



OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 22 November 2016

Session 5



The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 22 November 2016

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HEALTH AND SPORT COMMITTEE
12th Meeting 2016, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Clare Haughey (Rutherglen) (SNP)

COMMITTEE MEMBERS

*Tom Arthur (Renfrewshire South) (SNP)
*Miles Briggs (Lothian) (Con)
*Donald Cameron (Highlands and Islands) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Alison Johnstone (Lothian) (Green)
*Richard Lyle (Uddingston and Bellshill) (SNP)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
*Maree Todd (Highlands and Islands) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Alastair Cook (Royal College of Psychiatrists in Scotland)
Dr Andrew Fraser (NHS Health Scotland)
Bob Leslie (Social Work Scotland)
Carolyn Lochhead (Scottish Association for Mental Health)
Colin McKay (Mental Welfare Commission for Scotland)
Lucy Mulvagh (Health and Social Care Alliance Scotland)
Chris O'Sullivan (Mental Health Foundation)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (Committee Room 4)

Scottish Parliament

Health and Sport Committee

Tuesday 22 November 2016

[The Convener opened the meeting at 10:00]

Subordinate Legislation

General Pharmaceutical Council (Amendment of Miscellaneous Provisions) Rules Order of Council 2016 (SSI 2016/1008)

The Convener (Neil Findlay): Good morning, everyone, and welcome to the 12th meeting of the Health and Sport Committee in the current session of Parliament. I ask everyone in the room to ensure that their mobile phones are in silent mode. It is acceptable to use mobile devices for social media, but please do not take photographs or film proceedings.

The first item on the agenda is subordinate legislation, and we have one instrument to consider under the negative procedure. There has been no motion to annul the instrument, and the Delegated Powers and Law Reform Committee has not made any comments on the instrument. I invite comments from members.

Alison Johnstone (Lothian) (Green): I think that, previously, only pharmacy professionals from outside the European Economic Area were required to demonstrate appropriate knowledge of English. New legislation has extended that requirement to professionals from European countries. I fully appreciate that there is strong support from the health professions for that requirement and that patient safety is at the heart of it, but I wish to note that the Law Society of Scotland has previously raised concerns about it. In 2014, it noted that the proposals for language controls for health professionals

“raise equality and discrimination issues”

and that they

“may give rise to issues of direct race discrimination, which cannot be legitimised through the principle of proportionality.”

I put on record my hope that the requirement comes with adequate support for those professionals to learn English, if necessary.

The Convener: Thank you. That is now on the record and the matter will, I hope, be taken on board.

There are no further comments from members. Are we agreed to make no recommendations on the order of council?

Members *indicated agreement.*

Mental Health

10:02

The Convener: The second item on the agenda is our third evidence session on mental health. The session will focus on adult mental health services, and we have a cast of thousands. I am Neil Findlay, the convener of the Health and Sport Committee and an MSP for the Lothians. I invite everyone to introduce themselves—I do not want your biographies, just a brief introduction.

Bob Leslie (Social Work Scotland): I am the chair of the Social Work Scotland mental health sub-group. As well as representing Social Work Scotland, I manage mental health officer services for Renfrewshire Council.

Clare Haughey (Rutherglen) (SNP): I am the deputy convener of the Health and Sport Committee and the MSP for Rutherglen.

Tom Arthur (Renfrewshire South) (SNP): I am the MSP for Renfrewshire South.

Carolyn Lochhead (Scottish Association for Mental Health): I am the public affairs manager at the Scottish Association for Mental Health.

Miles Briggs (Lothian) (Con): I am a Conservative MSP for Lothian.

Chris O'Sullivan (Mental Health Foundation): I am from the Mental Health Foundation.

Donald Cameron (Highlands and Islands) (Con): I am an MSP for the Highlands and Islands.

Dr Andrew Fraser (NHS Health Scotland): I am the director of public health science at NHS Health Scotland.

Alex Cole-Hamilton (Edinburgh Western) (LD): I am the MSP for Edinburgh Western, and I am also the Lib Dem health spokesperson.

Alison Johnstone: I am an MSP for Lothian.

Richard Lyle (Uddingston and Bellshill) (SNP): I am the MSP for Uddingston and Bellshill.

Colin McKay (Mental Welfare Commission for Scotland): I am the chief executive of the Mental Welfare Commission for Scotland.

Maree Todd (Highlands and Islands) (SNP): I am an MSP for the Highlands and Islands. I am also a pharmacist specialising in mental health.

Lucy Mulvagh (Health and Social Care Alliance Scotland): I am the director of policy and communications at the Health and Social Care Alliance Scotland. We are co-conveners of the health and social care action group of Scotland's national action plan for human rights.

Colin Smyth (South Scotland) (Lab): I am an MSP for South Scotland.

Dr Alastair Cook (Royal College of Psychiatrists in Scotland): I am the chair of the Royal College of Psychiatrists in Scotland and of the Scottish mental health partnership.

Ivan McKee (Glasgow Provan) (SNP): I am the MSP for Glasgow Provan.

The Convener: Thank you. Wendy McAuslan will join us when she arrives. I invite Alex Cole-Hamilton to begin the questions.

Alex Cole-Hamilton: Good morning, everyone, and thank you for joining us. At the end of last year, our mental health strategy expired and we have been treading water on the issue ever since. We have now received a draft strategy that is being consulted on. I ask the panel to reflect on what the opportunity cost has been—if any—of the delay in producing a draft strategy and whether the draft strategy will answer the challenge of mental health in our society.

Dr Cook: The Scottish mental health partnership has worked with a number of partners to look at the strategy over a good period of time. The delay is less of a concern to us than the lack of ambition in the Scottish Government's proposals in the engagement document. We would rather that the Government took the time to get a strategy that is right for this time in Scotland, which would transform the direction of mental health services.

At the moment, the engagement document—like previous strategies—focuses on how we make our current mental health services better. I am absolutely behind that, and it is important that we do it. However, the partnership and stakeholders across Scotland would like to see a 10-year vision for mental health that takes us beyond good mental health services and begins to look at how we improve the mental health of Scotland's population and identify what we can do to at local and national levels to produce better mental health across all our communities.

There are many things that can help us to do that. NHS Health Scotland and the Convention of Scottish Local Authorities have co-produced the document "Good Mental Health for All", which is helpful in directing us some of the way. The other area that we would push for in relation to the strategy is a commitment at the Government level to resource the strategy, if we are really going to carry it out. Those are a couple of areas that we would be keen to discuss.

Alex Cole-Hamilton: Everyone agrees that we do not want to rush out a strategy if it is the wrong one. Is the lack of ambition that you describe

primarily characterised by the barrier of resources? Is it a cash issue?

