for a period of up to a maximum of 21 days, rather than the maximum of seven days that is permitted under the 1995 act. The proposal generated considerable comment. Respondents who supported it commented that it would allow for a more robust and informed assessment. However, not all respondents supported the proposal, and we acknowledged that by reducing the period of an extension to a maximum of 14 days.

The committee heard evidence at stage 1 from Dr John Crichton on the provisions extending the maximum period for the assessment order. He described how, in the most complex cases, that will allow the clinical team enough time to assess patients fully. In such cases, more time is needed than is presently available under the Mental Health (Care and Treatment) (Scotland) Act 2003 to determine whether the patient meets the treatability criteria and other criteria, as set out in the act.

Concern has been expressed that increasing from seven to 14 days the maximum period for an extension is, or may be, contrary to the rights, under the ECHR, of a person being assessed, particularly their rights under article 5, the right to liberty, and article 6, the right to a fair trial. Dr Simpson has just alluded to that.

However, I suggest that those concerns arise from a misunderstanding of how convention rights are secured in the context of an application for an extension of an assessment order. An extension can only be granted on application to the court, and then only for the period that the court permits. That is subject to a maximum period, which the bill provides is to be 14 days. I emphasise that that is the maximum; the court can, of course, determine a shorter period than the full 14 days.

When considering any application for an extension, the court has to comply with the Human Rights Act 1998. It can grant an extension only if, and to the extent that, to do so is compatible with the assessed person's human rights. Therefore, the compatibility of any extension with the assessed person's human rights is assured not by the statutory maximum period established by the legislation, but by the court's scrutiny of each individual case to ensure that the period of extension granted is no longer than is justified by the particular circumstances of that case. I emphasise that an extension may be granted by the court only on the basis of a report from the patient's responsible medical officer and will be determined on the basis of clinical need.

I ask Dr Simpson not to press amendment 111. If he presses the amendment, I ask members not to vote for it.

Dr Simpson: I thank the minister for his response. The fact that the court will determine the issue is very important, because that should protect the person's rights under the ECHR. On that basis I will withdraw the amendment at this stage. I will consult the Law Society as to whether we need to proceed with another amendment at stage 3.

Amendment 111, by agreement, withdrawn.

Section 29 agreed to.

Sections 30 to 34 agreed to.

Section 35—Transfer of patient to suitable hospital

The Convener: Amendment 58, in the name of the minister, is grouped with amendment 59.

Jamie Hepburn: Section 35(3) inserts new section 61A into the Criminal Procedure (Scotland) Act 1995, in order to close a gap identified in that act. New section 61A will allow for the transfer of persons who are awaiting trial and are subject to certain orders, described as remand orders, to a hospital that is suitable for their needs.

Amendment 58 extends that provision to cover patients who are subject to a temporary compulsion order. That will enable such patients to be moved to a hospital that is more suited to their needs, if it transpires that the hospital ordered by the court is unsuitable, and will ensure that they can be moved in the same way that patients on remand orders—that is, assessment orders, treatment orders and interim compulsion orders—can be moved.

Amendment 59 provides for the transfer of patients who are subject to assessment orders, treatment orders, interim compulsion orders and temporary compulsion orders to another hospital at any time during which the patient is subject to the order, and not only within the first seven days of admission to hospital, as proposed in the bill as introduced.

It is recognised that there might be situations where it does not become apparent until later that the hospital ordered by the court is not suitable or indeed that the patient's mental condition and therefore treatment needs might change over time, necessitating a transfer to a different hospital.

I move amendment 58.

Amendment 58 agreed to.

Amendment 59 moved—[Jamie Hepburn]—and agreed to.

Section 35, as amended, agreed to.

10:15

Before section 36

Amendment 112 moved—[Jamie Hepburn]—and agreed to.

Section 36—Compulsion orders

Amendment 61 moved—[Jamie Hepburn]—and agreed to.

Section 37—Hospital directions

Amendment 62 moved—[Jamie Hepburn]—and agreed to.

Section 38—Transfer for treatment directions

Amendment 63 moved—[Jamie Hepburn]—and agreed to.

Sections 39 and 40 agreed to.

After section 40

The Convener: Amendment 92, in the name of Dr Richard Simpson, is in group on its own.

Dr Simpson: Amendment 92 has arisen from discussions with Hundred Families, which is an organisation that supports families who have been affected by homicide involving individuals with mental illness. In the past 10 years, 137 homicides have been committed by those with mental illness, but only two appear to have been the subject of published reports by the Mental Welfare Commission, and few appear to have been the subject of adverse incident reviews by health boards. Of course, that might not be the case, but, as we discussed in relation to amendment 109 in the name of Adam Ingram, we do not know what the situation is with any clarity, given the information that is available.

We should compare the situation with that in England, where, over the same period, 321 reviews were carried out for the 576 homicides that happened. Although they are not perfect, those English reviews suggest that 25 to 35 per cent of those homicides could have been prevented. The United Kingdom confidential inquiry, in which Scotland participates, is helpful, but Scotland might not be adequately fulfilling its duty to victims' families if we do not require transparent reviews to be carried out in every case. Amendment 92 seeks to correct that failing.

The intention in amendment 92 is to provide, in primary legislation, clarity, consistency and accountability in the reviewing of and reporting on certain offences involving a person suffering from a mental illness who is already known to services. That provision is specified in proposed new section 63A(1) of the Criminal Procedure (Scotland) Act 1995, which amendment 92 would insert, and would apply, as proposed new section 63A(12) makes clear, to

> "murder, ... culpable homicide"

and

"such other offence as the Scottish Ministers may by regulations prescribe."

I would expect those other offences to include serious and violent assault and attempted murder.

At present, we have a dysfunctional reporting and review system that involves decisions by multiple organisations. The range includes the procurator fiscal deciding whether there should be an FAI; the confidential inquiry reports on homicide and suicide; the health board and the Mental Welfare Commission deciding whether to undertake reviews; and decisions by other organisations that might or might not have a role, including Healthcare Improvement Scotland and the Health and Safety Executive, especially in cases where a victim is a member of staff and the offence occurred in a workplace setting. Finally, the minister could require a review to be undertaken.

As I have said, the issue arose because of concerns expressed by Hundred Families, but for the record I make it clear that the number of murders, culpable homicides and serious assaults committed by persons with a mental illness, including those committed by persons with a severe and enduring mental illness, is tiny. My purpose in lodging amendment 92 is to ensure under proposed new section 63A(2) of the 1995 act that, if such a person is charged, the procurator fiscal will inform both the health board and the Mental Welfare Commission, and that, if the person in question has already been treated by that health board's mental health services or those in another board area, the board will be obliged to make inquiries and prepare a report for the commission. The purpose of those reports and the Mental Welfare Commission summaries that are also proposed in amendment 92 is to ensure that the board in question and other boards learn from such incidents and amend procedures or practices to reduce the likelihood of a recurrence. The reports must also be given to the victim, if they are still alive, or their family—although I gather that, as drafted, the amendment does not ensure that the report goes to the next of kin, which will need to be addressed at stage 3. In any case, this is about improvement, not blame. It is also about protecting people with mental illness in future and ensuring that the procedures, wherever possible, prevent them from committing these offences.

Nevertheless, I am aware of two concerns about my proposals, the first of which is timing. How long ago should mental health services have been involved to require a board to conduct an inquiry and produce a report? Given that such cases are likely to involve mainly persons with a severe and enduring mental illness, I do not propose any time limit. If there were no follow-up in cases involving persons with such a mental illness, that might in itself be the problem that the boards need to face.

Secondly, as the minister mentioned in relation to a previous amendment, discussions are on-going between the Mental Welfare Commission, Healthcare Improvement Scotland and health boards. That is, of course, welcome, but will the outcome be enshrined in law—perhaps in regulations—and will it cover all the points that I have made? I believe that victims, their families, those with a mental illness and society itself are all best served by putting the measure in primary legislation.

I move amendment 92.

Jamie Hepburn: I know that Dr Simpson has taken a considerable interest in the issue and has been working closely with victims' organisations, and I thank him for that work. It is important—indeed, it is imperative—that the voices of victims and their representative organisations are heard.

I understand that Dr Simpson has also met the Mental Welfare Commission to hear about the work that it is proposing to undertake with Healthcare Improvement Scotland. I have considered the commission's advice on how we can improve the reporting of homicides, which I agree should be improved. The commission is seeking a more streamlined system to ensure that lessons are learned and shared in order to provide comfort and reassurance to families in these tragic cases.

The commission already has a power under section 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003 to investigate cases of deficiency of care, and it has from time to time used that power to investigate homicides by patients. It has therefore proposed that, working with Healthcare Improvement Scotland and the Scottish Government, it should build on that to ensure that all cases are reviewed appropriately. In some cases, that would involve a review initiated by the local health board with oversight by the commission, but in cases in which there were serious concerns about the provision of care or reason to believe that significant opportunities to prevent a serious incident had been missed, the commission could conduct its own investigation. It would also be possible for a fatal accident inquiry, where appropriate, to be held. The commission is working with Healthcare Improvement Scotland to refine the proposal, which it hopes can be brought into effect soon. I propose to reflect on that proposal and, if it would help the committee, to write to the committee and update members in due course.

I have some concerns about whether amendment 92, as drafted, will achieve what is intended. The provision triggers the need for an inquiry on a person's being charged with an offence, which would therefore be prior to their conviction. That person could be acquitted, because they were not guilty or were found not criminally responsible for conduct constituting an offence by reason of mental disorder, and holding an inquiry at such an early stage would seem to cut across the criminal justice process and might be thought inappropriate prior to the final disposal of the case.

The publication of reports also raises potential confidentiality issues, especially in cases where a person is acquitted. Sensitive personal details related to mental ill health are not normally made public, and it is not clear how confidentiality is to be safeguarded.

In light of those concerns and, more significantly, in light of the work that is already under way, I urge Dr Simpson not to press amendment 92.

Dr Simpson: I very much welcome part 2 in general and the approach of trying to involve victims and their families in the process. I also welcome the on-going work between the Mental Welfare Commission and Healthcare Improvement Scotland to streamline the system. However, I have residual concerns that I do not think are being addressed, although it remains to be seen whether that is the case.

Those concerns are about the situation in which a health board does not deem an incident to be sufficiently problematic to justify an investigation or review, but the victim or their family feels that that is necessary. There must be a mechanism beyond going to the Mental Welfare Commission to ensure that, if a victim or their family raises an issue of concern, the health board is required to hold a review at an early stage.

I am not convinced that the matter does not need to be dealt with in primary legislation, but I accept that the minister raised important issues to do with charging a person with an offence and confidentiality. On that basis, I will seek to withdraw amendment 92 and consult those with whom I have been in discussion to see whether a further amendment should be lodged at stage 3. That might depend on the fuller information that we will receive from the minister, who has offered to update us on the issue before stage 3. I hope that that will at least give us an outline of where we are going. I fully understand that full regulations cannot be delivered but, if we get an outline of the principles involved, that will probably be sufficient for us not to require the measure in primary legislation, but I reserve my position on that.

Amendment 92, by agreement, withdrawn.

Before section 41

The Convener: Amendment 113, in the name of Dr Richard Simpson, is in a group on its own.

Dr Simpson: Amendment 113 arises from discussions with the faculty of forensic psychiatry. I should declare an interest in that I am a fellow of the Royal College of Psychiatry.

The first piece of legislation that was passed by the new Scottish Parliament in 1999, with which I was personally involved, was to tackle the situation arising from an appeal made under the European convention on human rights by Noel Ruddle against his detention in the state hospital at Carstairs following serious offences. That arose because the ECHR had been incorporated into Scottish law.

The Mental Health (Public Safety and Appeals) (Scotland) Act 1999 introduced the serious-harm test, under which patients who were convicted on indictment or complaint and subject to special restrictions by the court could be subject to indefinite hospital detention if a mental disorder was present and they were considered to pose a risk of serious harm to the public, irrespective of the appropriateness of the order or the treatability of the subject.

The legislative provisions in the 1999 act were subsequently extended in the Mental Health (Care and Treatment) (Scotland) Act 2003 to apply to all restricted patients in Scotland, who numbered about 250. Because of those provisions, there remained a small number of patients who became stuck in the forensic mental health system but who had been reclassified as personality disordered. In all likelihood, if the information regarding their mental disorder had been known at the time of sentence, they would not have been subject to a mental health disposal. In the case of Alexander Reid, the court of criminal appeal subsequently recognised that the change of diagnostic category could be considered as new evidence, and it allowed for a new disposal in his case. The process for raising his appeal took several years.

An alternative approach to the problem that is raised by cases such as that of Noel Ruddle is that there should be some mechanism by which the appropriateness of sentence can be reconsidered for patients whose diagnostic category has changed and whose detention in psychiatric hospital is consequently inappropriate. The whole approach in Scotland to personality disordered offenders was considered by a working group on services for people with personality disorder, which was chaired by Professor Thomson and which reported in May 2005. The report recommended that the Scottish Government consider whether a mechanism should be created to refer such cases to the Scottish Criminal Cases

Review Commission for consideration. That position was rearticulated in 2011, when the forensic network gave evidence to the commission on women offenders, which was chaired by the Rt Hon Dame Elish Angiolini.

