OFFICIAL REPORT
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Health and Sport Committee

Tuesday 29 November 2016

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 29 November 2016

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HEALTH AND SPORT COMMITTEE
13th 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:

Penny Curtis (Scottish Government)
Dr John Mitchell (Scottish Government)
Lauren Murdoch (Scottish Government)
Maureen Watt (Minister for Mental Health)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 29 November 2016

[The Convener opened the meeting at 10:00]

Mental Health

The Convener (Neil Findlay): Good morning, everyone, and welcome to the 13th meeting in session 5 of the Health and Sport Committee. I ask everyone in the room to ensure that their mobile phones are on silent. It is acceptable to use mobile devices for social media, but please do not take photographs or film proceedings.

Agenda item 1 is our final evidence session on mental health. I welcome to the committee Maureen Watt, who is the Minister for Mental Health; Penny Curtis, who is head of the mental health and protection of rights division in the Scottish Government; Lauren Murdoch, who is head of the mental health unit in the Scottish Government; and John Mitchell, who is principal medical officer in the Scottish Government.

I invite the minister to make an opening statement.

The Minister for Mental Health (Maureen Watt): Thank you very much, convener, and good morning.

Scotland should be proud of its commitment to improving mental health. Over the past decade, the visibility and awareness of mental health have risen substantially in the nation. There is better public awareness of mental illness, and the creation of access standards for mental health has raised the profile of service demand at health board level.

Scotland was the first nation in the world to introduce a waiting time target for child and adolescent mental health services and was the first country in the United Kingdom to introduce a waiting time target for psychological therapies. That is an indication of how seriously we take the issue.

We want to continue to drive improvements in mental health services and are committed to ensuring that children and young people of any age get access to high-quality mental health services as quickly as possible. We have moved away from a pre-target position of not having a good picture of what was being delivered nationally and now have clearer information about demand and capacity. As capacity and throughput have increased, we are seeing more people start therapy each quarter.

The increase in demand has been driven by better awareness of mental health services, greater recognition of mental health problems and a reduction in stigma associated with mental health conditions. Demand is projected to rise as services become more accessible. In response, the additional funding that we announced includes £54 million for mental health improvement. That has been designed as a comprehensive package of support and it offers a new approach to the improvement of mental health services, which is to be delivered through working with boards across Scotland until 2020.

However, CAMHS is only a small part of how we support young people's mental health. We must focus on the things that evidence tells us are most effective in improving outcomes for children and young people. In the forthcoming mental health strategy, we will set out the Scottish Government's vision for mental health for the next 10 years. That is underpinned by the additional £150 million that we are investing in mental health to 2020. Having a 10-year timeframe is important and I want to ensure that we take the opportunity to focus on the things that will make a real difference in mental health and wellbeing.

The new strategy will focus on themes, which include: prevention and early intervention; responses in primary care settings; improving the physical health of those with mental health problems; and improving access to mental health services. It will be organised around life stages, to support mental health throughout a person's life. Supporting progress in those areas will require new models in primary care to respond to mental health problems. We want to deliver changes that will support people to look after their mental health alongside their physical health, treating and understanding them in the same way.

Alongside a continued focus on improving access to support and treatment for people with mental health problems, we want to make mental health services more efficient, effective and safe.

We need to be able to show that what we do matters, both in clinical effect and personal experience. Services will have a continued focus on realising the human rights of people with mental health problems. I will ensure that our new mental health strategy takes a rights-based approach.

We are ambitious for improvement and believe that those priorities will deliver significant improvements in the mental health of the people of Scotland.

I am happy to discuss that further with committee members this morning.

Colin Smyth (South Scotland) (Lab): At the committee's evidence session last week, Dr Alastair Cook, of the Royal College of Psychiatrists in Scotland, said that the draft strategy lacked ambition. We heard people describe it as a strategy for mental health services—you touched on that—rather than a comprehensive mental health strategy. Is that criticism fair? Who was consulted prior to the publication of the draft?

Maureen Watt: As the First Minister made clear last week in her reply to a question from Willie Rennie, we have taken very seriously the feedback that we received on what was an engagement paper, rather than a draft strategy. What was published was the result of engagements that had taken place; the document was in no way a draft strategy but was a further engagement paper.