Dr Cook: No, it is both. There is a lack of ambition in the consultation document, which contains a series of actions but no overarching aim or objective. The lack of resource is a pressure across all health services at the moment. However, in recent years, efficiency savings in the health service and the local authorities have been applied across the board and the new money that has been identified as coming into mental health services nowhere near matches the efficiency savings that are coming out.

Naturally, NHS boards tend to respond to the pressures that are placed on them where there is urgent need for money, which tends to be in acute services. Overall, it feels as though the proportion of spend in health and social services on mental health is dropping. I do not have the figures, because it is difficult to get accurate figures for that.

Alex Cole-Hamilton: If I am right, the proportion has dropped from something like 12 per cent five years ago to nearer 9 per cent now. Do you have a figure in mind? The general practitioners have asked for 11 per cent.

Dr Cook: No—I do not have a specific figure in mind.

Carolyn Lochhead: On the question whether the proposals meet the challenge of what we need from a new mental health strategy, there are things that look positive in the draft that we have seen. Before the election, we asked for a 10-year strategy because, in the recent past, we have had three-year strategies. We pushed for a 10-year strategy, which we have got and we are very glad about.

The eight priorities that are in the engagement document are good, and we support them. However, there are additional things that we would like, which we will no doubt come on to discuss. We are keen to see more on employment, primary care and, in particular, psychological therapies. Prior to the election, we talked a lot about the idea of an ask once, get help fast approach, and that is the overall approach that we are looking for. That comes from speaking to people who are in need of a mental health service of some kind. We often hear that services are generally quite good once people get into them, although that is not uniformly the case. The difficulty for people is in getting to the right service or support.

Alastair Cook mentioned the need for more ambition and more of a vision. We want a clear vision for the strategy. For us, that should be about transforming the culture of mental health, not just in services but more broadly so that, at any point when somebody needs help, whether

that is in the health service, in school or in employment, they can take that ask once, get help fast approach. It takes a lot of courage to seek help for a mental health problem, and people should not have to summon up that courage more than once—they should be routed to the right help when they first ask. We hope that the new strategy will help to transform culture so that that becomes the case.

The Convener: The NHS Health Scotland written submission states:

“Estimates suggest that only 1 in 4 people with significant symptoms of mental health problems are receiving treatment”.

Clearly, that is not happening.

Chris O’Sullivan: I thank Alex Cole-Hamilton for the question about the challenges that we foresee. I should explain to the committee that we are a national charity that focuses on prevention in mental health. One of the great opportunities with a decade-long plan is that we can play the medium to long-term game, and that is where prevention sits. We firmly believe that addressing mental health across policy areas is a skeleton key that can unlock quite a few of the challenges that we face in Scotland going forward. I know that the mental health partnership shares that view.

The jewel in the crown of the strategy should be equitable and accessible mental health services that take a human rights-based approach and that enable people to get help and to move through that help on to recovery. We might think that that is a simple ask, but it is not necessarily—we have work to do on that. Equally, we would very much like a 10-year strategy that focuses resource and ambition across policy areas, including justice and children’s work. It should take forward some of the excellent progress that has been made through the likes of the getting it right for every child programme and the strategies on ageing and working life, orienting those around mental health.

In the past two iterations, mental health policy has, to an extent, been somewhat orphaned within a very specific set of civil servants in the Government. We would like a strategy that firmly places the responsibility for addressing mental health across Government, as an asset for Scotland going forward.

Dr Fraser: What we have is not so much a mental health strategy as a mental health service strategy. As such, it is quite adequate, although more could be done on primary care. If we want a mental health strategy, we need to go upstream to the prevention elements. We need to widen the vision and, as Chris O’Sullivan said, look in other areas.

There are plenty of areas where, if we built on work that has been done or took the issue

seriously and went about the business of implementation much more enthusiastically and comprehensively, we would yield mental health gains. That applies to parenting interventions, for example. Serious attention should be given to bullying in schools and, heading on through the life course, we need enlightened policies on good and fulfilling work, social inclusion at community level and justice, which Chris O'Sullivan mentioned. Some people are in serious trouble and we have good evidence that support for people with complex co-occurring problems, including mental health problems, is effective. I also highlight homelessness, because homeless people are at real risk and have very grim health indices. Underneath everything, there is the floor of human rights.

The strategy could borrow, but also build on, some of those elements from policy areas other than health, in order to create a vision that is ambitious.

10:15

Lucy Mulvagh: I want to address a couple of points that have been made about the time that has been taken. I, too, welcome the fact that the strategy has been extended to 10 years, although ideally it would be even longer than that, given that mental health is something that we want to address through the life course. We also welcome the quite explicit focus on human rights and the rights-based approach. That is very welcome, given that it was only one of the commitments in the previous strategy. If we are to achieve transformational change and a rights-based approach, we need to nurture that, which will take some time.

We have, however, picked up on a concern that the strategy focuses on only two elements of the rights-based approach. Some people use the participation, accountability, non-discrimination and equality, empowerment, and legislation—**PANEL**—principles, but the vision document pulls out only a couple of those. We think that those five elements of a rights-based approach are interdependent. Accountability is particularly important in mental health, as is the legality aspect.

The Mental Welfare Commission's response has picked up on points around mental health legislation, and the strategy could, in the future, review and revise mental health legislation so that it is more in line with international human rights standards—for example, the United Nations Convention on the Rights of Persons with Disabilities.

Bob Leslie: I echo the sentiments that have been expressed around the table. Social Work

Scotland feels that, although the strategy is welcome, it is not really transformational enough—it is very service led. Social work is not mentioned in the strategy despite its having an integral role to play in supporting people with mental health issues, nor is the role of the mental health officer, who plays a very important role in protecting the rights of individuals at times in their lives when they are vulnerable, when they may be about to be placed under statutory measures of care.

As has been said, some of the key groups in society, such as those who are involved with the criminal justice system, are, sadly, not mentioned. Equally, the strategy is not embedded in current policy and legislation, and links to things such as GIRFEC, self-directed support and the integration agenda of health and social care will impact the ability to deliver the strategy in its current form. The strategy is intended to inform and help with strategic planning for the integration joint boards, but many children's services and criminal justice services sit outwith the structure of the IJBs. Our colleagues in Highland Council and NHS Highland have a completely different model of management and structure.

There are a number of challenges around, and that is really just an opening position from SWS.

Colin McKay: I will struggle to come up with anything new after that. We generally agree with those views, but I will make a couple of points.

One is about how we carry out the strategy, if we are genuinely talking about a 10-year vision. I echo the view that there is quite a lot that is welcome in the document, but it feels like a three-year mental health services plan rather than a 10-year vision. In a way, that is not surprising if it has been produced in a matter of weeks, because it is difficult to produce a 10-year vision.

It seems almost a constitutional point that, if we are genuinely talking about a transformational vision that will survive two or three parliamentary sessions, it is not right that the current Government produces it more or less within St Andrew's house and then says, "Is this okay, guys?" The Government needs to have a much more substantive dialogue and engagement with people who use mental health services, the wider community and the people who are affected by the things that make people mentally unwell, such as poverty.