Amendment 113 seeks to create a mechanism whereby patients whose diagnostic category has changed following sentence can have the appropriateness of that sentence reconsidered in the light of the current or revised diagnosis. It will affect those restricted patients who, having been admitted on a mental illness or learning disability diagnosis, are subsequently recategorised as having a personality disorder. The patients find themselves stuck within the mental health system, with their continued detention justified on the basis of their personality disorder and the risk of the harm that they pose.

The faculty of forensic psychiatry believes that individuals with personality problems are far better supported and managed within the prison system than the mental health system. The amendment will provide a mechanism that allows individuals similar to Alexander Reid to have the courts review their disposal. The current system is extremely cumbersome and costly, and it is not in the best interests of the patient, society or the victims.

10:30

The amendment allows for the Mental Health Tribunal for Scotland to review the appropriateness of the mental health disposal following a review of a compulsion order with or without restrictions. If the tribunal considers that the on-going compulsion order is inappropriate, depending on the clarity of the situation and bearing in mind the interests of justice and the principles of the 2003 act, then it may make reference to the appeal court to reconsider the sentence. This would probably apply to only a small number of individuals seeking to obtain a more appropriate disposal from the court.

Finally, the benefit of this amendment would be that, if even that small number of patients currently stuck within the mental health system were transferred to the Prison Service, there would be savings to the national health service of something in the region of £200,000 per patient.

I move amendment 113.

Jamie Hepburn: Dr Simpson’s amendment 113 opens up very complex issues in proposing new powers for the tribunal and courts that would revisit the decision of the court in its original sentencing and disposal. It also opens up what can be very complex, competing, clinical opinions about diagnosis.

I understand that the amendment is designed to address concerns among some psychiatrists that patients who are diagnosed—or indeed misdiagnosed—as having a mental illness or learning disability and, on that basis, made subject to a compulsion order or compulsion order and restriction order may later be diagnosed as having only a personality disorder. If the court had had full medical evidence based on the later diagnosis, that may have resulted in a prison sentence rather than a mental health disposal for the patient. Yet, once in the hospital system the patient cannot be released because they continue to satisfy the test for a compulsion order or compulsion order and restriction order because of the risk of serious harm that they pose.

It appears to me that the proposal would result in a significant shift in how mentally disordered persons are dealt with by the criminal justice system and, indeed, by the health service after conviction. The present position in the 2003 act is quite clearly that a patient who meets the conditions for a mental health disposal and requires to be detained may, in many cases, most appropriately be detained in hospital rather than in prison.

The 2003 act provides that “mental disorder” includes “personality disorder”, meaning that it is possible for a patient who has a personality disorder with no co-occurring mental illness to be detained in hospital. A more fundamental change to the definition of mental disorder in the 2003 act would be required to prevent that.

An amendment to the Criminal Procedure (Scotland) Act 1995 extended the time period for an interim compulsion order from six months to 12 months, to ensure that a full and rigorous assessment of the offender’s mental disorder is undertaken before the final disposal is made. It is very unlikely that an offender would be misdiagnosed in those circumstances, making it much less likely now that a patient would receive a hospital disposal from the court that would create the scenario that Dr Simpson describes.

All patients subject to compulsion orders and restriction orders have the right to apply to the tribunal and to have the orders reviewed periodically. In addition, there is already a means for patients to have their cases considered on appeal. The same appeal route is used for those offenders who receive a prison sentence but who argue that they should have received a hospital disposal.

Amendment 113 is well intentioned. However, it deals with a major issue and, given the implications for the criminal justice system, not one that I believe we should sensibly be considering without thorough consultation. On that basis I urge Dr Simpson not to press his amendment 113; if he does, I strongly urge members not to vote for it.

Dr Simpson: The numbers affected by my amendment 113 would actually be very small—the minister has almost conceded that in the statement that he has just made. I agree with him that, normally, a period of six to 12 months might seem long enough to ensure that there is not a misdiagnosis, but in practice there will still be a small number of individuals affected. Detention in a state hospital for such people is inappropriate and they will wish to be transferred to prison. At the moment, as is clear from the Alexander Reid case, the legal requirements to get the category changed by the court are cumbersome and costly.

Given that reports were made by Professor Thomson in 2005 and that evidence was submitted to the Angiolini committee in 2011, I am concerned that it is not a new problem that has just arisen in 2015 but yet another area in which there has been an extensive period during which the Government has had the opportunity to consider matters and come to a conclusion.

I will withdraw amendment 113 at the present time, but I reserve the right to have discussions with the faculty of forensic psychiatry and look at bringing the amendment back at stage 3, unless the Government wishes to consider introducing its own amendment or giving a guarantee at stage 3 that the wider review to which it has committed will include a review of that particular area.

We must resolve the situation, thus saving the individuals concerned from being detained for longer within the state hospital, which is not good for them, and also in order to ensure that the limited resources of forensic psychiatrists are appropriately applied to those who will benefit from them, rather than continuing to be applied to those who are detained inappropriately in the state hospital.

I hope that the minister will consider what I have said.

Amendment 113, by agreement, withdrawn.

Section 41—Information on extension of compulsion order

Amendment 64 moved—[Jamie Hepburn]—and agreed to.

Section 41, as amended, agreed to.

Section 42 agreed to.

After section 42

The Convener: I call amendment 65, in the name of the minister, which is in a group on its own.

Jamie Hepburn: Amendment 65 deals with an issue highlighted by the Mental Welfare Commission in relation to the revocation of a restriction order.

Part 10 of the Criminal Justice (Scotland) Act 2003 contains provisions in relation to compulsion orders and restriction orders. There are various provisions that allow for applications or references to be made to the Mental Health Tribunal for Scotland in respect of those orders. When the tribunal considers that it is necessary for a compulsion order and restriction order patient to remain subject to a compulsion order but that the restriction order is no longer necessary, it must make an order under section 193 revoking the restriction order.

Section 196 provides that the revocation does not take effect until the occurrence of certain events, including the expiry of the appeal period and the determination of any appeal lodged against the tribunal decision. Section 198 provides that, from the day on which the tribunal makes the revocation order, the patient is treated as being subject to a compulsion order. Accordingly, from the day on which the revocation order is made, the patient is subject to various review requirements.

That means that from the day of the tribunal hearing, the patient must be treated as though they are a compulsion order patient even if the tribunal’s revocation of the restriction order has not yet taken effect. That could lead to the registered medical officer being required to carry out a review of the compulsion order despite the patient continuing to be subject to a compulsion order and restriction order.

Amendment 65 ensures that the provisions work as they should. It has the effect that a patient whose restriction order is revoked should not be treated as being subject to a relevant compulsion order within the meaning given by section 137(1) of the 2003 act—and its attendant review requirements—until such time as the revocation takes effect.

I move amendment 65.

Amendment 65 agreed to.

Section 43 agreed to.

Section 44—Right to information: compulsion order

The Convener: Amendment 114, in the name of Dr Richard Simpson, is grouped with amendments 115 and 116.

Dr Simpson: Amendments 114, 115 and 116 stem from discussions with the Law Society, and the aim is to achieve simplification and clarity.

In the new section 16A proposed by the bill, the statutory language is somewhat cumbersome. Amendment 114 would have the effect of deleting reference to subsection (2) as a qualification of section 16A(1); amendment 115 adds a new subsection (4)(e); and amendment 116 deletes the proposed subsections (2), (3) and (4). The effect of the amendments is to create a fully modified section 16A(1) of the Criminal Justice (Scotland) Act 2003, which the Law Society believes will be simpler and clearer.

I move amendment 114.

Jamie Hepburn: Amendments 114 to 116 in Dr Simpson's name are intended to improve the clarity of the text that is to be inserted as new section 16A of the Criminal Justice (Scotland) Act 2003, but they seek to do that by taking three separate sentences and collapsing them into a single, very long sentence. I do not think that that makes the proposed new section clearer; it does quite the opposite. The choice between saying something one way or another comes down, in large part, to personal taste, but legislation is prepared carefully and just moving words around on the statutory page can change their legal effect, which is the case with amendments 114 to 116.

The amendments change the emphasis, which changes how readily victims' rights to information arise. Under the bill as drafted, the default position is that information is to be given to a victim when the criteria in the new section 16A(1) are met. That right can only be disapplied in exceptional circumstances. The amendments change the emphasis by requiring exceptional circumstances to be ruled out before any entitlement to information ever arises.

The second problem is that the amendments would leave the new subsection (4) out of the proposed new section 16A. I am not clear why that is being proposed. New subsection 16A(4) is clearly important, because it states when a victim's right to information about a patient comes to an end.

As I do not think amendments 114 to 116 will make the proposed new section 16A clearer and, more importantly, because they would change the proposed new section's effect in unintended and unhelpful ways, I suggest that Dr Simpson should not press amendment 114 or move amendments 115 and 116; if he does, I urge members to vote against them.

Dr Simpson: I hear what the minister has said and I will go back and have some further discussions with the Law Society. I will not seek to press amendment 114 at this time.

Amendment 114, by agreement, withdrawn.

Amendments 115 and 116 not moved.

The Convener: Amendment 120, in the name of the minister, is grouped with amendments 121 to 125.

Jamie Hepburn: Amendments 120 to 125 are all amendments to part 3 of the bill, which provides for victims of mentally disordered offenders by introducing a statutory notification and representation scheme for victims of such offenders who are subject to certain orders. The intention is to develop a scheme that resembles as closely as possible the scheme that is available to victims under the Criminal Justice (Scotland) Act 2003.

In lodging the amendments, I have considered the work of the forensic network's victims' rights and victims of mentally disordered offenders guidance short-life group. The group includes representatives from the national health service, social work, Victim Support Scotland, Hundred Families, the Mental Health Tribunal for Scotland, Police Scotland and the Scottish Prison Service because of their expertise in operating the victim notification scheme under the 2003 act.

I have also taken into account the view that the committee set out in its stage 1 report that the scheme should not discriminate against mentally disordered offenders. The amendments reflect that concern and are intended to ensure that victims have rights to information and to make representations in a way that reflects as closely as possible the provisions for victims under the 2003 act.

Amendment 120 clarifies the information that will be relayed to victims when the Mental Health Tribunal directs conditional discharge under its powers in section 193(7) of the Mental Health (Care and Treatment) (Scotland) Act 2003, or when the Scottish ministers vary the conditions of discharge under section 200(2) of the 2003 act, which gives the Scottish ministers powers to recall a patient who has been conditionally discharged from hospital.

The effect of the amendment is that information may be provided about a patient and about any conditions have been made imposing restrictions on the things that the patient may do after his or her conditional discharge. In practice, the restrictions will commonly be about where the patient is prohibited from going and persons with whom the patient may not have contact.

10:45

Amendments 121 and 122, along with the whole approach to developing the victim notification scheme, have been proposed to mirror the criminal scheme as closely as possible so that victims of crimes have as comparable rights as possible. The policy aim that we are trying to achieve is a proportionate position to ensure that the victim has information that is pertinent to them—in this case to know that the patient's rehabilitation has reached the point at which they will be unescorted in the community.

The amendments will mean that a victim will be entitled to make representations on the first occasion that a decision is being made about granting the patient unescorted suspension of detention. The approach taken to granting unescorted suspension of detention is usually planned and, depending on the patient's progress, that plan can be updated on multiple occasions during a year, ranging from very minor changes to larger ones when the patient progresses more quickly. It would be disproportionate for victims to be provided the opportunity to make representations on each occasion unescorted suspension of detention is granted. It would also potentially impede a patient's rehabilitation. The amendments achieve the right balance.

Amendment 121 relates to offenders subject to hospital directions, and amendment 122 relates to cases in which offenders are subject to a compulsion order and restriction order. Amendment 123, which means that victims will provide representations to ministers in writing, has been proposed to mirror the position taken in the criminal justice scheme, in line with our approach to the victim notification scheme as a whole.

Amendment 124 provides for the situation in which a patient who is conditionally discharged is recalled to hospital by ministers. The amendment means that victims will have the right to make representations when a decision is being taken to grant unescorted suspension of detention for the first time after the patient is recalled.

Amendment 125 is intended to clarify how the tribunal will take into account representations that victims make when taking a decision about granting conditional discharge of a patient. The tribunal will be required to take into account the victim's representations when considering what conditions to include when granting conditional discharge. That is intended to include conditions that would directly affect the victim, such as an exclusion zone that the patient cannot enter or a condition of no contact. Victims may make representations on how a decision might affect the victim or members of the victim's family.

I move amendment 120.

Dr Simpson: I understand the purpose of amendments 121 and 122: to insert "for the first time". I have some slight concerns, in that when someone is granted unescorted leave for the first time it might be for a brief period, which may be followed by a much longer period of unescorted leave—weekend leave, for example. If the provision is to apply just for the first time, it seems a little restrictive. Will the minister explain whether there would be a process of rehabilitation in which victims would be notified of a longer period of unescorted leave, if that was deemed to be appropriate and in the victim's interest? Leaving it just as the first time is, as I understand it, overly restrictive.

Jamie Hepburn: The first thing to observe is that this is a new mechanism. It is not a reduction in victim's rights, as it creates rights in the first instance. We should also be clear that victims organisations representatives have not been lobbying for the right to representation on each occasion. We constituted a working group to come up with the proposals and that group critically included victims organisations such as Victim Support Scotland and Hundred Families, with which Dr Simpson said that he had been working.

The amendments are about striking a balance and it is proportionate that victims should have the right of representation in the first instance, rather than on multiple occasions. Such a mechanism could be considered to place an onerous requirement on victims themselves, who may not welcome it in every circumstance. In addition, we want to reflect as closely as possible the victims' rights process that is in place for the criminal justice system. The amendments reflect how things are set out in the criminal justice system.