The document drew the huge number of 598 responses. We have been gathering views from the national conversation that the Cabinet Secretary for Health and Sport started in August 2015, which lasted until March. Since then, we have had a programme of events to gather people's views. The events have been attended by 412 people; Lauren Murdoch can give further details about them.

Lauren Murdoch (Scottish Government): We have had public engagement events in Aberdeen, Dundee, Glasgow and Edinburgh. There was also an event that Children in Scotland ran for us, which consulted 49 children, a Young Scot round-table event, a workshop with the Convention of Scottish Local Authorities and an event with the Health and Social Care Alliance Scotland.

There have thus been quite a number of events since we launched the engagement paper. Prior to that, in my role as the head of the mental health unit I met organisations to talk through and develop the policy that led to the engagement paper.

Maureen Watt: Since coming into post, I have met a huge number of organisations as well. I think that I have met all the organisations that the committee has taken evidence from in its past three sessions.

Colin Smyth: It was not entirely clear who specifically was spoken to prior to the discussion document being published, given that it met with widespread criticism. In their written evidence to us, the Scottish Association for Mental Health, the Mental Welfare Commission for Scotland, the alliance and social work interests all talked about the lack of ambition in the original document and the need for a transformative vision.

Are you able to give an absolute commitment that the final strategy will reframe what we are talking about and be about not just mental health services but an absolutely transformative approach to mental health strategy?

Maureen Watt: It will certainly not be about just mental health services. We want to make sure that it is visionary in what it wants to achieve over the next 10 years. I want it to be visionary and ambitious; we also need to make sure that it is practical and deliverable. That is what we have been working on in developing the strategy, along with all the partners that we talked about.

Colin Smyth: We welcomed the appointment of a dedicated mental health minister. However, in focusing mental health on one department and one minister there is a danger of working in silos. Do you have the authority to go to every other Scottish Government department to make sure that they are all contributing to the strategy? It is not just about the health service and mental health services: it is about education, decent housing and employment opportunities for people in deprived areas, for example. Do you have the authority to cut across departments to make sure that the strategy has their full support?

Maureen Watt: You are absolutely right. One of the hallmarks of the Government has been its cross-cutting nature, so that it does not work in silos. We have to make sure that all the different policy areas that you outlined are involved in the strategy. I am working with Jeane Freeman on reducing poverty and we are working with education on welfare reform and the disability delivery plan. We are also working across employability and the justice system, which is also important. We have to make sure that we deliver a joined-up approach to mental health.

Alex Cole-Hamilton (Edinburgh Western) (LD): I want to build on Colin Smyth's point. Dr Cook, from the Royal College of Psychiatrists, recognised that the document is a consultation paper and not a strategy. He said:

"There is a lack of ambition in the consultation document, which contains a series of actions but no overarching aim or objective."

This is going to be a 10-year strategy, and we have been waiting for a year since the last one officially expired, albeit that we have still been operating under its terms. If the Government had an overarching aim or a big idea, it would have given a hint of it in the consultation document.

In the same breath, Dr Cook went on to say ,about the additional funding of which you speak:

"the new money that has been identified as coming into mental health services nowhere near matches the efficiency savings that are coming out."—[*Official Report*, *Health and Sport Committee*, 22 November 2016; c 5.]

All that is in response to delays in treatment times and access to treatment that Lucy Mulvagh, from the alliance, said are "absolutely outrageous".

Can you offer your reflections on the fact that we are not investing in mental health at all and we do not have ambition in the area?

Maureen Watt: You have raised a number of points, Mr Cole-Hamilton.

We asked all the people that we met and all those who contributed to the strategy what the strategy's vision should be. I have to say that there is probably not agreement on what it should be and some people did not have an idea about that. However, the vision that is nearest to where we want to get to is the one that the Scottish mental health partnership provided to us:

"Our vision is of a Scotland where wellbeing flourishes, where a focus on equality, prevention, support, human rights and recovery means good mental health for all, where people can get the right help at the right time, expect recovery and fully enjoy their rights free from discrimination and stigma."

We will develop that through the new mental health strategy.