In fact, the Government has done a lot to commit to broader public engagement in other aspects of its work—for example, it was recently at the United Nations, joining up to developing citizen participation—but that approach does not seem to have fed enough into the document. It feels like we should commit to doing something transformational about the issue over a long

timeframe, and that should be done in a different way.

On the point about rights that Lucy Mulvagh in particular mentioned, all policy should be rights based. Indeed, the Scottish Human Rights Commission's submission contains a lot about a human rights-based approach that is very helpful in fleshing out ideas about the PANEL approach and what that would entail. However, we are talking about the only group of people who live in the shadow of coercion, and it is important that a mental health strategy recognises that, ultimately, some people will be given care and treatment that they do not want and which they have not asked for. That is different from everybody else who accesses health and social care, and we cannot have a mental health strategy that does not acknowledge that.

Elements of the current document say something about that, but I should say—we might get a chance to expand on this later—that about 10 years ago Scotland was genuinely world leading in having a rights-based approach to mental health care and treatment. If you speak to people in Northern Ireland, Australia and Canada, they will say, "We all learned from what Scotland did in the early 2000s." However, we are not world leading any more. We need only look at Northern Ireland, which has just passed radical mental health and capacity legislation. There is a chance that we could be world leading again, but I certainly find it difficult to imagine that, in 10 years' time, we will be saying that the legal framework that was devised in the late 1990s is that one that we want in the light of the UN Convention on the Rights of Persons with Disabilities and other things. A 10-year strategy needs to include a reasonably fundamental look at the framework for compulsory care and treatment.

The Convener: I was looking round the table to see who would know this and I happened to look at you, Mr McKay. Was the draft strategy produced by someone sitting in an office in St Andrew's house, or was there a working group? Were you people consulted before that draft saw the light of day?

Colin McKay: There was engagement.

The Convener: What does that mean? Some engagements last a while—others last only a short time.

Colin McKay: As I understand the process, officials from the mental health division came out and spoke to various people. That has certainly been our involvement. There were a couple of general events involving some stakeholders—indeed, I remember an event in the hotel opposite St Andrew's house—and some one-on-one discussions.

The Convener: Is that what you would have expected to have happened?

Colin McKay: It was helpful but, as I have said, in the context of a 10-year vision, I would have expected something a bit more structured and substantive.

Dr Cook: I am not going to be too defensive of the division, but it has said that the document that was produced for consultation at that point was very much about engagement, and there was some input leading up to it. I understand that well over 600 responses have been received, and the people in the division are now working their way through them. Again, the draft strategy that they are producing is based on that information rather than on any further process, but my understanding is that we still expect to see the strategy before Christmas.

The Convener: We would always expect any draft to be commented on and critiqued, but it seems as though this one has missed the mark pretty widely.

Colin Smyth: I want to touch on the issue of waiting times. The Scottish Government has set a maximum waiting time target of 18 weeks from patient referral to treatment for psychological therapies for at least 90 per cent of patients. However, the figures show that, for the quarter ending June 2016, the target was met for only 81.2 per cent of people. Will panel members say why they think that the target was missed and whether they support SAMH's call for an inquiry into the failure to meet current targets?

Later in the meeting, the committee will consider a petition that calls for the mental health waiting time target to be reduced. Do the panel members think that it should be reduced?

Carolyn Lochhead: The target to see people who have been referred for psychological therapies within 18 weeks is important. As you said, currently only 81 per cent of people are being seen within that timescale, and that position has been broadly static for a while. Five health boards currently meet the target.

Members will not be surprised to hear that SAMH supports the call for an independent inquiry into why current targets have not been met, given that we made that call, but beyond that there is much that we could learn if we looked a little more into the statistics, which come out regularly. For example, we know that NHS Greater Glasgow and Clyde and NHS Ayrshire and Arran deal with notably more referrals per head of population than other health boards. Glasgow is one of the boards that is meeting the waiting time target. We would like to know why it is able to do that, given that it deals with more referrals per head of population.

We would like to know more about what therapies are being provided. A couple of years ago, we made some freedom of information requests and found that the majority of health boards could not tell us much about equalities data, for example, so we do not know whether different groups are getting more or less access to psychological therapies. We question why health boards are not collecting that data or aggregating it in a way that enables them to review what is going on. Boards were not collecting, at aggregate level, details of the therapies that were being provided, so they could not tell us what they were providing. Of course, that is recorded at the individual level but, if it is not reviewed at board level, we question how boards know what they need to plan for.

There is a lot more that we would like to understand about the good practice that is going on and about what we can learn. There is good practice in England, where the improving access to psychological therapies programme seems to be getting good results, with 61 per cent of people being seen within 28 days. There has been investment in 3,000 new therapists, so quite a lot of funding is going into the initiative. There is a lot that we could look at to see what we can learn.

The vision document talks about rolling out computerised cognitive behavioural therapy for people to help to meet the target. There is an evidence base for computerised CBT, and it can work for many people, but other approaches have an equivalent evidence base, such as one-to-one CBT and behavioural activation. In the interests of choice, we would like approaches that have just as strong an evidence base to be rolled out, too.

A lot of people are waiting for services. At the end of the last quarter, I think that 18,000 people were waiting to start treatment. There is a lot that we need to learn. We would like the target to come down to 12 weeks, to bring it more into line with other health service targets. We are not sure why the target in mental health should be higher.

You asked whether we support the target continuing. We are doing a bit of policy work internally to inform our position on the national review into targets and indicators for health and social care, on which the committee recently took evidence. We have not reached a final position on that. We are wary of losing mental health targets, because targets drive investment and improvement, but we accept that we might be able to do something better if we took a wider approach, particularly on the psychological therapies target. We know a great deal about how long people wait and the points on their journey, but we do not really know whether people felt better at the end of their treatment and what helped or did not help them. We think that the

target could be improved, but we hope that we do not move away from it entirely without giving it careful thought.

The Convener: Do you want to come back in on that, Mr Smyth?

Colin Smyth: No—that was pretty comprehensive. It will be interesting to hear from the other witnesses.

Lucy Mulvagh: I will pick up on a couple of points that Carolyn Lochhead made. We are encouraged that the group that is conducting the national review into targets has said that it will take a wider approach rather than just consider the waiting times numbers and percentages game. Waiting times are incredibly important, but it is also incredibly important to know about the quality of care that people receive when they get access to support and services and what the outcomes are for those people. We are very keen to see an increase in measurements around personal outcomes, approaches and so on. Again—I know that I sound like a stuck record—we think that taking a rights-based approach is important.

Taking a transformative approach to mental health and building on a framework of rights would help to underpin outcomes with values. That would empower people and lead to participation in decision making and things like that, rather than creating a narrow focus on percentages and numbers.