We are trying to treat people on an equal basis and strike the right balance. The proposal, which is informed by representatives of victims organisations, is the correct way forward and I urge the committee to support the amendments.

Amendment 120 agreed to.

Section 44, as amended, agreed to.

Section 45—Right to make representations

Amendments 121 to 123 moved—[Jamie Hepburn]—and agreed to.

Section 45, as amended, agreed to.

Section 46 agreed to.

Section 47—Associated definitions

The Convener: You can hear the tone in my voice that says that we have witnesses waiting and we are trying to get through this.

Amendment 124 moved—[Jamie Hepburn]—and agreed to.

Section 47, as amended, agreed to.

Section 48 agreed to.

Section 49—Amendments to the 2003 Act

The Convener: Amendment 117, in the name of Dr Richard Simpson, is in a group on its own.

Dr Simpson: The effect of amendment 117 would be to ensure that recorded matters under section 64 of the Mental Health (Care and Treatment) (Scotland) Act 2003 are included in the orders that the tribunal may make when confirming the determining or varying of a compulsion order.

Section 65(4)(a) of the 2003 act sets out the definition of "recorded matter". The tribunal can specify a recorded matter when making or reviewing a compulsory treatment order. In essence, a recorded matter is regarded as an essential element of the patient's care and treatment. If a recorded matter is not provided, the registered medical officer must refer the matter to the tribunal under section 96. That reflects the Millan principle of reciprocity.

Recorded matters are a means of ensuring that patients get the essential elements of the care and treatment that they require, and can be used to secure care and treatment that might not otherwise be provided. That is a significant benefit to some patients.

Currently, recorded matters can be specified only in compulsory treatment cases. They cannot be specified in cases where the treatment is under a compulsion order or a compulsion order with a restriction order. The view of the Law Society is that patients with such orders would benefit from the inclusion of recorded matter provisions. Compulsory treatment orders are civil orders, whereas compulsion orders and compulsion orders with restriction orders are criminal justice orders. All patients should have the right to obtain the essential treatment that they require, regardless of their route into the mental health care and treatment system.

I move amendment 117.

Jamie Hepburn: I thank Dr Simpson for lodging his amendment. I have considered the case that exists for introducing provisions for the tribunal to specify a recorded matter in cases where the patient is under a compulsion order or a compulsion order with a restriction order. I am confident that the existing provisions in the 2003 act work well for patients who are subject to a compulsion order or a compulsion order with a restriction order. However, I am happy to consider whether improvements could be achieved by extending the use of recorded matters to those who are covered by such orders.

However, I am unsure why the amendment is for section 49. Section 49 is in part 3, which is exclusively about "Victims' Rights"—that is its title. Section 49 contains amendments to the 2003 act in connection with victim notification only and is not at all suitable for unrelated topics, whether they involve the 2003 act or otherwise. Amendment 117 is not related to victim notification, therefore in my view it is extremely confusing to put it in part 3.

It seems to me that the amendment should be in part 1 of the bill, given that part 1 makes a large number of amendments to the 2003 act on a wide variety of topics apart from victim notification. I note, also, that the amendment on its own does not appear to do what it is intended to do and should perhaps have been accompanied by other consequential amendments.

I would be very willing to work with Dr Simpson to try to lodge an amendment or amendments at stage 3 that could better achieve the aims that are set out in amendment 117. On that basis, I ask Dr Simpson not to press his amendment.

Dr Simpson: I have no further comments, and I seek to withdraw amendment 117.

Amendment 117, by agreement, withdrawn.

Amendment 125 moved—[Jamie Hepburn]—and agreed to.

The Convener: Amendment 118, in the name of Nanette Milne, is in a group on its own.

Nanette Milne (North East Scotland) (Con): Amendment 118 was suggested by the Law Society of Scotland to deal with an omission—as the society sees it—from the 2003 act.

Section 320 of the 2003 act provides for a route of appeal to a sheriff principal against certain decisions of the tribunal. An appeal can be brought by the individual concerned or by a number of "relevant parties" as defined in section 320(5). Those include named persons; a guardian of the person; a welfare attorney; the mental health officer; or the person's responsible medical officer. However, that fairly comprehensive list omits to mention a person's curator ad litem where one is in place. Curators ad litem are people who are appointed by a court for people who lack the appropriate capacity to instruct a lawyer.

In the 2011 case of Brian Black as curator ad litem to the patient v the Mental Health Tribunal for Scotland and Scottish ministers, the inner house of the Court of Session found that curators ad litem did not have the statutory right of appeal to a decision by the tribunal. The Black case pointed to the power of curators ad litem to bring judicial review against a tribunal decision, but that is quite a different mechanism from an appeal and requires a virtually complete alienation of reasonableness in a public authority's choices before its decision can be overturned.

The omission appears to be fairly straightforward but it leaves those often vulnerable people without an effective legal remedy against decisions of the tribunal. That puts those individuals at a considerable disadvantage, which is neither justifiable nor intended in the drafting of the 2003 act.

I move amendment 118.

Jamie Hepburn: Amendment 118 relates to an important issue that is linked to the debate that we had last week regarding the appointment of named persons. Nanette Milne's amendment highlights concerns about the ability of patients who lack the capacity to instruct their own legal representation to exercise rights of appeal under the 2003 act.

The amendment would allow a curator who had been appointed to represent the patient at the tribunal or before the sheriff principal a right of appeal in those circumstances. Currently section 320(2) of the 2003 act entitles a relevant party to appeal to the sheriff principal against the decision. A relevant party includes

> "the person to whom the decision relates ... that person's named person ... any guardian of the person ... any welfare attorney of the person ... the mental health officer; and ... the person's responsible medical officer."

It is therefore not the case that the patient does not have effective remedies under the 2003 act.

My amendments on named persons included amendment 43—which was agreed to—to provide for a listed person to exercise rights to make an application or appeal, where the patient has no named person and does not have the capacity to initiate an application or appeal. A listed person is defined as any guardian or welfare attorney; the patient's primary relative, if any; or the patient's nearest relative. A listed person would be able to initiate an appeal under sections 320 to 322.

In my view, the provisions in the 2003 act and in the bill that we are considering ensure that patients without capacity are not disadvantaged. I am willing to consider the merits of the principle and the provisions that are set out in Nanette Milne's amendment 118. However, as with amendment 117, I am unsure why the amendment seeks to amend section 49. As I said previously, section 49 is in part 3, which exclusively concerns victims' rights, and I am therefore not sure that it is suitable for amendment in that way. It seems to me that the amendment should seek to amend part 1 of the bill, as part 1—as I said previously—makes a large number of amendments to the 2003 act on a wide variety of topics apart from victim notification.

On that basis, I urge Nanette Milne not to press amendment 18 so that we can discuss the matter in advance of stage 3. If Ms Milne presses her amendment, I urge members not to support it.

Nanette Milne: On the basis of what the minister has said, I seek to withdraw the amendment at this point.

Amendment 118, by agreement, withdrawn.

Section 49, as amended, agreed to.

Before section 50

The Convener: Amendment 119, in the name of Nanette Milne, is in a group on its own.

Nanette Milne: Amendment 119 makes provision for practitioner psychologists to be considered alongside medical practitioners for the purposes of the 2003 act, which would allow them to take on the statutory roles of approved medical practitioner and responsible medical officer. As members will be aware, the amendment follows extensive representations from the British Psychological Society.

At present, only medical doctors are registered as AMPs and only consultant psychiatrists perform duties as RMOs. The proposals for a greater role for psychologists aim to reflect the fact that the primary treatment for a number of mental health problems is psychological. In many situations, a psychologist may be the best-placed professional and the one who is most familiar with a particular patient's case.

11:00

The situation is already quite different in England and Wales, as the equivalent roles were opened up to practitioner psychologists under the Mental Health Act 2007. The same high standards of learning and familiarity with mental health law are expected of all approved clinicians in England and Wales. The change has widely been seen as a success.

Practitioner psychologists are already recognised as having the skills to supervise people under the criminal procedures that are set out in section 135 of the 2003 act. There are a number of vulnerable individuals for whom psychological therapies are particularly relevant: people who have learning disabilities, people on the autistic spectrum, people with personality disorders and people with eating disorders. The contention is that the most appropriate person to undertake AMP and RMO roles in those cases will be the one who is most familiar with the individual's treatment and care, and that there will be a positive impact on the patient's rights from that measure.

Although that is a significant change, we can point to England and Wales for an example of a similar system adopting it and see evidence of how it has operated in practice. If the Scottish Government were minded to conduct further investigation and consultation on the proposed change, there would be plenty of opportunity for that to be done after it was included in the bill. It will require further action from ministers to put the provisions into effect and have psychologists registered as AMPs and RMOs. The British Psychological Society has said that it does not expect uptake from psychologists to be high in the initial years, but making the change now would lay the groundwork for it to become far more commonplace in the future.

I move amendment 119.

Dr Simpson: The Royal College of Psychiatrists—my college—is not in favour of amendment 119, but its view is somewhat old-fashioned. The change is occurring in England.

The amendment would not apply to the totality of practitioner psychologists. We should achieve a mechanism whereby approved practitioners from psychology are enabled to support their colleagues in dealing with the limited number of cases in which they will have the primary role. The royal college's view on the matter is out of date. In the 1980s, I was personally engaged in ensuring that all patients who were referred to psychologists no longer had to go through psychiatrists, which was the case at the time.

The amendment is helpful. Regulations might be required to determine which practitioner psychologists should be allowed to register as AMPs and RMOs, but it would be helpful to have the extension. It would also be helpful to understand how the change has worked in England. At the moment, I do not have any information on that but it would be useful to know about it. If it has worked well, the time has come for us to adopt a similar approach.

Dennis Robertson: There is a role for psychologists under the bill. I ask the minister to meet Nanette Milne and others on the committee to discuss further how we can include psychologists, but I will not support the amendment. I hope that the minister will agree to meet to determine how we can progress the matter, because it is important.

Mike MacKenzie (Highlands and Islands) (SNP): I add my support to the comments that Dennis Robertson made.

Jamie Hepburn: I thank Nanette Milne for lodging her amendment. I met representatives from the British Psychological Society, who set out their proposals on the specific role that psychologists play in the care and treatment of people under the 2003 act. In particular, they highlighted the often pivotal role that they can play in care and treatment for people with learning disabilities and within forensic mental health services. I am sure that we all value and appreciate the work that they do in that regard.

I recognise the fact that mental health services are delivered by multidisciplinary teams. Those teams will be different in different locations and in caring for different patients. The legislation sets out a wide range of duties for medical practitioners, and it would not be prudent to make the change that Nanette Milne proposes without proper consultation.

The British Psychological Society has made a case for the role that psychologists could bring to some of the duties under the 2003 act. If we were to make the change, I would want to see the case for how that role would work in practice and what it would mean for all those duties. I would also want to understand how the different professions that make up multidisciplinary teams can be used to undertake the roles that are set out in the act effectively to best support patients.

I am concerned to ensure that any changes that the Parliament makes to the legislation can be implemented sensibly. The amendment would extend all duties of medical practitioners to practitioner psychologists. I am not sure that that is what is intended. Rather, the intention is something more specific that identifies exactly which duties the practitioner psychologist or, indeed, another clinician should be able to undertake. If we were to amend the bill, I would want to understand what those duties were and how that proposal would be implemented.

I am unsure why the amendment appears to be for the general provisions in part 4 of the bill. Although the proposed new section that the amendment would insert into the bill is headed "Interpretation", it is not for the interpretation of the bill. Rather, it would insert material into section 329 of the 2003 act for the interpretation of the provisions of the 2003 act. Indeed, it would affect the legal and practical operation of the act as a whole. The amendment belongs more properly in part 1, as it would make a large number of amendments to the 2003 act for a wide variety of topics.

In addition, the amendment does not deal merely with some technical or formal matter of labelling or interpretation. It deals with the crucial issue of who is to be regarded as a medical practitioner under the 2003 act. Therefore, I suggest that it is unhelpful to the reader of the bill to put the measure under the innocuous heading "Interpretation" at all, as that conceals the true range and nature of the change to the operation of the 2003 act.

I do not support amendment 119, not because I do not think that there is merit in considering the duties that professionals other than doctors could undertake but rather because proper consideration and consultation are needed before we change the legislation. The bill is intended to make technical changes to the operation of the 2003 act in light of the McManus review. I appreciate that there is a desire to take the opportunity to make other changes, but we should try to keep it fairly focused and consider other changes in due course.

I have already indicated the Government's intention and willingness to review the inclusion of those with autistic spectrum disorder or a learning disability within mental health legislation. I am also very willing for us to consider the role of psychologists in mental health legislation, but only if we are fully and properly informed.

Dennis Robertson requested that I discuss the matter with anyone who wants to discuss it with me. I am happy to do that but I urge Nanette Milne not to press the amendment and, if she does, I urge members not to vote for it.

Nanette Milne: On the basis that the minister has indicated his willingness to have further discussions on an important subject that needs to be progressed at some point, I am willing to withdraw the amendment.

Amendment 119, by agreement, withdrawn.

Sections 50 and 51 agreed to.

Long title agreed to.

The Convener: That ends stage 2 consideration of the bill.

I ask members to agree that, after a suspension, we move directly to agenda item 3 so that we do not delay our witnesses any further.