10:30

The Convener: Does Alison Johnstone want to come in?

Alison Johnstone: My question is not on that particular issue.

The Convener: Okay—we will come back to you later. Does any other member want to come in on that issue? Miles Briggs, do you want to come in?

Miles Briggs: No.

The Convener: Okay. I will bring in Ivan McKee.

Ivan McKee: My question is on targets. There is a focus on the 18-week target. Considering everything in the round, is that the right thing to measure? Should we be measuring other things as well?

We have heard that, if there was more of a focus on what is happening at tier 2, we might fix a lot of issues in advance so that problems do not get so bad and people do not have to go to tier 3. If resources are diverted to give people a first appointment but the rest of the process through tier 3 is not focused in the way that it should be, is

there an issue there? Measuring the quality of the outcome is important. All those things can be measured, and numbers can be used to measure them. Should we have a broader range of number-driven targets for some other aspects in addition to what currently exists?

Dr Cook: Over the past decade, since the targets were first talked about and brought in through the “Delivering for Mental Health” plan, we have welcomed the fact that there are targets in mental health, because that has put mental health on the agenda at a health board level and in other places. However, I am not sure that the current targets are sophisticated enough to drive the sort of change that we want. They have been hugely successful in increasing the number and availability of psychological therapies and child and adolescent mental health services therapies. However, as Ivan McKee said, we have seen in CAMHS in particular an expansion in tier 3 services. That means that it is more difficult for CAMHS to work with schools and do other things that are a huge part of what they ought to be able to do.

With regard to psychological therapies, fewer psychologists and people with psychological therapy skills are working in our community mental health teams with individuals with severe and enduring mental health problems, because the resource in psychological therapy services has moved very much towards meeting the target, as that is the priority.

Although we support the targets in mental health because they keep mental health on the agenda, we need to be much more sophisticated in looking at those targets and really start to think about how they improve outcomes rather than focusing so much on the numbers.

Bob Leslie: The focus on targets is good in some respects, as it has driven access to certain services with which there was previously a problem. However, the danger with targets is that we view the delivery of services on a wide scale of one size fits all. For example, we would develop a CBT programme or a particular intervention in a certain area, and people would be offered those things, but that would not address the needs of the individual or give the outcome that they are looking for. We have to be cautious about targets, as they do not always deliver what we might wish them to.

Chris O’Sullivan: I have two points. First, we certainly support equity between targets in mental health and targets in other areas of health because that reduces people’s perception of mental health as being somehow different.

Secondly, at both ends of the prevention scale, access to psychological therapies is very

important. It is important that people get rapid access when they need it following a first episode of a mild to moderate mental health problem, because that enables them to continue in their job or with their caring responsibilities and all the other things they do, and it helps workplaces to see that someone is recovering from a transient episode of a mental health problem.

That is critical at the other end of the spectrum, too, and not just for first access. We need to understand how people with on-going mental health problems access psychological therapies and how those therapies are used. There is certainly scope within a 10-year strategy to do real user-journey research about how people use services of all kinds at different points and how that use interacts with the targets that are set from time to time.

The Convener: In relation to targets, if we want to change them, what should we be reporting on, measuring and counting?

Colin McKay: That takes us to the point about rights and outcomes. The Government measures access to one particular kind of intervention, which may not be the right intervention for people. I have a 10-year vision in which the role of Government and Parliament is to set an ambition for outcomes and what we want to change in people’s lives. Exactly how that change is delivered will change over time, and there may be different ways in which we achieve outcomes for people. Some of those ways might involve people having greater choice about what would help them to achieve an outcome. A particular psychological therapy might not make a difference for a particular person.

Targets certainly have a use. If there is clear underinvestment in a particular area of care in the health service or the social care system and the Government or Parliament wants to change that, that is a legitimate short-term aim for which to set a target. However, on the broader ambition, what you set should be based on a sense of what the outcomes are for people and how to get the system to work out how to deliver those outcomes in a way that responds to what people want. Some of the approaches that have been tried over the past few years, such as self-directed support, are all about people saying, “This is what would make the difference for me. It would allow me to live a flourishing life rather than an impoverished existence.”

Although people with mental health problems could be the ideal customers of approaches such as self-directed support because their needs can be quite individual and can fluctuate, the approaches have not worked for those people because of problems with access and the way that the systems are designed. Setting an ambition that is about services responding to people’s own

sense of how they can get well and maintain good mental health would allow the system to be more responsive, rather than just responding to centrally set targets.

The Convener: I do not know whether you meant to say “customers”, but it sits very wrong with me that we regard people with mental health problems as customers.

Colin McKay: I did not say “customers”; I would not say “customers”.

The Convener: You did. You may have said it inadvertently, but you did say it. Sorry.

I will raise a couple of things. According to the submission by Colin McKay's organisation, three out of four people with mental health problems are not getting treatment. If three out of four people were not being treated for a broken leg, and if that many people with a physical condition were dying decades before they should, there would be an outcry. I do not understand why there is not an outcry about those figures. I find that absolutely astonishing. Should we be measuring, recording and analysing people's life expectancy and access to services?

Lucy Mulvagh: I agree that it is absolutely outrageous.

I wanted to come in on the question of what we should be measuring. When we talk about rights and recovery, it can seem as though they are quite ethereal, theoretical-level things or that they are to do with courts and legal action, but there are tools that have been created at an international level for in-country use that provide indicators on rights and recovery within mental health service settings. One example is the World Health Organization's QualityRights Tool Kit. The United Nations has come up with a suite of indicators that can be used to measure people's enjoyment of the right to the highest attainable standard of health, the right to an adequate standard of living, the right to adequate housing and so on. There are already things out there that we could be adapting and using in a Scottish context, taking into account the realities of our national situation.

Chris O'Sullivan: I agree, convener, that it would be wonderful if we could monitor the absence of outcry—and produce that outcry.

On your previous point, many moons ago, when Vox Scotland was first set up, the conference that we put together to co-design Vox was called, “User, consumer, survivor, refuser”, because of the different senses of identity that people with mental health problems have in the world. One of the challenges that we face is giving a voice to some of the most voiceless people in our society. People like me who have had mental health problems, and who have agency, control and

education and so can come and speak before committees are one thing, but there are people experiencing compound inequalities and complex trauma who have no voice and are furthest away from agency and they are legion. It would be useful to begin to monitor some of their experiences, including the injustice they experience, through detailed and intelligent research.

Colin McKay mentioned self-directed support as something that we have tried. Self-directed support is set out in law—people are legally entitled to self-directed support, yet we find time and again that people with mental health problems are unable to access self-directed support, either because they do not meet eligibility criteria or because they are told that self-directed support does not apply to people with mental health problems. That smacks of systematic discrimination, which needs to be addressed.