Members *indicated agreement.*

The Convener: I thank the minister and his officials.

11:08

Meeting suspended.

11:13

On resuming—

Carers (Scotland) Bill: Stage 1

The Convener: We move on to agenda item 3, which is two evidence-taking sessions on the Carers (Scotland) Bill. I apologise for the delay, but it was important to finish stage 2 of the Mental Health (Scotland) Bill.

Until now, our oral evidence has mainly focused on carers, but today it is the turn of local authorities and health services. We welcome to the committee Councillor David O'Neill, president, and Beth Hall, policy manager for health and social care, the Convention of Scottish Local Authorities; Paul Henderson, service manager for Perth city, mental health, drug and alcohol, Perth and Kinross Council; Penny Nowell, joint planning and commissioning manager and carers strategy lead officer, Dumfries and Galloway Council; and Alison Jarvis, community nursing programme manager, NHS Lothian.

We will go directly to questions.

11:15

Nanette Milne: A key feature of the evidence that we have heard from carers is on whether eligibility criteria for support should be set locally or nationally. The carers organisations believe very strongly that only if some element of those criteria is set nationally will there be equity and certainty for carers. Many of them pointed to the situation in social care more generally, where over the years eligibility thresholds have been raised as resources have become more constrained, and they are concerned that resources will be focused on crisis care to the detriment of preventative support.

I am aware that in its evidence COSLA puts the opposite view and suggests that we focus on the local setting of criteria. However, there was some variation between the councils. What are the panel's thoughts on the matter? Do you have sympathy with the views of the carers organisations and do you think that they will get equity if criteria are set locally?

Councillor David O'Neill (Convention of Scottish Local Authorities): I have sympathy with the view that has been expressed and I understand why carers would think that way. However, we have lots of evidence that shows that the closer you take decisions to the service user and the community that the services are aimed at, the better the outcomes you get. Setting out the criteria in legislation will reduce flexibility, innovation and the ability to deal with people on an individual basis. Our client base is made up of people who are very diverse and who have different needs and aspirations, and to have one set of eligibility criteria for the whole of Scotland would not serve them well. I understand where the carers are coming from and that there should be a focus on outcomes—the outcome that we want to achieve for individuals—but it would be counterproductive to try to find a one-size-fits-all approach for every community and individual in Scotland.

Paul Henderson (Perth and Kinross Council): I agree with those comments about local democracy and the fact that councils should be able to set their own criteria. We find that we are already making allowances for carers, particularly in the preventative approach that we are taking, and we would not want to have criteria that missed that out. Our approach is based on a locality model, in which we listen to the needs of local carers, and our fear would be that a single set of criteria would drive that away.

Alison Jarvis (NHS Lothian): I can see both sides of the argument. I understand what people are saying; although variation is good, a degree of consistency, too, can be important. I understand where both the carers organisations and COSLA are coming from, and I could be persuaded either way.

Beth Hall (Convention of Scottish Local Authorities): I understand the concern about the need for consistency, but that can be addressed through being consistently transparent about how eligibility is approached. In the context of finite resources and demand that will always outstrip the available resource, there must be some way of deciding who gets what and of prioritising and targeting resources. That needs to be done locally, because demand varies not just between councils but within council areas and over time. It is constantly fluctuating.

As a result, councils need to be able to adjust eligibility criteria at a local level in order to manage demand. As David O'Neill has said, that is how we get the best fit between demand and provision and is the best way of ensuring that resources are used flexibly to meet outcomes. Trying to do that at a national level would be like using a much blunter tool, and it is not the best way of getting the most flexibility and the best outcomes for individual carers.

Penny Nowell (Dumfries and Galloway Council): Like Alison Jarvis, I can see the carers' point of view, but I also fully endorse what my colleagues have said about councils needing flexibility. Dumfries and Galloway is a very rural region and we need to be able to flex to take that rurality into account. A lot of people who are retiring to the region do not have family connections and so on, and we need to find ways of supporting those carers, depending on priority of need.

Nanette Milne: I, too, can see both sides of the argument. Personally, I think that, not just in this but in lots of fields, decisions are often best made at as local a level as possible. That said, although it is a cliché, I understand the concerns about the postcode lottery that quite a lot of carers have expressed. They are appreciably concerned about that.

Penny Nowell: In the past few years, authorities and health boards have seen the implementation of the national carers strategy and the carers information strategy. In Dumfries and Galloway, quite a lot of services are accessible to all carers; there is information and support on specific conditions such as dementia and other mental health conditions, and there is generic region-wide support. That situation will not change.

Paul Henderson: I agree with that. From a practical—and a value—point of view, I think that, because we are supporting more older people in the community for longer, we are, by necessity, having to support more carers. We are doing that already, and we are addressing carers' needs in a more preventative way, because, in the majority of cases, they are the people who are keeping people in the community for longer. As I have said, we are already going down that route out of necessity.

Councillor O'Neill: We have been going down the self-directed care road for the past while now. If we do something that specifies a particular part of a service for the service users for whom we are trying to provide, that kind of contradicts what we are doing with self-directed care, the purpose of which is to give people flexibility and decision-making powers.

The Convener: We have a couple of supplementary questions on that area.

Dennis Robertson: On flexibility, my understanding is that even if there are national criteria, there will still be some flexibility to ensure that areas such as Dumfries and Galloway or, indeed, my constituency of Aberdeenshire West are covered. However, I have a problem with the local aspect. Having worked in social care for more than 30 years, I am aware of the restriction of resources. With regard to outcomes and prevention, which has just been mentioned, my concern is that the bar gets raised too high. That is what has been happening in local authorities for years; when the needs increase and you have less resource to meet them, you raise the bar. However, if you raise the bar too high, people do not get a service, and we need some assurance that we are providing a level playing field across all authorities to ensure that we are meeting carers' demands.

The Convener: What we are picking up is that in some areas eligibility criteria are being used to manage diminishing resources.

Dennis Robertson: That is what I am getting at, convener.

Councillor O'Neill: I understand where people are coming from on that. Our support for carers operates according to local needs, but if you set nationally agreed criteria, some people will get a lesser service than they currently get. Local authorities have, in conjunction with service users, been able to design services that are suitable for them, but if there are national criteria, they might have to impose something less suitable.

Dennis Robertson: Nonsense.

Councillor O'Neill: No, it is not nonsense.

The Convener: I am not having heckling, Dennis—not even from you.

Dennis Robertson: I was following up on my question, convener.

The Convener: I heard a wee shout there—we are not having that. Other people want to contribute to this discussion; indeed, I see Bob Doris, Mike MacKenzie and Rhoda Grant. If you want to ask a follow-up question, I ask that, first of all, we get a response to your previous question from the panel.

David O'Neill has already responded. Does anyone else wish to?

Paul Henderson: Following on from my last comment, I make it clear that this is about a preventative approach. We are now supporting people who you might say had fallen outside the community care eligibility criteria, and we recognise that if we do not put preventative services in place now, we will end up having to provide more crisis support later. That is a key factor, particularly in relation to supporting carers. What we are finding is that, if we do not put the support in place now, it has to come in later as crisis support, which requires more costly services.

Beth Hall: Going back to the national criteria and where the bar should be set, I think that if you have national eligibility criteria that guarantee that carers' needs above a moderate level, or whatever the level might be, will be met, it becomes necessary to meet any increase in demand by shifting resource from other social care groups in order to maintain the absolute bar or level that has been set for one particular group—in this case, the carers. I think that that was what David O'Neill was trying to highlight. Within the context of finite resources, protecting provision at one end means that resources have to come from somewhere else when demand increases. That brings me back to my earlier point about the need to be able to respond to the fact that demand fluctuates. Let us face it: we are all dealing with a situation in which resources are finite.

The Convener: I call Bob Doris.

Bob Doris: I did not realise that I was going to get in so early, convener. That is good.

I am sure that it is not deliberate, but I wonder whether we are conflating eligibility criteria with locally provided resource. For example, it has been decided nationally that any young person at primary school who stays three miles away from their school must get a bus pass. However, some local authorities have decided to provide a pass to young people who stay two miles away, and there is a cost implication to that. What is the panel's view of the notion of eligibility criteria that are set nationally in consultation with COSLA and other local authorities and stakeholders to identify the carers who should definitely be provided with a service? Local authorities can then prioritise at a local level if they so choose and have local discretion to give added value to that.

I have to say that I am picking up resistance to any direction at all from the centre. Given that, as MSPs, we get the phrase "postcode lottery" thrown at us all the time, we expect national standards on, for example, who pays prescription charges. In that case, it has been decided at a national level that nobody pays, but I have not heard anyone say that the fact that one part of the country cannot decide whether to charge for prescriptions goes against local democracy.

In the context of eligibility criteria that were nationally set and consulted on, the question would be about who qualified for support rather than what that support would be. There would be a permissive power to allow local authorities to go further if they wished. I understand the financial pressures that local authorities are under, but the carers whom I represent will see a defensive approach from the witnesses here this morning. In the spirit of the way in which I am asking my question—that is, in terms of certain key benchmarks that we can all agree nationally for carers, irrespective of whether they live in an urban or rural area, and without saying what the localised manifestation of that support would be—can you at least concede that we should perhaps consider some form of national eligibility criteria and then a permissive power for local authorities to go further if they wish? We would not be stipulating the service that you had to deliver, just putting in place some sort of gateway mechanism to ensure that carers, irrespective of where they were in the country, got a degree of service.

Councillor O'Neill: My understanding of the bill is that it sets out a duty; indeed, it is prescriptive even to the extent that it includes what would normally be covered in guidance. As a result, it will remove flexibility; it is seeking to design a one-size-fits-all service, and we do not think that that is a particularly good way to go for individuals. Services have to be designed to suit the individual and cannot be one size fits all. If there were to be legislation that prescribed the strategic outcomes, that would be fine, but, as I understand it, the bill as it currently stands is prescriptive.

11:30

Beth Hall: Expanding on that, I think that there is a bigger issue about democratic accountability with regard to use of resources. Prescription charges, for example, are not dealt with at local level, whereas social care is the responsibility of local authorities, which have to be democratically accountable for the resources that they invest in that respect. Part of that accountability and responsibility means coming up with a way to decide who gets what when there is a finite amount of resource. If the committee is picking up a theme about that needing to happen at a local level, what is probably underpinning it is the fact that, as I have said, social care is the responsibility of local authorities. The other issue is that moving away from that model of democratic accountability for the use of resources—and setting aside for the moment what that means for councils—means that one group of people who use social care services will have nationally defined entitlement while another will have locally defined entitlement.

It would be useful to be clear what we are talking about. When we talk about eligibility, we are talking about an eligibility framework that consists of eligibility criteria and eligibility thresholds. Those are two different things, and the distinction is quite important. The criteria are about how we categorise need; because that needs to be transparent, we categorise it as critical, substantial and moderate. In a sense, that system already operates at a national level, in as much as we have national eligibility criteria that can be used. As for thresholds, they are about deciding at what level those needs will call for the provision of services. From a local authority perspective, the difference between the two is very important, and we are saying that eligibility thresholds need to be set locally.

It is not entirely clear in the bill what is meant by the term "eligibility criteria". We would understand that to mean how we categorise need, rather than the thresholds that we use to decide whether someone is eligible for a service. There is a lot in there and if, in our responses, we seem to be coming down on both sides or are perhaps not being clear, that might be why.

Paul Henderson: I do not want to appear defensive; we are very supportive of carers and wish to support them more. As Beth Hall has said, it is important to clarify what is meant by "eligibility criteria". For example, there are national eligibility criteria for adult care, but within those criteria, councils can set the thresholds. For us, the issue is the permission to set the thresholds rather than what we have to provide being fixed at a national level. It is important that councils have the local accountability to set their own thresholds.

Penny Nowell: Again, I am sorry if we appear defensive, but our social work departments are struggling to balance the books in order to deliver a range of services to meet very diverse needs.

I have spent a lot of time trying to model what kind of costs we are looking at. I know that that takes us further than eligibility criteria, but that process is really challenging because, even in a relatively small authority like Dumfries and Galloway, we do not know all the carers who identified themselves as carers in the last census. We do not think that that is relevant—or rather, we do not think that the census is accurate, because we have identified even more carers through other means. If we do not even know the figures, it is hard to model these things and come to some idea of the kinds of costs that we are looking at.

Bob Doris: I will not reply on that point, as it is a separate question and, as the convener pointed out, I was asking a supplementary.

I thank Ms Hall and Mr Henderson in particular for giving a bit of light and shade to the discussion about national eligibility criteria. The bill says "may" rather than "must", but there is more discussion to be had about what those might look like.

Rhoda Grant: I want to go into the financial aspects of this. There seems to be an issue about how you gauge the criteria. COSLA's submission points out that the financial memorandum uses the figure of £300 for a short break, although COSLA's estimate of the average cost is closer to £967. There will be a whole range of figures depending on where someone lives in the country. Given that we are not sure how many carers will be eligible or what costs are to be accrued, have councils done any work on what the costs will be? Some of the services are already being provided to carers, so surely there must be an idea of costs, using the census and other work. Also, the bill is not based on every carer being covered from day 1, which concerns me, but is based on increasing percentages being covered going forward, so the costs will increase over time. Has any work been done on realistic costs or on where the financial memorandum might fall short? What work does the committee need to do when examining the bill?