I go back to the extremely important point that I made earlier, which is that someone's experience of mental health services and the support available to them should be consistent, no matter where they are in Scotland—no matter which board or local authority, nor whether you move between boards. There are some places in Glasgow where it is very easy to move between two boards and there are places in Edinburgh where if you move to the next street you will move teams, and so have a completely different experience. We need to have a certain consistency across the piece.

Dr Fraser: To return to the strategy for a moment, the desire for mental health care to take its place alongside the care of other types of health and disease is implicit in it. The strategy's ambition is for mental health to live alongside physical health conditions and for access to treatment for mental health conditions to be every bit as important as for a broken leg, and to be as urgently and competently addressed. The question to ask is how that can be done. Yes, there are all the service responses that we have talked about—access to services, the right services and the right style of services—but the strategy also needs to consider the causes of the illnesses.

That goes back to what we want to achieve and the outcomes, as well as access to and experience of services. We must consider the reasons why people become ill and are unable to climb out of despair or distress. We know the scale of such things and we know that there are ways out. We need to apply that as part of a broader strategy, going beyond the health and, sometimes, social care implications.

Clare Haughey: I thank those organisations that have given the committee written reports, which have been helpful, particularly the NHS

Health Scotland report, which looked at health inequalities and the impact of social determinants in health. As you might be aware, one of the strands of the committee's strategic plan is to test health policy and strategy against inequality and examine how they help to address health inequalities. We have heard that we need to do something, but I want to hear what witnesses think can be done to help to reduce some of the health and social inequalities experienced by those who have mental health problems.

I must declare an interest in that I am a registered mental health nurse.

Dr Fraser: It is me again. NHS Health Scotland's submission sets out several areas for action. The challenges that we have been set by people who have considered this are not just areas of high-level intent and ambition, but things that we are going to do. If we assume that people are familiar with our submission, what can we go on to say about the interventions?

10:45

We cannot dodge the issues of people's means, their income, the level of poverty they experience and the stigma that comes with not being able to afford things for themselves or their children, such as the cost of the school day. Those may be loosely related to mental health, but if a person cannot afford to have their children go to school and look the way that other children look and cannot afford the basic activities that other children do, that is not good for mental wellbeing.

That is only the start. We need to look at fundamentals like that. I have already mentioned such factors as the school ethos and the effectiveness of schools. Other areas of policy that we are dealing with are attainment and bullying. There are specific interventions linked to schooling, and then we go on to working age and older age and so on. There are actions that we can take to prevent mental illness occurring on a very large scale if we get them right for the whole population. We are aware that mental illness is banked up among particularly the poorest in our society, but it is not only there. It is in all areas, but particularly represented among the people who have the least means and the least sense that they have power over their lives and their circumstances.

The basis of our submission to the committee was that we need to put mental wellbeing in that context. As an agency, along with service provider and policy-linked colleagues, we need to rise to the challenge of saying what that is going to be—what that is going to look like—and clothe the vision with interventions towards outcomes that really mean things for people.

Dr Cook: It would be hugely helpful if, as part of a 10-year strategy, we had an aim to reduce the gap in life expectancy between people with mental health problems and people without. That would drive a lot of behaviours.

If we think about what actually works—to answer Clare Haughey's question—then we need to go quite far back, to pre-conception, support during pregnancy, the perinatal period, childhood and what can be done in schools. It begins to touch on the point that the convener made about the three quarters of people with mental health problems who are not seeking help. We need to develop in our communities much greater confidence and resilience at a young age so that people are more able to self-manage if they cannot prevent some of those early factors.

That is the general education of our population about awareness of mental health. We all have mental health, all the time; on some days it is better than others. For some people, it is worse for a long period of time and they need to be supported. As well as a general level of population awareness, we can target specific groups where we know that there are risks—such as high risk families and children as they go through school—and identify people who are developing serious mental health conditions at the earliest possible stage so that we can help them.

We know that early mortality is largely caused by excess smoking, obesity, alcohol and drug use within those groups, together with some impact from suicide and other issues. That is where early mortality comes from. We need to intervene early, before those hopeless and helpless behaviours set in with people with serious mental health problems.

Early intervention, childhood stuff, perinatal care and greater community awareness of mental health across the piece: from those, we begin to get an ambition for where we should go in the next 10 years.

Alison Johnstone: I address my question to Dr Cook. In his submission, he says:

"We need to consider how we plan our communities with a view to improving mental health. We need to think about what support employers can offer workforces in improving mental health."

We know how workplace stress affects far too many people and that welfare services need to be designed in a way that respects the needs of those with mental health difficulties. The other committee that I sit on in Parliament is the Social Security Committee, and there is huge overlap of those services. I ask you to expand on what you would like to see happen in our communities and in our workplaces and welfare services.

Dr Cook: Others witnesses have already touched on the fact that we need to get much greater mental health awareness across all policies and across all our thinking about policies. In particular, opportunities will come through the Community Empowerment (Scotland) Act 2015 that will mean that we will start to look at how community planning partnerships function and work. I do not get a sense that community planning partnerships really have much awareness of the mental health impacts of what is happening in local communities, so we could start to look at that.

When we look at any work that community planning partnerships do with employers, we should certainly say how mental health policies in those employers should be encouraged and supported, and we should similarly do so when we look at the welfare situation. If we look at almost any policy area, we will find that there is an impact and a potential impact, which could be potentially positive or potentially negative, on mental health. It is about identifying and using that.

Alison Johnstone: Dr Fraser, in your submission you touched on

“limited control”

being

“associated with an increased risk to mental health”.

That can involve a person being on a zero-hours contract and having no control over their working hours or things being planned for a person's community and their view not really being taken account of. It is clear that we are ignoring the impact on mental health of some decisions and life circumstances. Is there anything that you would like the committee to highlight in particular to the Government?

Your submission also mentioned introducing

“a minimum income for healthy living”.

I think that that would make a huge difference. Will you expand on that point?

The Convener: Alison, could I suggest that, at the end of the meeting, we go round the table and ask people to talk about the one thing that they want us to take away?

Alison Johnstone: Certainly.

The Convener: I hope that that will help to give people time to think about that.

Dr Fraser: I will address Alison Johnstone's two issues.

On control, Alastair Cook has already touched on community empowerment and the values in that. The values underneath the social security consultation that is going on are laudable. The

issue is operationalising those values and asking what they mean at a day-to-day level.

We recognise that the fundamental causes of health inequalities and other inequalities are to do with income, wealth and power, and power is the most difficult one of those to operationalise. At the individual level, it is about a person feeling that they have a say in their treatment. That was Colin McKay's point. At a community level, it is about a person feeling that they have a say in the wellbeing of a community that has a basic level of assets so that they can engage and build on them. At a democratic level, it is about a person feeling that there is local and national democracy and accountability.

However, it is the general value of accountability in services under the human rights framework, as Lucy Mulvagh pointed out, that really would unlock the key to empowerment if we created that value in services and supports for everyone, but particularly for people who are most vulnerable. We have evidence that intensive interventions for people with complex problems are cost effective and lift them out of the positions that they are in.

Alison Johnstone's other area of interest was a minimum income. People can get on with life if they have sufficient income to send their children out to school confident that they will cope materially with the cost of the school day. If people could socialise and know that they could take their place in social situations supported by a minimum income that is more than we are currently talking about, we would see mental health gains and health gains generally, as that would mean the evening up of income differentials. It is not just about narrowing inequalities; the health dividend is undoubted.

Clare Haughey: I want to come back to the point that I made about health inequalities. What measures can we put in place to reduce the inequality in mortality rates for people who have mental health problems? Dr Fraser has partly addressed that, but other members of the panel might like to expand on what he said. Dr Cook mentioned that alcohol and smoking are among the main issues.

Lucy Mulvagh: On the point about inequalities and reducing mortality, I would like to pick up on some of the comments that Alastair Cook made. There is an increasing focus here in Scotland on the ACEs—adverse childhood experiences—approach, which is a trauma-informed approach that has had incredible results in America, for example. There is increasing interest in it here—in fact, next Monday, NHS Health Scotland is running a national conference on ACEs, which will be chaired by Sir Michael Marmot. It will look at the evidence from various projects around the country that are taking that approach, which

examines what happened to individuals as children. There is a basic questionnaire with a set of 10 questions. Depending on what someone's score is, a prediction can be made about their life chances of acquiring conditions such as diabetes and cancer, regardless of the so-called risky behaviour that they might have gone on to engage in, such as smoking and using alcohol and drugs, as a natural response to the trauma that they experienced in childhood.

Using that approach, coupled with the work that Alastair Cook mentioned on strengths, resilience and asset-based approaches, of which there are some great examples in Scotland, we can try to overcome the inequality. However, given that we are talking about an intergenerational approach, it will take time. It is a good approach, because it seeks to address the whole person; it tackles the issue not just in health and social care services or mental health services but in schools, the criminal justice system, local community centres and so on. That is one practical thing that we could do.

We could also consider co-production as a rights-based approach. That would involve co-producing responses and strategies such as the mental health strategy—strategies that will address other inequalities—and engaging actively and in a meaningful way with the people who are affected, listening to their experiences and basing our responses on what works for them already. That is another practical thing that we could do. There are encouraging signs of that in the social security consultation, in which there has been a heck of a lot of engagement, but co-production is about more than just engaging with and consulting people. It is about getting people in a room, sitting down with them and enabling them to draft the document alongside civil servants or those who are on the relevant committees.

What can the Health and Sport Committee do? It can take more evidence from people at the sharp end and listen to what is happening in their lives, what is important to them and what works for them.

Carolyn Lochhead: I have two points to make about tackling inequalities. One of them is about employment and the other is about stigma. We know that, in general, good work is good for a person's mental health most of the time, if they are well enough to work, and we would like there to be greater recognition of that in the next strategy. The discussion document talks about making sure that the new employment programmes in Scotland involve mental health, but we think that the strategy needs to say a lot more about that.

We know that if someone has a severe mental health problem, they are very likely to be unemployed. About half the people who are on employment and support allowance receive it on

the basis that they have a mental health problem. We also know that if someone is employed in a job in which they have a reasonable amount of control and a sense of satisfaction, that is generally good for their mental health, as long as they are well enough to work. We think that that is a really important area for the strategy to focus on. Links to the new employment programmes are important, but we must make employment a health issue. We need to have conversations about employment in the primary and secondary care sectors in situations in which people are well enough to have those conversations.

We know that there are some good employment programmes, and we would like them to be introduced more widely in Scotland. The individual placement and support programme that SAMH and others run has extremely high success rates in getting people into, and helping them to stay in, employment. The review of the EQOLISE—enhancing the quality of life and independence of persons disabled by severe mental illness through supported employment—trial that was carried out in six European countries found that the IPS approach is cheaper and twice as likely to get people into work, and that it helps them to stay in work for longer and to have better outcomes. Currently, the IPS approach is used in only 15 per cent of community mental health teams in Scotland.

We think that that is a bit of an open goal and there is something that we can do. We are already doing it, we know that it works, and it will give people more opportunities and more income, which is really important, along with more of a sense of control. It will also start to reduce inequality. We really hope that there will be a big bit of work on employment in the next strategy.

11:00

There is not a great deal about stigma in the discussion document that we saw earlier in the year. SAMH, with the Mental Health Foundation, was proud to be one of the managing partners of see me, the anti-stigma campaign, which is doing excellent work and has had good support from the Scottish Government. However, we think that stigma needs to be tackled not just through the see me programme but at all levels in the mental health system. It continues to be difficult for people to talk about their mental health and the fact that they might be having problems with it. It is hard to seek help for a mental health problem and everyone that you might encounter while you are on your journey to get that help needs to understand that and to be committed to helping you to dismantle the stigma that you might have encountered. That is very important for tackling the inequalities that we see.

Chris O'Sullivan: We have just done a new piece of research on the experiences of people in work and a bit of economic analysis of the impact and contribution made by people who have mental health problems in the workforce. We did not get much media coverage because we went with a positive and the media always want a negative angle. Our economic analysis showed that the value added to UK gross domestic product by people who are working with mental health problems is £226 billion, or 12.1 per cent of GDP, as compared with a cost of £26 billion.

"Cost", "burden" and "drag" are terms that you hear in the public narrative about mental health problems. I will link that cunningly into my call for the committee to recognise and call out mental health inequalities as a mainstream inequality that links to all the other areas of inequality. In 2011, the Christie commission report into the future of public services called for inequalities to be addressed, for a systematic approach to be taken to addressing failure demand, and for co-production to be adopted as a means of going forward. I still cannot think of three better ways of addressing mental health inequalities.

Failure demand is the one that we have not really touched on in today's debate. With the pressures that we are under in the current fiscal environment, we are at risk of creating a new generation of failure demand. If we do what we should do to address inequalities through perinatal and early years support at the beginning of the life course, we cannot forget that the child who is experiencing an adverse childhood event today somewhere in this city has 80 years—or, more likely, 60 years, given the challenges to life expectancy—of failure demand ahead of them.

Colin McKay: I want to reinforce a couple of points and make one new point. We started talking about life expectancy a while ago and what to do is a classic wicked issue. We do not quite know what to do but there are a lot of things to do. The role of a 10-year strategy is to say, "We are going to do this. In 10 years' time, we are going to reduce by half, let's say, the difference in life expectancy." It is like climate change: we do not know how we are going to reach the climate change targets, but we have set ambitious targets and we are going to change systems to meet them. That is what we should be doing for life expectancy.

We have done it in the past for suicide. When we set the suicide target, I do not think that we quite knew how we were going to get the numbers down, but we did get them down and quite substantially. We need to set ambitious goals and work over the 10 years on how we will make the difference, and it will mean a lot of different interventions.