Beth Hall: We have been working with our members, asking them for information on costs. We have shared that information with the Scottish Government, which has considered that, along with data provided by colleagues. As the committee will have gathered from COSLA's submission, we do not agree with the figures in the financial memorandum. There are three main reasons for that: we do not agree with the unit cost of assessment that is presented, we are concerned about the speed at which carers may come forward following the announcement of the new duties, and we are concerned about the total numbers.

On the unit cost of assessment, when we initially had discussions with the Government we were happy with the figure that was arrived at. We took information from councils, removed the outliers and looked at average costs and the figure came out at £176 per assessment. However, in the financial memorandum, £176 per assessment was presented not as the mid-point but as the top point, with other costs below that. We are concerned that that is not realistic and is not a reflection of our understanding of the costs.

Rhoda Grant spoke about carers not being covered immediately by the bill. In the sense that the duties of the bill would apply across all 759,000 of Scotland's carers from day 1, all carers will be covered immediately. We then find ourselves in the business of trying to figure out how many of those 759,000 people will come forward and how quickly. That is very difficult, as we recognised in our submission to the Finance Committee.

We looked at other areas of service provision where there is a universal entitlement—the bill will introduce a universal entitlement to a carer's assessment, although not all people will take that up. If you look at how demand built for free personal and nursing care, for example, you see that the rise was much sharper than is profiled in the financial memorandum to this bill, where the profile is low and slow.

Similar legislation has been introduced in England but has only just come into force. The Government had to revisit its impact assessment—the UK version of a financial memorandum—twice, to revise the figures up. That indicates that demand is coming through quicker than expected in England.

We are saying that there is a high risk that demand will outstrip the resource that is made available, as more carers come forward or as carers come forward more quickly. At the moment, all that risk lies with local authorities and with carers, as they will have increased expectations of what can be delivered.

You asked about the committee doing further work. Our further work has involved asking the Government to revisit the figures and agree with us a model for estimating costs. They cannot be certain; we just want to agree a model. We want to monitor the true cost of implementation and for the Scottish Government to fund any excess requirement, if demand exceeds capacity. That would be a more appropriate sharing of risk, but so far we have been unable to secure agreement to all that.

That was quite a long answer, but there are many unknowns and it is a difficult area.

Penny Nowell: In Dumfries and Galloway, we have tried to model some of the costs. We did an initial, basic version when we responded to the COSLA questionnaire back in January and I have revisited it a number of times since. When I discussed it with my colleagues in the third sector, they told me that I had forgotten to take into account the fact that we do not have the capacity in the third sector at the moment. That is a significant issue to take on board. Although we welcome the growth of the third sector in helping us to deliver support to carers, it obviously has its processes and so on to go through, which must be taken into consideration.

Paul Henderson: In Perth and Kinross, we have done some financial modelling, based on the stats that we have. Our unit cost for completing a carer's assessment came in at £215, which is much higher than the high-level cost that is presented. We asked a social worker how long it took to complete a carer's assessment and they said that it was a day and a half. The unit cost was a proportion of a social worker's salary, based on that figure.

We have concerns. We have approximately 3,600 registered carers, yet we know from the 2011 census that 13,000 people identified themselves as carers. We have extrapolated from that what we would need if every one of those 13,000 people needed a carer support plan, which is another £200,000.

We have been working on the care costs of providing respite or replacement care, although it is quite difficult to get a sense of what they would be. We are more concerned about the waiving of charges and how that is interpreted. Does that just include some form of respite care? Do you start looking at day care as a form of respite? That is one of our concerns on that area, although maybe that is going off the subject a bit.

The Convener: The question was a supplementary flowing from the question on eligibility criteria, so we will leave it at that. I will bring in Mike MacKenzie.

Mike MacKenzie: It is all right, convener. We have explored the area thoroughly.

The Convener: There is just one question that I would like to ask about the calculations of cost. Has any calculation been done on the benefits of proactive engagement with carers or the preventive benefits that might flow from early engagement with those carers who do not require anything at present, but who might do in future?

11:45

Paul Henderson: A cost benefit analysis of that has not been carried out, but in our plans, particularly when it comes to information and advice, we think that such preventative support would stop a crisis later on. We have not worked out an amount for that, but we know that it is something that we need to do. We support that element—it would help to provide information, support and advice early on—but we have not done any calculations about the extent to which that would alleviate things.

Penny Nowell: I did such a calculation—it was just a back-of-the-envelope calculation that involved thinking about how many carers we have in Dumfries and Galloway and knowing how many carers we have who care for more than 50 hours. An amazing number of care hours are being delivered every week. I came up with a staggering figure of millions of care hours per year. If that is translated into an overall cost using a basic unit cost of £18 an hour, it is a huge amount of money—even at £10 an hour, say, it is a huge amount. That is the amount of money that is being saved in health and social care provision. We undoubtedly all see working in partnership with carers as a vital element as we move forward with the delivery of health and social care.

Alison Jarvis: This point does not relate to the convener’s question, but in the discussion about preventative care the idea that there are small interventions that can make a big difference comes up time and again, not just with patient groups on long-term conditions but with carers. The concern is always that, if the focus is on the high end of caring or on the discussion about eligibility criteria, we will miss the opportunity for preventative interventions, whether in health or social care. If we think about the push towards preventive and anticipatory care, we must invest at such relatively low levels, because that will make a big difference.

Penny Nowell: A final point is that I have often found that if carers have the knowledge that support is available, they do not access it. At one point in my life, I was a carers support worker. I tried to encourage carers to come to mental health support groups, but I think that I used to meet more people in Tesco than I met at the carers support groups, because people would say things like, “I’ll come along when I need to—I’m sure you need to support someone else who has a greater level of need than I have at the moment.” People felt that that safety net was very important for them.

The Convener: Did COSLA do any work on the possible benefits of the bill in terms of early intervention or prevention?

Beth Hall: In common with Paul Henderson, we have not done a considered piece of work at national level to look at the financial benefits of those outcomes. That is quite complicated to do in a robust way; it involves looking at things such as social return on investment models. I think that all the work that underpinned the joint carers strategy and the joint young carers strategy took as a starting point consideration of how more preventative approaches could be maximised in the knowledge that that would take demand out of the system later on, which is better for everyone.

In addition to those two pieces of work, there was the work that was done on the change fund. Part of the change fund was to be used to improve support services for carers. The premise for that was that it was very much about shifting the balance of care and looking at much earlier intervention.

The Convener: Did local authorities achieve that with the change fund, or was that another case in which the money was used just to meet the current demand rather than to pursue the preventive aspect?

Beth Hall: No. I have not brought figures on the change fund today, but there was a focus on looking at and reporting on what that money went on and that is in the public domain. I am sorry that I cannot give you a summary read-out today, but the information is available.

Alison Jarvis: It is always difficult to cost something that has not happened, whether it is that someone did not go into hospital, or that their length of stay in hospital was shorter, or that there was not a complaint, or whatever. That is a problem with all preventative spending. A lot of the change fund spend was for things that did not happen, in a positive way. To cost that and show the benefit, or even to prove it, is always a huge challenge.

Paul Henderson: We estimate that most of the support we provide is not discretely provided for carers. It is provided for the service user or the client, usually in some form of day care, and invariably benefits the carer as well. We estimate that we spend approximately £800,000 on carers specifically, but we know that we support carers in many other ways with up to about £14 million for day care and so on.

It is quite hard to say that this particular amount is for the carer and this is for the service user or client. That is what made some of the financial modelling figures we were producing for the COSLA submission quite difficult. We had to try to extrapolate parts of spend. The amount that we spend for carers discretely is not all that we are providing for carers.

Bob Doris: I am interested in discussing finances.

Alison Jarvis talked about innovation, using money more cleverly and not allowing eligibility criteria, irrespective of where and how they are set, to squeeze out innovation.

A lot of carers are looking after elderly loved ones. We have health and social care integration, with integrated boards at the forefront now. I know that this is not specific to the bill, but I wonder whether there needs to be some reflection on the opportunities that that brings to have more early intervention for carers, using not just local authority cash but the whole gamut of cash that now comes on to the table from health and social care integration. Even some brief comments would be helpful, to get that on the record. Also, should there be some cognisance of the need to promote best practice, either in the bill or in the regulations that follow?

Alison Jarvis: It is always good to support innovation, it is always good to support early intervention and it is always good to support anticipatory care. The challenge is that resources get sucked into dealing with crisis care and the people who are most in need. That is a dilemma in all sorts of areas. It certainly is in healthcare.

Councillor O'Neill: The change funds have been useful, but some have been more useful than others. We have been more successful with some than others. As the convener hinted and Alison Jarvis has just said, when the aim is to disinvest from something to put resources into what the change fund has shown to be successful, a care crisis that comes along can be particularly difficult to handle. Should we nevertheless do it? Should we be doing more in the way of prevention? Absolutely.

Beth Hall: I could not agree more about harnessing the resources of a wider range of services and using the opportunities that are afforded us through integration. There is a lot that can still be done to use resources in a smarter way. We know that there are challenges around eligibility and finite resources.

We were keen to see greater consideration of self-directed support approaches in a health context. The needs of someone who is in receipt of services under integration should not have to be categorised into social care needs, with flexibility through the self-directed support option, and healthcare needs, where SDS does not apply.

When the Social Care (Self-directed Support) (Scotland) Act 2013 was going through Parliament, COSLA made a case for that duty to be extended to the NHS. That did not happen, but that does not mean that further work could not be done through guidance and through future bits of legislation harnessing those opportunities. One of the things that we have learned, which underpins self-directed support, is that sometimes a carer is accessing a very expensive service that is not actually the best way of meeting their needs and that, if you give the carer a personal budget, their outcomes will be met in a far more innovative way than we have managed previously.

Paul Henderson: There are lots of examples of using the change fund and the integrated care fund to provide preventative services. We have set up carers cafes and dementia cafes. There are carers workers in the hospital to support that part of the discharge. More recently, we have developed carers support workers to be part of an integrated care team, particularly to identify people earlier, before they are in crisis. We put in respite and replacement care before they end up in crisis, because crisis breakdowns cost us huge amounts of money.

Alison Jarvis: And they cause the carer distress.

Paul Henderson: Absolutely.

Bob Doris: I will not follow up on self-directed support. It has not worked well at a local level in Glasgow. I will not indulge myself by telling you why I do not think that it has worked well in the slightest—it has withdrawn choice from a lot of vulnerable people whom I represent. Is there an opportunity for the bill, as scrutinised and amended, to focus the mind of the new integration boards more than might happen otherwise by using wider moneys to support carers to do some of that preventative work? You do not have to answer that—it is up to you.

Penny Nowell: I would support that. It was disappointing to see something that was mostly targeted at a duty on local authorities just as we were about to get into the discussions and work around developing strategic plans and locality plans. I am pleased that carers are being considered—they are being considered in Dumfries and Galloway—but it would be good to see that beefed up a bit more in the legislation.

The Convener: Dennis, will you help me out by pursuing the questions that you have been asking about getting it right for every child and young carers?

Dennis Robertson: Yes. I will explore the setting out of a duty to undertake appropriate assessments. Is the current legislative framework adequate or do we need to improve it for our young carers?

Beth Hall: Our approach has always been to say that young carers need to be treated as children and young people first and as carers second. It is important that young carers have the same right to have their outcomes met as other children and young people have.

We have a concern about how what is set out in the bill fits with GIRFEC and its outcomes approach. Having a separate young carer statement will mean that a young person has two parallel plans, which will have an impact on holistic planning and co-ordination of support—everything that GIRFEC is trying to achieve. There is a risk that young carers will be put in silos and that there will be a subset of needs that is treated differently.

If the decision is made to proceed with introducing the young carer statement, we would like the statement to be part of the child's plan when one is in place. We should not go down the road of having separate plans for subsets of needs.

That also raises the question whether, if there is a separate plan for young carers, there should be a separate plan for young people with disabilities or from black and minority ethnic communities. A separate plan would run counter to the policy direction, which is about focusing on outcomes for children and young people and ensuring that those are delivered, irrespective of the needs that give rise to them. That is where our thoughts are at present.

12:00

Alison Jarvis: It is important that we think about the transition from young carer to adult carer. The transition points are always tricky, but they present an opportunity, too. We should consider how the transition process works for someone who is moving away from being a child under the GIRFEC strategy. It is important that we pick that up.

Penny Nowell: To draw on that point, some of the feedback that I have had from carers centres has focused on the value of the young carer statement as the person moves towards becoming a young adult carer. However, I have also had feedback suggesting that terminology such as "statement" feels a bit official—like a police statement, for example—whereas the GIRFEC plan is perhaps less controversial.

Dennis Robertson: Would having a statement in place highlight the fact that someone has a lead or key worker? That could be achieved through GIRFEC, but having a young carer statement in place would facilitate a process that is not currently provided for and would perhaps help with the transition period. Do you agree?

Beth Hall: The key point is that the provision for such a lead is not in place. Our concern relates to the fact that a major new piece of legislation, the Children and Young People (Scotland) Act 2014, will come into force in August next year. It will require a named person for every child and a clear focus on ensuring that the child is safe, healthy, achieving, nurtured, active, respected, responsible and included, according to the SHANARRI outcomes. That leads us to question whether a separate bill is needed, given that it will be passed just before the 2014 act, which will cover that area, comes into force. That runs the risk of confusing the situation and making co-ordinated planning for young people more difficult.

Rhoda Grant: Convener, I have a supplementary question and a substantive question. Can I ask both?

The Convener: Yes.