We know that we have not got any money so it would be helpful for the strategy to think about where money is being wasted in public services. People end up in the justice system and cost the police, the courts or the prisons vast amounts of money when they could be supported through crises in different ways. People in crisis are a classic area in which lots of different public service actors get involved and spend a lot of money but we do not help people who are in crisis very well. That would be an area for focus.

It is important to look at inequalities within mental health and at who does worst out of the mental health system when they have mental health needs. They are people who have borderline personality disorder, for example, or people who have autistic spectrum disorder.

The investigations that we have done show that the tragedies tend to involve not people whose bipolar disorder responds to medication and who get the medication but people whose needs are not met by the current services. We need to do better for people with such labels, which are often used to exclude people from services rather than to support them.

Maree Todd: I am particularly interested in Colin McKay's submission, which mentions the legislative framework. We have heard from a couple of people about the difficulty that folk with mental health problems have in accessing or using self-directed support, and we have also heard that power is very important and fundamental to our health. I wonder whether the issue of non-consensual care, which as you say is unique, is part of the fundamental problem. I know that that is a can of worms, but I am interested to know your thoughts on how we could improve that.

Colin McKay: Coercive care is currently being debated at the UN level. The UN Convention on the Rights of Persons with Disabilities, which Lucy Mulvagh mentioned, is a challenging document because some of the people behind it say that we should not have coercive care at all. We are not sure that we can get to that point quickly, but an issue that underlies that is how we take decisions for and with people with mental health issues or other mental disabilities.

Recently, we published a document on supported decision making, which represents a fundamental change. Historically, we have had a system that is based on the idea that, if a person lacks insight into their condition, we have to take decisions for them. We decide what is best for them, and they just have to take it. That is a caricature but, ultimately, that is the way the law is framed. Supported decision making is about maximising the extent to which the person has some say in their care and treatment and what matters for them. That is happening across

healthcare in general. Doctors are saying, "It's not for us to decide what's good for you. It's for you to decide what works for you." The Millan principles in the Mental Health (Care and Treatment) (Scotland) Act 2003 are already supporting that, as are things such as advocacy, which is also in that act, but we have not done enough to make that the lived reality for people who experience the possibility of coercion.

At the moment, within the commission, we would say that coercive care is difficult to do without. Ultimately, people are sometimes so unwell that we have to take decisions for them, but the way we do that could change fundamentally. Over the next 10 years, we should certainly be working out how to do that.

Maree Todd: You mentioned personality disorders as a particular area in which there is unmet need. Would Colin McKay or other people round the table like to expand on why that is so?

Colin McKay: I will let others talk about the detail, because people such as Alastair Cook will have much more to say than I do but, historically, there has been a sense that people who are labelled as having a personality disorder do not respond well to medication and that is not the answer for them, so it has almost been an exclusionary diagnosis. It is a way of saying, "We haven't got anything for you. Please go away and sort yourself out." That is changing, and there are interventions that can support people with personality disorders, but our systems are not terribly well set up to deliver those at present. Others might want to say a bit more about that.

Chris O'Sullivan: I echo what Colin McKay said. I am sure that Alastair Cook will have thoughts, too, but I add that one of the challenges to increasing access to mental health services is the temptation to provide the simple treatment to the highest possible number of people. We hear time and again—I know that colleagues do, too—that some of the more complex people, particularly those who have had adverse childhood experiences and are living with profound trauma, completely confound the system as it is currently configured, and when that system and those staff are overloaded, the people who are the most complex and the least empowered are sometimes the most let down by the system. That has to change.

Dr Cook: I agree that, within the mental health system, some people are better catered for than others and that people with personality disorders sometimes feel that they are at the bottom—the Cinderellas of the Cinderellas.

There is now evidence about things that can make a difference. There is increased evidence of the benefits of psychological therapies for people.

We know that effective care planning can be very useful but, at the moment, where people end up in the system very much depends on where they enter it. Someone with the same level of difficulties could just as easily end up in the criminal justice system or in a secure forensic mental health unit, or they could be left in the community and told, "You don't have a mental health problem, so we can't offer anything for you."

The college has a working group that is looking at making some recommendations about how to get a consistent approach, and that working group has expanded across a thing called the personality disorder network, which is a multi-agency organisation. I expect the group to report early in 2017. The college would certainly be looking to have a campaign to improve support for people with personality disorder next year. I hope that the working group will be pulling together the evidence from the different services across Scotland, some of which are producing good outcomes, and that we will be able to use those to suggest to people in other areas of Scotland how they might proceed.

The Convener: We are almost at the end of our time. I will go round all the witnesses and ask them to tell us the one thing that we should include in our report, as Alison Johnstone requested.

I have one final point to put to Alastair Cook. In your submission, you say:

"Services are struggling with significant issues created by ongoing requirements for efficiency savings and the impact of health and social care integration on budgets."

If they were "efficiency savings", the service would be getting better. Are efficiencies being applied and the service getting better, or are we calling something else "efficiencies"?

Dr Cook: I will use my day job as an example. Our mental health service has a budget in the region of £55 million to £60 million per year. The health board applies an efficiency to that: last year, for example, we were looking at a 5 per cent efficiency. There has been some investment in mental health services—what is being taken out is roughly £3 million and what has come in has been something like £1.2 million, so there is a £1.8 million deficit in our mental health services funding this year. That £1.8 million is not then being reapplied in mental health services, but is included in the overall health board budget. The same is happening to local authority colleagues. The biggest focus for health boards is, naturally, the things in which they are under most pressure—how they deal with unscheduled care, accident and emergency waiting times and waiting times in the acute sector.

The Convener: All of us on the committee have our own particular bees in our bunnets. This is mine: are they efficiencies or are they cuts?

Dr Cook: There are cuts in the budget to mental health services.

Miles Briggs: We have not really had a chance to touch on the subject of gatekeepers for adults. I have two specific points for the panel to address. First, will links workers help to improve services and signpost people to the correct treatments, and how will they do that?

Secondly, there has been a huge increase in prescription of drugs to treat mental illness. Are there people in Scotland who are being prescribed medications for mental illness who should be signposted towards alternative psychological therapies?

The Convener: If witnesses do not wish to answer Miles's questions, you can skip them and just give us the one point that we should include in our report. If you want to roll the two things into one answer, that would be really helpful.

Bob Leslie is lucky—you can go first.

Bob Leslie: We need much more support for third sector organisations that help people to self-manage their conditions. It is very important to say that equal access to employment supports the improved aspirations of people who have mental health conditions, particularly with the current revision of the welfare system. That will have a great impact on people with mental health conditions and mental incapacity, in terms of the challenge of helping people who are caught up in the benefits system, and who face the impacts of change, to navigate the very complex landscape that is emerging in social welfare.