Rhoda Grant: A point has been raised about how the named person requirement and the child's plan will interact with the young carer statement. According to some of the evidence that we have received, young carers are reluctant to have the statement shared with their named person, especially if they are caring for someone with drug and alcohol problems. They are not clear that they would want that information to be known—for example, by their school headteacher. That would depend on how sympathetic a person might be on the issue.

If a young carer wanted their information to be confidential, how would it be dealt with? Could services be set up to support someone and highlight to the named person that the young person is a young carer—that is important in a school setting so that adjustments can be made to allow the young person to benefit from education—while not including or passing on some of the more personal aspects of that caring role?

Beth Hall: The key point is that the child or young person should be in control of the information and of which details are shared with whom. I am sure that the witnesses who will give evidence in the next session will go into how that all plays out with regard to the 2014 act.

The quick answer to your question is that, irrespective of whether we have a separate young carer statement, the approach to the named person and the child's plan and the way in which information is shared among the professionals involved should be predicated on involving the child or young person in deciding what information is shared with whom.

Rhoda Grant: My other question is about information and advice services. I have spoken to groups of carers and I know that some services have been set up in an ad hoc way by people who have been carers and have noted a lack of information and advice for carers in their communities. A number of organisations in the third sector provide such services, but there is a concern that, because the bill places a duty on local authorities, they will bring all that work in house and some of the good local knowledge will be lost.

I am looking for a bit of comfort for those organisations. I feel that, if those services are out there, it is for local authorities to support and develop them to ensure that they provide the services that the bill requires. Will you give me some thoughts on that?

Paul Henderson: When we in Perth and Kinross Council have consulted carers locally, information and advice has come up again and again. In response, we are commissioning an information and advice service from the independent sector. We do not necessarily see such a service as lying only within the local authority, but nor do we have independent sector services that are doing that work. We are commissioning a special service to ensure that we provide that information and advice. It will not be a local authority service; it will be a partnership.

Penny Nowell: Ensuring that carers get the right information and advice at the right time is a challenge. We, too, commission the third sector to deliver that. Through the carer aware training that the third, independent and statutory sectors are delivering—we are starting to deliver it to people such as hairdressers—we are trying to make everyone aware of where they can signpost people to. Unfortunately, that will always be an on-going challenge. We find that, particularly in rural areas, people can be caring for a long time before they find out that a simple service is available. I hope that the adult support plans will help to benefit carers in that way.

Councillor O'Neill: The public sector does not have a monopoly on wisdom or knowledge. If somebody out there, such as in the third sector, knows what they are talking about, let us use them.

Paul Henderson: We have good evidence that lots of carers out there do not realise that they are carers or what services there are. I mentioned information and advice services, which there are not enough of, given what we need to do.

Another issue is people declining carer assessments. We have about 625 carers a year declining a carer assessment when the client is assessed. Why is that? It might relate partly to information and training for social workers, but it is not enough just to provide an information and advice service. We need to do a lot more among our workforce and the public to raise awareness of carer issues.

Alison Jarvis: There is so much information and advice out there, so we should not reinvent the wheel. Whether the provider is NHS 24, NHS inform or local services, the information and advice needs to be gathered in one central place so that people know where to find it, and people need to be signposted. Often, the information is out there, but people do not know where to look for it or, as Paul Henderson said, they do not realise that they are a carer and that there is information and support that would make a difference to them.

The Convener: Alison, you are representing the national health service. What is its role and what part does it play? There are critical points for the identification of carers that the committee has heard about lots of times, which involve discharge policy and unplanned admission to hospital. Does that identification happen, should it happen and what responsibility should the national health service have for identifying carers and informing them at that point?

Alison Jarvis: The health service has a huge responsibility, which we have touched on a bit. The issue is hugely complex. Some of it concerns self-awareness and ensuring that staff make the most of opportune moments to identify carers, because people often do not realise that they are carers.

I draw the committee's attention to research that was done with primary care and carers of people who are at the end of life or who have advanced illness. We would think that that group of carers would be easy to identify and that those people would see themselves as carers.

However, in a relatively small study that was done in Edinburgh, there were three main barriers to identifying carers. One was that becoming a carer is often a gradual process. That is true for lots of illnesses, such as lung cancer, dementia and so on; there are not many situations such as a stroke when people are catapulted into a caring role. More often the process is gradual, and people do not appreciate that they are carers until they are quite far down the line. Often as the cared-for person's condition deteriorates, the caring role becomes so engulfing that the carer can no longer separate out their needs as a carer from those in looking after the cared-for person.

Another issue is legitimacy. There is ambiguity about the legitimacy of the carer's needs not only in the carer's mind but in the professional's mind. General practitioners and hospital staff often think that their focus has to be on the care recipient. Lots of work has been done in NHS Lothian and in other board areas on staff awareness training, but sometimes we focus only on the cared-for person. Carers are so focused on the cared-for person that there is a need to be explicit about the legitimacy of carers' needs.

It is assumed that, if we open up a universal right, huge numbers of carers will self-identify. That fairly small study showed that the vast majority of people who were identified as carers did not self-identify; they were identified through opportunistic conversations with a range of people in a practice, such as reception staff, GPs and nurses. People are often hesitant to identify themselves as carers.

There is a lot of work to be done on staff awareness and confidence. Sometimes people do not ask because they are anxious about opening up a Pandora's box of needs and service demand that cannot be met. However, that should not be the case; often what is needed is just a recognition and a validation of what carers are doing, rather than large service inputs.

The Convener: I will bring in the local authorities. There is a big responsibility for all this on the national health service. Does it fulfil that responsibility? Can I provoke a response?

For instance, as an anecdote, I arrived at a situation where emergency services had been called. If I had not been there that day, that relative would have gone into hospital. The presence of a carer and the reassurance that it gave prevented the hospital admission; the precautionary, default position was that that 88-year-old person would have gone into hospital that day as a result of a fall in the house.

The role of carers relates to notification of admission to hospital and discharge from hospital. Whether we are working effectively with that role and whether the bill will encourage doing so is the wider question today.

Councillor O'Neill: I thought that you were asking me to have a fight with the NHS.

The Convener: I thought that I would liven the session up—we have only about five minutes left anyway.

Councillor O'Neill: In the past we have been particularly poor at joined-up working. Health and social care integration is absolutely the right thing to do. I think that five pilots have been running for about seven years. In my neck of the woods—Ayrshire—the health and social care partnerships are up and running, and the rest of Scotland is coming along. That will go an awful long way to addressing a lot of the issues.

Should attention be paid to the role of carers in health and social care integration? Absolutely, because carers play a vital role. There is recognition of the amount of money that is saved in the public sector because of the role of carers, and they deserve to get our support in return.

12:15

Penny Nowell: I will come in on the back of what Alison Jarvis said. We find that carers might be told about the support, information and advice that they can get and where they can access that, but they often move forward with it only when they are told about it by another carer or by a professional such as a GP or primary care worker. We tend to forget about the influence of those people in motivating people to lift the phone and make the initial contact. For a carer in the middle of the complexities of life generally and with caring responsibilities on top of that, finding the time to do something as simple as lifting the phone can be challenging. Integration needs to have a far greater role in the bill to bring all those things together.

Paul Henderson: Locally, the health service supports carers, particularly through the change fund. For example, we had health check workers for carers and we had a care support worker, as I previously mentioned, who was based in our local hospital and did fantastic preventative work. From our point of view, it would be great if there was more of a health presence in the bill, because it seems to be almost purely focused on the local authority, which jars with the integration agenda, as has been mentioned.

Penny Nowell: Under the change fund we, too, offered carers across the region a health and wellbeing check, followed by mentoring support if it was identified that they needed extra support on things that would help their health and wellbeing, such as losing weight or stopping smoking. Unfortunately, that support came to an end when the funding from the change fund ran out.

It is the role of primary care to give such support, because carers are also patients of GPs. That support could have been picked up by primary care but we have failed—in Dumfries and Galloway, anyway—to follow that through, at least at the moment.

Beth Hall: I will flip that on its head for a second. Rather than ask what we would have liked to see in the bill as duties on health boards or the direction on health, we should think about our ambitions for integration authorities to result in more flexible and better integrated services, improved locality planning and the delivery of greater involvement for communities in how services are shaped locally.

COSLA's response outlined key concerns about where we think that the bill is too prescriptive and restrictive. For example, although duties will be placed on local authorities, the services will be very much devolved. We have concerns about that on behalf of health as an integration partner.

To flip the issue on its head, we see integration authorities as the way to drive forward improvements for carers. We outlined in our submission concerns about there being too much prescription of processes and inputs and not enough focus on outcomes—that applies to health, too.

Dennis Robertson: I have a question for all the witnesses. The bill places a duty on local authorities to have an information and advice service for carers, rather than local authorities just being able to establish one. Would an information and advice service provide opportunities for carers and others to take up available resources? Should there be a duty to establish an information and advice service?

The Convener: Can we widen that question? We discussed advice earlier. As well as the issue of resources, there is the question of how capacity would be affected by such a responsibility. We have been through the money thing. We will argue that we do not get enough from Westminster; you will argue that you do not get enough from the Scottish Government. That negotiation will take place somewhere other than in the committee.

Will we be able to deliver on the expectations that such a requirement will create, given the capacity issues that exist? Dennis Robertson mentioned access to good independent advice, but there are also the assessments that will need to be carried out and the increase in the number of people who will be involved. What calculations have been done on the capacity issues and whether the bill's ambition will be delivered? When it comes to outcomes, how will a duty to provide information and advice make a difference to individuals?

Beth Hall: Local authorities already have information and advice duties under the Social Care (Self-directed Support) (Scotland) Act 2013, which also apply to carers. We recognise that we need to get better at providing information and advice, but we are not sure that the bill needs to layer additional duties on top of the duties under the 2013 act.

Greater investment in information and advice will make things better. It is a case of ensuring that the information and advice is accessible for a range of groups. We were surprised that additional duties on information and advice were included in the bill, for the reasons that I have outlined.

Paul Henderson: Information and advice is already dealt with in the national carers strategy. As I mentioned, at local level carers tell us again and again that they want an information and advice service, which is why we have commissioned one. They say that they want a single telephone number and a single website that they can use to get information. We feel that that is already part of our strategic objectives. Providing information and advice is essential to meeting the need for a preventative approach. That is part of our plans, and I am not sure whether a duty is needed, because that is already a strategic objective.

Dennis Robertson: Is the point that we have an information and advice service in some places but not in others? In the places that have it, it is working well, because there is a hub or a one-stop shop, but other areas have no such facility. Paul Henderson has identified good practice, but that good practice might not be replicated in other areas.

Alison Jarvis: Perhaps the committee has a biased sample here. A desire on the part of carers for information and advice comes up regularly. As I said, the information and advice might be out there, but people do not always find it.

The Convener: As there are no other questions from the committee, I thank the panellists for attending. I am sorry for the delay in starting. We have your written evidence, which is clear and will assist us in our deliberations. Thank you for joining us.

12:23

Meeting suspended.

12:30

On resuming—

The Convener: We have delayed our second panel of witnesses on the Carers (Scotland) Bill long enough. I welcome Trisha Hall, social worker and manager, Scottish Association of Social Workers; David Formstone, convener of the community care standing committee, Social Work Scotland; Fred Beckett, north-east social work carer team manager, Glasgow City Council social work services; and Tam Baillie, Scotland's

Commissioner for Children and Young People. We will move directly to questions.

Rhoda Grant: The bill talks about young carers and about removing the caring role from pre-school children. Is that the right approach? Is it possible to do it, and should it cover children who are in school as well as pre-school children?

Tam Baillie (Scotland's Commissioner for Children and Young People): I absolutely agree that it is the right approach. For children who are under school age, we have to approach this from the point of view that they are children first and carers second. There should be no acceptance of very young children, in particular, having a caring role. It may be that they can make a contribution, but I really do not think that it is feasible for them to have a caring role. Even for children above that age, we have to strike a balance between the child's capacity and our expectations in relation to their caring role.

That is not to say that caring is always burdensome. Children sometimes thrive in caring situations, which can give them a sense of responsibility, but we have to make sure that they have a childhood. One of the complaints of children who are young carers is that they do not get recognition and, as a result, do not receive support. We have witnessed many children quite literally being deprived of their childhood because of overbearing caring responsibilities. If the bill does nothing else, it will help to redress that balance, which too often is stacked too much towards our expectations of the child in their caring role.

David Formstone (Social Work Scotland): I agree. Particularly for younger children, there is a risk of formalising the caring role and almost placing a formal responsibility on them for their parent. An older carer may be able and willing to take on that responsibility but, particularly where there may be protection issues, there is a conflict there. Certainly, it is not desirable for younger children to have that caring role.

Trisha Hall (Scottish Association of Social Workers): I absolutely agree that it is not acceptable for children to be working. The law is really clear that children under the age of 13 are not allowed to work in private enterprise or anything like that, and we should not accept them working in any other way.

By the same token, this is about making a sympathetic assessment of what is needed so that a child deemed to be in need does not become a child at risk. We need to be clear about the support systems that we are putting in. I hope that the bill will lead to people seeking support in situations in which they might have been wary about doing so previously for fear of getting an assessment that might have ended up with their child being taken away. The message has to be very clear that that is not going to be the case and that we are trying very hard to put in support mechanisms so that a child can have a childhood.

Fred Beckett (Glasgow City Council): I absolutely agree with that. Having a child who is below school age take on a caring role is a sad indictment of our society; we should do everything that we can to alleviate that caring role and give that child a childhood.

Rhoda Grant: You will be aware of comments from previous witnesses about the young carer statement and the child's plan. The committee heard concerns from representatives of young carers groups about confidentiality and the child's willingness to have their young carer statement shared with their named person. The child might have concerns, for various reasons, about the named person knowing that information.

Where should the line be drawn? Can the statement and the plan interact? Is there a need for two separate plans, or should there be just one? How can we best support young carers?

Trisha Hall: It is about developing a relationship and making it clear that information should be shared with—we would hope—the consent of the young carer. If there is no consent, the information should be shared only if it is deemed that the young person may be at risk. There are very clear guidelines on that.

David Formstone: It is clear that there will be a use for both the plan and the statement. For example, where a child does not have a child's plan and is primarily a young carer, they will have only a young carer statement. Where there is an overlap and the child is thought to be in need or at risk, we would be concerned about the existence of parallel plans.

The point about confidentiality was made earlier. Keeping the child at the centre and consulting them is really important, but there will be occasions on which there will be a need to share information. For example, if there were concerns about a parent with drug or alcohol issues, and that information was being kept by one social worker as part of a carer statement but was not known to the named person or the lead professional under the GIRFEC arrangements, that would certainly carry risks. We would have to share with the child the need to breach confidentiality to ensure that the information was known to the named person and other people with a responsibility for protecting that child. Protection should be paramount.

Tam Baillie: The issue is tricky. The named person provision is central to new legislation—the Children and Young People (Scotland) Act 2014—

which is about to come into force. As I understand it, under the bill, the issues for young carers will be highlighted through the young carer statement, but the whole purpose of the 2014 act was to take us down the route of having a single plan.

For children who have a child’s plan in place, that is fine—we can include the young carer statement as part of that. However, a much bigger group of children will have a young carer statement, and I am puzzled about where that sits in the overall legislative landscape.

Rhoda Grant has asked a tough question with regard to information sharing. The information-sharing provision in the 2014 act takes a rather light-touch approach—as does the guidance—to the question of which information should be shared and which should not be shared. Practice on that will develop, but there is a light touch because so much comes down to the judgment of the people who hold the information and who, on the basis of wellbeing, are expected—or, rather, are under a duty—to pass it on.

I checked the advice in the latest guidance on the parts of the 2014 act that contain the named person and child’s plan provisions. There are only two mentions of young carers, and both of those are examples. In fact, in the section of the guidance on the child’s plan, there is no mention of young carers. The bill may highlight that there is a gap in the considerations that go into developing a child’s plan. The issue is not just with the bill, but with the 2014 act, which is just about to come into force.

I am absolutely behind the notion of shining a brighter light on young carers, but, because of the all-encompassing nature of the 2014 act, we have to think carefully about how future legislation maps on to that landscape, especially as we are just at the start of that process.

There are a lot of issues to be sorted with regard to the named person. I support the named person, but it presents challenges when there is a desire—as there is in the bill—to focus on a group of children who have specific needs, such as young carers.

The Convener: Does anyone have comments on what Tam Baillie has said?

Fred Beckett: On implementing the approach in practice, in Glasgow we are working hand in hand with the education service on that service having the child’s plan. We currently have a young carer’s assessment, but we will match the SHANARRI and GIRFEC indicators so that we build on the assessment in relation to the caring role.

Currently, we are looking to share information with the named person, whether they come to us first or come through education. We have issues around confidentiality and how we support young people—obviously, there is a tie-in with child protection.

We are concerned about duplication, although we think that GIRFEC is the way ahead and that we should be working hand in hand with schools, which are ideally placed to identify young carers. We have not got to the minutiae of how we can share the information—we will be guided on that—but clearly the direction of travel is for us to work hand in hand with the education service, and to base that work around the child’s plan.

Dennis Robertson: I will pursue the point. You mention integration with the education service, but there is also integration involving child and adolescent mental health services, given that we are looking at local authority and health board integration. Do you think that, through the young carer statement, the bill will help children who come to the attention of CAMHS because of issues around caring?

Tam Baillie: I would go wider than just CAMHS. Essentially, any service that deals with adults but with which children are involved, such as those that deal with drugs, alcohol or substance misuse, mental ill health or disability, should consider the needs of children.

Most often, the issue of information sharing has come up in tragic situations where there have been child protection issues, but there is also the question whether a child is taking on any caring responsibilities and whether that is appropriate given their age and stage of maturity. Should we be making sure that those children have the necessary support?

Identification is principally done through schools and through GPs and health services, but specialist services that deal with some of our most vulnerable families may well become aware of children who are living in such situations and who are in need of protective measures or additional support. Children who are identified as young carers can be in some quite difficult situations.

The bill will help attune people to asking whether a child is assuming caring responsibilities, whether that is appropriate and what support should be put into that family, not just for the adult who requires support, but in the best interests of any child who is living in that situation, in order to meet their needs.

To that extent, the bill will help, because it will make people much more aware of what we think is a huge number of children who are not being identified right now.

Trisha Hall: I really struggled to get feedback from members of our association on the bill—that was partly because there has been so much new legislation this year on mental health, children and young people, self-directed support, public bodies and so on.

An example that stands out for me is that of the police, as the referring agency, recognising that a young person in a household is doing things that, in the police's view, they should not be doing. Three of our members raised different scenarios in which the police identified that something needed to be done. The strapline is that it is common sense to see that; how common sense relates to support mechanisms is another debate.

There is more recognition of young carers' issues now than there has been in previous years.

12:45

David Formstone: I echo Tam Baillie's point. With the integration of health and social care, in a number of authorities, including my own, children's services and adult services will be separated—they will essentially be two different organisations. I guess that the inclusion in the bill of a young carer statement and an adult statement should focus social workers' minds, whether they are working in children's teams or adult teams, when they come across children—or, indeed, adults—who have caring responsibilities. I certainly see the statements as a benefit of the bill.

Fred Beckett: The bill provides a significant opportunity for the future. Last year, we identified 300-odd young carers across Glasgow, through GP referrals, for example—predominantly, through the firefighting side of things. However, we do not see the most vulnerable children—the ones who are living with mental health issues or addiction. However, those children go to school. The Children and Young People (Scotland) Act 2014 and the bill give us an opportunity to pick up those children and do the preventative and anticipatory work, rather than the firefighting work. Dennis Robertson is absolutely right that, by the time they get to the CAMHS team, the children are very damaged and vulnerable. The bill gives us the biggest opportunity that we have had to get into schools—the key agency in a child's socialisation—so that we can look at them holistically and make a difference in their lives. We need to get this right, otherwise, 10 years from now we will still be doing traditional, firefighting social work. We know who the children are, and we know that they are vulnerable. We have a huge opportunity to get education on board and work in a preventative and anticipatory way to support them for the future.

Dr Simpson: I have a supplementary on Mr Beckett's point about cases in which the parents have addiction problems. Have any of you been consulted about the drug and alcohol information system—DAISy? Do you know about it? The current working group is examining the new data collection system for drug and alcohol addiction. I tried to design a system in 2007, but it has never been followed through—it was one in which the children's needs were looked at in the addiction services, so that that information could be transmitted properly.

Tam Baillie: Are you on the group?

Dr Simpson: No. Because I am a politician, I had to come off the whole thing. The group subsequently found a way to abandon the programme that I had got to the point of the development of a piece of software in 2007. The powers that be decided that, once I was out of the way, they would not continue it. Here we are, eight years later and still without a collective data collection system.

Tam Baillie: The committee could usefully write to DAISy to say that the issue of data collection has been raised and that there is an opportunity to at least flag it up as part of its consideration.

Dr Simpson: Yes—if you feel that that would be useful. Thank you.

The Convener: You see—it was worth waiting to give your evidence. Dr Simpson and Mr Baillie are a great double act. I invite responses from other panel members.

Trisha Hall: In a previous life, I worked for Aberlour Child Care Trust. We worked with a lot of substance abuse services and we started an evaluation study whereby we used the wellbeing indicators for the adults as well as for the children involved. We started following them over the years. Sadly, it was the usual story and we did not have enough funding and so on. The committee might want to look at measuring longer-term outcomes to see whether they are being achieved. We are very process driven. We keep coming up with new ideas and systems, but it would be really helpful if we also put in some of the measurements in order to state at the end of a period whether we have made a difference and to show the evidence and see the impact.

Members tell me that what really works for them is hearing about areas in which things are working. The integration of health and social care in the Highlands has gone a wee bit faster because it was the pathfinder area. Our members there have had more success—and perhaps more funding—than some other areas have had. People have found it useful to hear about what worked in the Highlands.

It is about not just measuring what works but sharing it by getting people together, rather than through another website, because nobody has time to read them anymore.

David Formstone: Certainly carers—or however they would define themselves—of people with drug and alcohol problems, whether they are parents, spouses or other family members, are a hidden carer group. They are less likely to receive formal community care services, such as home helps, day care or whatever. They may have occasional residential rehab admissions, but on the whole they are less known to social work departments and others. There is a need to raise their profile.

The Convener: I hesitate to return to the process, because I think that the committee agrees that we need to identify best practice, focus on outcomes and look at the role of prevention. However, we need to go back to the issue of process.

The earlier evidence session got quite heated around the question of identifying and supporting carers who are not identified and supported. Is there a capacity issue around such assessments of children and adults? The witnesses in that session questioned whether there was sufficient capacity. We anticipate that more carers will be identified and helped, which might prevent certain things from happening. However, given the pressure in the system, what capacity does social work in particular have to identify particular groups of carers who might be a lower priority in terms of what is currently being addressed? What will the impact of that be on capacity and, indeed, on outcomes for those who are a higher priority but will see some capacity drift away from them?

Tam Baillie: I will answer the question about identification, because I think that my colleagues can answer the question about capacity.

For the past five years, I have had the privilege of attending the young carers festival. The messages from young carers are quite mixed—on the one hand, they want relevant people such as teachers to know about their caring role so that they can be sympathetic and give them some flexibility when it comes to expectations about homework production, or the time that they come into school; on the other hand, some young people say that it is their family’s business and they do not want people to know about it.

It is difficult to get the right balance. I would always advocate listening to the views of children and young people, but in this case their views on what they want to happen are quite mixed. We should err on the side of asking the question of the young person, so that we know at least who has a caring role. There is some doubt over how many young carers we have. I do not think that we will know the actual number until we start to ask young people more systematically about their caring responsibilities. That goes back to the awareness of those who work with them, such as those in schools, GPs or specialist workers who deal with the adults who are cared for. Through that, we will get a better idea of the numbers.

The Convener: How do they shift the resource that is dealing with the front-line? The house is burning down and if they leave that, given the resource capacity, to go and do assessments for people who have a lower priority, what happens?

Tam Baillie: We are talking about universal services, so they should be able to do that.

The Convener: Yes, but I am just asking the practitioners.

Fred Beckett: I have a Glasgow perspective on the issue, which I will just throw out to you. Capacity is not a new challenge for us; in 2009 we were inspected by the then Social Work Inspection Agency when we had done only 86 carers assessments, and its recommendation was that we must offer all carers an assessment. We then had to get our house in order.

To put our services in context, social work is in partnership with primary care, acute care and third sector carer centres. Over time, we have learned that we cannot look at the carers agenda in isolation but must see it in context, in that a person becomes a carer only when someone is diagnosed with a long-term condition. Around 10 years ago, we were looking for carers in the Tesco car park but now we go to the GPs and the acute sector hospitals and identify people by design rather than by accident.

In 2011, we launched a carers partnership and had challenges around capacity. We identified 3,200 new carers last year, but we did not identify the tens of thousands that we were expecting—a figure of 76,000 has been quoted in that regard. However, we started to identify people earlier—in GP surgeries and closer to diagnosis—and prevented them from getting into crisis situations.

Last year, 470 of our referrals came from primary care and 105 came from acute care. However, 72 per cent of our referrals came in early through our preventative red-amber-green eligibility system. On the challenges in responding to demand, a colleague in the voluntary sector described demand as a dripping tap rather than a flood, and I would adhere to that description. We responded to demand by providing anticipatory preventative services and creating a type of assessment that was level with the risk. We could not do a comprehensive, eight-page carers assessment for everyone, so we started screening assessments and delivering services in that way.

What we have learned, overwhelmingly, is that we can get caught up in the processes. We may have trained a social worker, but are we providing the right level of assessment? The feedback that we get from individuals who are accessing the service in a preventative way suggests that they are very happy with what they are getting, so we need to continue with that work.

The challenges in delivering services are nothing new to us. Carer assessments are an add-on to the traditional social work role, and they may be part of our work in conducting a single shared assessment. We are not expecting to do it all, but that way of working has helped us to rise to some of the challenges, and we will—I hope—not be seeing tens of thousands of people knocking on the door.

The point was made earlier about the need to work with the NHS in an integrated way. We need the NHS to tell us as soon as possible when someone is diagnosed with a long-term condition so that we can help and support that person in a preventative, anticipatory way. When we get that right, we avoid people getting to crisis point, and we deliver better outcomes in a way that is less resource intensive.

In the old days—10 years ago, for instance—people just turned up on their hands and knees to see the duty social work team. We have tried to turn that around, because we have better ways of delivering services.

David Formstone: As an association that represents senior social work managers, we are not in favour of having an unrestricted definition of carers, for reasons that I am sure have already been covered this morning.