11:15

Carolyn Lochhead: In primary care, we think that the links workers are important and will help people to get quicker access to services. SAMH would like some different models to be tried out, including having links workers operating as part of a cluster, as well as being located in-house. There is a commitment to provide 250 new links workers, but the fairer Scotland action plan says that only 40 of them will be in place by 2018. We think that that is a little bit slow and would like more to be in place by then. We also think that all GP surgeries in Scotland should have access to a links worker.

On the second question, we want better access to things such as psychological therapy, and we want people to have greater choice, but we think that medication has an important place in treatment and is important for many people. We often find that the reporting—and, to be frank, the political debate—around the statistics, particularly

in relation to antidepressants, is not helpful. People should have the choice to get whatever evidence-based treatment and support they agree with their healthcare provider, and they should certainly have a broad range of options.

The one point that we would like to be included in the committee's report is that SAMH thinks that the biggest thing that could be done as part of the next strategy would be to transform the culture of our mental health services and our education and employment services, so that people genuinely can ask once and get help fast.

Chris O'Sullivan: I echo Carolyn Lochhead's sentiment. On links workers, there is a crucial role for them to play in brokering connections to the system for people who do not know how to interface with that system. For young people, there is the "one good adult" approach, which can also apply to people who are excluded or marginalised as adults. During recovery, we often see that a strong relationship with a good and supportive person—regardless of their professional role—is the thing that helps people to move forward. That might help with unnecessary prescribing, of which there is undoubtedly some, which can result from people not feeling able to access the other options that are available to them.

What is the one point that we would like to be included in the committee's report? I am going to say prevention, aren't I? One crucial thing that the committee could do to push the direction of the strategy would be to ensure that mental health is freed from the constraints of being regarded as a specialist health issue and is instead anchored in all policies, without compromising the need for innovation and resources in mental health services for those who need them.

Dr Fraser: We are doing some work on evaluating links workers; the results of that work will be published soon. The question that I ask is this: how professional do they need to be? There is a lot to be said for peer help and youth workers, who have an awful lot to offer. I am talking about people who are not what would conventionally be regarded as a health professional workforce. The evidence base on youth workers is not great, so we should do something about that. I like Chris O'Sullivan's point about the "one good adult", and would echo it.

On the one point that I would like to be included in the committee's report, this is a bit of a dodge, but I say that there should be full-cream implementation of the Christie principles. That includes prevention and other things. The Christie report is hanging there and we have not really taken it on and lived it. If we were to apply the Christie principles to mental health, as we could apply them to other areas of public service, we would be getting places. I would start with very

young people and young adults, because they are the ones whom we need to nurture.

Colin McKay: On the links workers, we recently took part in a themed visit to people with severe and enduring mental illness who are living in the community. We saw that they are getting their medication and are being kept well enough to not have to go back to hospital, but we also saw that a lot of them are leading extremely impoverished lives, are isolated and are unable to access the jobs market. There is a need to think more broadly. Rather than simply asking, “Are you psychotic today?”, we need to ask people how we can help them to flourish. That is about rediscovering some of the values of social work from back in the 1960s, which were about helping people in a community to live flourishing lives and to contribute to society. Links workers and so on can help with that.

Without being sarcastic, the one big thing that I would ask for is that the strategy be a real strategy. We and the Scottish Human Rights Commission published a report called “Human rights in mental health care in Scotland”, which includes a diagram—a logic model—that illustrates what we are trying to do within a few years. Among the stated aims are:

“Service users and carers enact their rights ... a Scotland ... where care is person-centred and self-directed ... free of mental health stigma & discrimination ... in which recovery is a reality for all”.

We had to set out the medium-term outcomes that would contribute to those aims, the shorter-term outcomes and the actions that would get us there. We had to ask whether we believe that the things that we are doing will get us there. My worry about public services is that it is easy to announce something—that is not a bad thing—but we have to ask whether it will achieve the desired outcome, to which we might have to say, “I don’t know”, or “Probably not.” If we are going to have a 10-year strategy, it needs ambition and focus.

Lucy Mulvagh: Thanks very much for the question about links workers—I was hoping for an opportunity to mention them. As one of the organisations that has led on the national links worker programme, we are delighted with what it has achieved. The only point that I would add to what everybody else has said is that the links worker programme is quite a transformational approach to primary care, because it is not just about the relationship between the community practitioner, the links practitioner and the people who access the service in the practice to which they are directed. It is also about transforming the culture within primary care and how primary care is delivered. It is a practical thing that we can do to

transform our approach to mental health, as well as to the wider health and wellbeing agenda.

The point that I would like the committee to take away is, unsurprisingly, about rights. We would love the committee to call for the next strategy to be not only explicitly based on human rights, but to be developed using a human-rights based approach—for example, on a co-production basis with people who access services and support and with unpaid carers. We would like it to be built on a framework of human rights, with explicit references being made to human rights and human rights standards in its commitments, and we would like it to be measured against those human rights indicators. That might even extend as far as taking human-rights based budgeting approaches to how we finance and fund delivery of support and services, whether in the public sector or as part of the vast majority of services and support for mental health that are delivered by the third sector.

Dr Cook: A lot has been said about links workers. We need a transformation in primary care, at this time. General practice is struggling, so a better system for accessing mental health services within practices will be hugely helpful to everybody, including general practice colleagues.

I am concerned that we tend to look at antidepressants in a black-and-white way—we say that they are a bad thing. Antidepressants are a great thing if they are the right thing for a person. It is important that we encourage identification of mental health problems that will benefit from antidepressants at the same time as we offer psychological therapies. Psychological therapies combined with antidepressants can sometimes be the right treatment. It is not a case of choosing one or the other. We sometimes need both.

My big ask is for parity in how we treat mental health. The National Health Service (Scotland) Act 1978 says that mental and physical health should be equally regarded, but we need genuine parity in the resources and attention that are applied to mental health and in our understanding of better mental health in our whole community.

The Convener: I thank all the witnesses. I am sure that I speak for the committee when I say that we have found your evidence to be exceptionally helpful. Thank you very much.

11:24

Meeting suspended.

11:27

On resuming—

11:28

Meeting continued in private until 12:39.

Petition

Mental Health Services (PE1611)

The Convener: The third item on our agenda is a first look at petition PE1611, on mental health services in Scotland. I ask members for their comments on the petition.

Ivan McKee: We could perhaps feed the petition in to the on-going work of the targets review.

The Convener: We could pass it on to the review, given that the petition calls for a reduction in the target.

Ivan McKee: If the committee is content, the review group could consider that in the round with everything else that it is looking at.

The Convener: Are you talking about the review that is chaired by Sir Harry Burns?

Ivan McKee: Yes.

The Convener: Some of the issues that the petition raises were raised in today's evidence, so we can incorporate them into our report, as well.

Is it agreed that we will take those actions and leave the petition sitting for the moment?

Members *indicated agreement.*

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