First, there is the impact on practitioner time: the ability of practitioners carrying case loads to prioritise their work to deal with the people who are most in need and most at risk would be prejudiced. Notwithstanding the extra funding that might accompany the bill, it is unlikely in this day and age that local authorities will significantly increase the size of social work teams. They would be wary of creating new posts and permanent posts, so it is likely that social work teams will remain the same size. Social work time could be diverted away from pressing matters towards issues—albeit very important ones—concerning carers.

An accompanying issue concerns the diversion of scarce resources. Again, councils are currently dealing with budgets that are declining or staying at the same level. If we are talking about diverting resources not necessarily towards the cared-for person but for the benefit of the carer, that would, without any additional resources, be a second concern for us.

There is a slightly more conceptual point that relates to concern about universalising the caring role. There would potentially be quite a shift from private to public, with the carer role bringing carers into the social work net when there are other ways of dealing with the situation such as capacity building in the community, along with a much wider carers strategy. I can go into that point in more detail later: it is not just about improving social care, but about putting in place a range of other measures that will help carers to continue in their role.

Trisha Hall: People sometimes still go back to section 12(1) of the Social Work (Scotland) Act 1968, which places a duty on local authorities

> "to promote social welfare by making available advice, guidance and assistance on such a scale as may be appropriate for their area".

That legislation has never been repealed, although there are variations in new bills that have come to fruition.

I think that a lot of social workers still really want to work as change agents and community workers, as part of a hub working in the community. That is a culture change that we still need to promote as much as we can. There is nothing as damaging as individual social workers doing detailed assessments and identifying need, and then saying, "But we can't do anything about it, because we do not have the resources."

There must be a fine balance. If a need is identified, we need to be confident that we can meet that need. Glasgow is a good example of the way in which we do that. Other authorities have tried to have that conversation in order to move more towards a public health model, to be more preventative and to enable that culture change. Rather than making it the duty of certain professionals to do the work that needs to be done, those authorities have tried to make it something that resides in the community so that people in the community have a role to play. In that context, it is very important that we maintain some of the support mechanisms that already exist.

A young carer whom I knew used to go to the youth club. That was her time away—it really kept her going. The youth club is now closed, because there was no money. Such examples are very simple, but they are very important in this context.

13:00

The Convener: David Formstone mentioned wider support. Tam Baillie talked about how people see the role of the family and the extent to which they see caring as the family's business. I suppose that I am trying to get at what the balance should be between intrusion and support, in terms not simply of community capacity but of the family's capacity to care. How can we support that without being too intrusive, to the extent that we chase the carer away when the assessment shows that a carer should be there? We do not want to clash with any of that.

David Formstone: I absolutely agree. In case my comments were seen as negative, I should say that I think that there are a lot of positive aspects to the bill. My concern is about raised expectations. Carers might be drawn to come and ask for a support plan, but that might or might not be the appropriate avenue for them. I appreciate that the committee is concentrating on devolved powers around social care, but if we are to support carers properly, we must take into account all kinds of tax and welfare benefits, as well as access to further education and flexibility around employment; I am sure that the committee is well aware of all those matters. A national carers strategy needs to reflect all those things instead of being targeted at a particular profession, such as social work or health. It should not be a case of implementing support plans, regardless of whether that is what people are looking for; they might want better community-wide support.

Tam Baillie: There will be occasions when a child is part of a range of supports in the wider family network. There might well be no need for support that is additional to whatever role that child is playing, but there will be other occasions when there is a need for some additional support. I question whether that must always come through social work. A range of agencies could be involved with the family. There was quite a debate about the role of health services. There are voluntary sector organisations, and there might be specialist organisations that could play a role. I do not necessarily see the burden of support falling just on social work. We should use a range of organisations around a child to enable them to have the best family life that they can, whatever their circumstances.

Fred Beckett: We are learning a lot about the needs of carers. I keep going back to the long-term conditions. We have had nurses in our teams for some time. We can predict which conditions people will be diagnosed with that will have a high care burden—they include motor neurone disease, Parkinson’s and multiple sclerosis. There is a role to be played by the NHS. I was a social worker. If you walk into a health service and say, “Have you got any carers?”, you do not get very far, so we recruited nurses. As a result, we have had a massive increase in getting people identified earlier in primary care.

There is a role for the NHS to play as part of the standards of contract in identifying patients, supporting them and their carers, and providing specialist information about how to manage conditions. Social work does not have to do all that. There is a role for the NHS to play. It is already doing that, but perhaps that is not counted in however it looks at its services.

Equally, much of the information that the carers who come to us as part of the partnership want—we work hand in hand with Alzheimer Scotland and Chest Heart & Stroke Scotland—is about managing the condition. One of the biggest increases in demand in Glasgow is for training—people want to be shown how to move with assistance and how to manage conditions. Increasing that capacity does not all have to be down to the local authority or carers. We need to work with condition-specific services on the long-term conditions; I am talking about tier 1 self-supported care.

We do not always come with a bowl and say, “Give us more money”; we look at how we can provide that anticipatory support in a creative way across all the services out there and how we can get them to work together more effectively. Ideally, by doing that, we will deliver better outcomes for carers and the person whom they support; we will also shift the balance of care by reducing the numbers of falls, hospital admissions and accident and emergency appointments. That meets the strategic priorities as well as delivering on the better outcomes.

Bob Doris: Before I go on to my substantive questions, I will mirror what Mr Formstone said about the wider carer strategy, irrespective of where powers or responsibilities sit. I have been told by some carers that, for example, the carer’s allowance is £10 less a week than jobseekers allowance. It is often the case that carer’s allowance goes unclaimed because there is clawback from other benefits, and there is an underlying entitlement that passports a person on to other benefits. Therefore, we appreciate that the matter is more complex than just having young carer statements, adult carer support plans and the like.

My questions are on the young carer statement. My first question is just to get some brief information on the record. The bill says that, when a young person reaches the age of 18, if an adult carer support plan is not in place the young carer statement should stay valid and deal with the transitions. Is that desirable? Is that the correct way to go? Do you have any additional steer to give the committee or the Government on how to ensure that that works effectively?

Tam Baillie: Transitions are difficult for a whole range of aspects of children’s lives. Generally, we are very poor at the transition from children’s services to adult services. It is welcome that consideration is being given to how the young carer statement would somehow carry forward until such time as an adult carer statement is in place, if that is the right terminology. However, you would need to put a time limit on that.

The issue of when children move from child-focused services to adult services is worthy of consideration. We have exactly the same problems with additional support for learning when young people are leaving care and even when they are moving from education to employment. Those are difficult times for those young people. The proposal to continue a young carer statement in those circumstances is a modest one. It may help, but you may want to think about how long it should continue for. The expectation should be that an adult carer support plan is in place before a person's young carer statement ends.

David Formstone: It makes sense not to have a sudden cut-off at 18. One would assume that a young carer is caring for an adult. Therefore, if the adult is receiving services, those services will be in place and provided through adult social work teams. That aspect should therefore not be a problem.

The issue may be about how to support an 18 or 19-year-old meaningfully with their plan. That may have happened with their named person or children's social worker; moving into adult services, where social workers have a much higher number of client service users, the issue may be about whether a young person could be intensively supported for any length of time.

Fred Beckett: We are on new ground when children turn 18. In Glasgow, we have an integrated service, so we have adult workers working alongside young carer workers. The fundamental change is when a person hits 18. A person's caring role should be alleviated up to the age of 18; they should then be supported in their caring role when they are 18-plus.

Each circumstance is individual, and we would need to look at it. Where we have had young people who were detrimentally affected by their caring role, we have looked at self-directed support. For example, it is not appropriate for children with parents with MS to be taking on moving with assistance or a personal caring role. Therefore, we have supported those children to return to school and to have a childhood. The issues overlap.

If we have known that a child has been a carer from a young age, and they are hitting 18 or are older and they are still detrimentally affected, we should be looking at ourselves and asking what we have been doing with them up to the age of 18. We should be asking big questions not just of social work but of wider services and how we alleviate the impact on children.

We have adopted a family-based approach. There are ways of taking children out of households, providing the services and then putting them back into the same environment. We must raise questions with the whole family. If we need to move down the adult support protection route or the child protection route, we have to do that, but we should be asking families what they are doing to allow their child to have a future. We should be asking whether there are small changes that we can make to prevent us hitting a crisis further down the road.

There are also a lot of services that support young people in schools, such as careers advice. Are they aware of the issues that face young carers? Do we just write off people's future plans for college or higher education because they are a young carer, or do we look at how their named person finds out about the situation? They are passing through the system—they do not just get into crisis at 18. It is a question of having preventative, anticipatory services.

Trisha Hall: I fully agree with what has been said, but I also think that it is helpful for there to be a formal point of recognition that there is somebody or something that allows for the young carer to have additional input. It may well be that somebody has divided loyalties and will not want to say that they want to move out or to have a relationship and go somewhere else. There may be issues about attachments and about being frightened, or they might not want to say, "I want more help". However, the fact that they are coming to the end of their support statement and going into something else might allow for somebody else to come in to make an assessment and allow a bit more freedom.

Bob Doris: That is very helpful. Having all of that on the record will help us with our scrutiny and enable us to pose some questions to the Government.

We have heard that the young carer statement will allow anticipatory planning and that, if people can see an emergency happening down the line, they will be able to mitigate the effect, but the young carers we met as part of our evidence session in Glasgow—I am not talking about the legalistic aspect of the bill, because they were over 18, but they still define themselves as young carers as they are young and in a caring role—said that going to college and getting on with their life was their respite break.

How do we tie in other agencies to future planning? That is not about mitigating the burden of care or anticipatory planning for emergencies; it is just about future life planning. Is there a role for wider public agencies such as schools, colleges, universities and Skills Development Scotland in relation to the awarding of apprenticeships? Who is doing that job? Where does it fit in?

I am trying to paint a picture of a web of support to allow young people who happen to be carers to get on with their lives in as close to normality—or their normality—as possible. They will have the same aspirations as everyone else. Sometimes, although not today, the chat has been about how we support young carers who have significant burdens of care to get some respite, but my question is about the longer term planning aspects and ensuring that they are not held back in their personal lives as individuals because of the burden of care.

Does the bill fit into any of that? Can you give us any pointers on how we can give a nod to some of it? That is the evidence that I got from the session that we had in Glasgow recently.

Tam Baillie: You might want to look to the approach to corporate parenting responsibilities that is taken in the Children and Young People (Scotland) Act 2014. There is a long list of public bodies in schedule 4 to that act, and they are now under the obligations in part 9 of the act. For example, my office is part of the corporate parenting responsibilities—people who read this evidence will find it quite amusing, because we opposed the proposal.

The 2014 act takes a wide perspective to the agencies that are responsible for young people leaving care, and a long list of bodies were included as having duties under it. If you have a list of relevant agencies, you might want to think about that. My advice would be to keep the list to those that are absolutely relevant. You have already mentioned some of them.

David Formstone: I take on board Mr Doris's point, but I would like to widen out the support to include all carers.

Transitions are important. For example, carers who are parents might get full-time support from schools and, often, a lot of support from health services. Suddenly, the child leaves school—maybe a special school—and the local authority might struggle to provide a five-day replacement service through day care and other activities. Carers who are in employment might then struggle to stay in work, and they come to us saying, “If you don’t give us this support, I’ll have to give up my job.” In other cases, carers may want to take on education, or they may be reconsidering the whole caring role, saying, “I have done this for 21 years. I would like some respite.”

That touches on one of our concerns about the whole issue of outcomes as opposed to needs, which you may have rehearsed previously. How do we distinguish between personal outcomes for the carer and outcomes that are to do with the caring role? If the bill is couched in terms of aspirations and outcomes, we may struggle to distinguish a caring outcome from wider outcomes.

Fred Beckett: I reiterate what David Formstone says about the difficulties of looking at the carer in isolation and looking at the cared-for person.

We need to get better at future planning. A child does not just decide at age 18 to go to college or university. If they decide further back down the road, there is an opportunity for conversations. We overlap with SDS. We look at telecare and assistive technology in order to allow people to have more freedom and more choices. We need to get better at looking forward at those issues and planning for them.

Dennis Robertson: I may be picking this up wrong, but I am slightly concerned by David Formstone’s remarks. I am looking at empowering carers as individuals to have lives of their own outwith the caring role. If I understand David’s remarks, he is saying that he is concerned that he may not be able to facilitate the care of a person if their carer suddenly spreads their wings and goes off to college, university, employment or wherever and leaves a vacuum. Is that what you are saying—that the resources might not be there to facilitate care?

David Formstone: I would be absolutely in favour of empowering a carer or person who no longer wants to be a full-time carer to be allowed to do all those things, and we should be doing our part to facilitate that, but there is a harsh reality of limited resources. The fact is that social work departments and local authorities are increasingly struggling to fill in a whole week of support to allow a carer to carry on employment or enter education.

It is certainly not something that we would be against. We would absolutely wish to empower carers as far as possible.

The Convener: If there are no other questions, I thank the witnesses for being with us today and take note of the written evidence that they have given us. That concludes our business for today.

Meeting closed at 13:17.

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

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

All documents are available on
the Scottish Parliament website at:

www.scottish.parliament.uk

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

For information on the Scottish Parliament contact
Public Information on:

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

e-format first available
ISBN

Revised e-format available
ISBN 978-1-78568-677-1

Printed in Scotland by APS Group Scotland