You also asked about money. We have the extra £150 million over and above that which is spent on mental health. That amount of money has increased by 38.9 per cent during the past 10 years.

On the overall budget and efficiency savings, every health board has to make efficiency savings but the money is reinvested. Extra money is therefore going in. My colleagues and I are making sure that that money is being directed to where it can make the best impact.

Alex Cole-Hamilton: It troubles me when you say that stakeholders cannot agree on a vision, because it sounds as though the Scottish Government does not have a clear idea of what that vision should be. We are going to lock stakeholders into a 10-year strategy, so I hope that we can amend it once people agree what the vision should be.

I understand that new money is coming in, but that does not answer the question about the problem of money haemorrhaging out at the other end through the efficiencies that organisations and arms of the health sector are being forced to make.

I welcomed your appointment, minister, I really did. The First Minister was very gracious and said that you would be appointed in response to Liberal Democrat calls for a mental health minister. We applaud that and I have worked well with you in the past. However, you must be frustrated that, without the necessary tools to effect meaningful change, people might look at your office as window dressing for a problem that the Scottish Government is unwilling to solve.

Maureen Watt: You were absolutely wrong to say that money is haemorrhaging out of the health service. The health service budget is increasing overall, and in order to keep that going we must make sure that the money is well spent and used to the best effect. That is what we are doing. Efficiency savings mean exactly that. Money is reinvested in the health service; it is not haemorrhaging out to anywhere else.

10:15

Alex Cole-Hamilton: Those were not my words but those of Dr Cook, from the Royal College of Psychiatrists. He said:

"new money that has been identified as coming into mental health services nowhere near matches the efficiency savings that are coming out."—[*Official Report, Health and Sport Committee*, 22 November 2016; c 5.]

Maureen Watt: Perhaps someone in the health service would like to give another view.

Dr John Mitchell (Scottish Government): The efficiency savings apply across the whole range of health services. I think that Dr Cook's point was something to do with parity of esteem and the importance that organisations attach to mental health being considered a priority, with the money that comes into mental health and the efficiencies that are made in mental health staying in mental health.

Efficiencies have been made with no detriment to patient care—in fact, things have improved. An example is the efficiency of in-patient psychiatric bed use, which we know about from the two censuses that we did over a year. We have made a significant reduction in our in-patient beds, while managing to maintain enough availability for people who need them and reduce the number of out-of-area-placement beds that we need for children and young people.

Alex Cole-Hamilton: In answer to a freedom of information request that I made in the summer, we discovered that children were being turned away from in-patient CAMHS tier 4 beds because there were insufficient people to staff them. The beds might be there, but they are not always available, are they?

Dr Mitchell: The Mental Welfare Commission for Scotland's report welcomed the big reduction in the number of children who were being admitted to general adult psychiatry beds rather than child and adolescent beds. We are going in the right direction, despite a reduction in the total number of psychiatric beds.

Maureen Watt: We would always want to make sure that patient safety is paramount before

admitting a child. The other week, I visited the Dudhope young people's in-patient unit and met staff and patients. The unit seems to be working well, and that is what we want to see.

As Dr Mitchell said, we want to make sure that, as far as possible, we treat young people at home in the community rather than take the step of putting them in mental health beds.

Clare Haughey (Rutherglen) (SNP): Thank you for joining us this morning, minister. I am mindful that, over the past several weeks, the committee has heard information from lots of bodies and organisations about mental health, but we have not fed that information into the mental health consultation. How would you feel about the committee writing to you with some of the information that we have gathered and asking whether that can be considered as part of the 598 responses that you have received?

Maureen Watt: I am happy to discuss that with the committee. I want to publish the strategy this year. I do not know when you intend to publish your inquiry report, but if the committee wished me to, I could consider holding off publishing the strategy until January—at the latest—to take into account what you might wish to put forward.

The Convener: That would be helpful. We finish our evidence sessions for the inquiry today, but we will need a bit of time to gather our thoughts and for the parliamentary officials to assist us in drafting the report. It would be remiss if we did not feed into the consultation, given the evidence that we have taken, and it would be good if the Government could indicate whether it was willing to give us that time. We are not talking about months—perhaps a week or so.

Maureen Watt: Will you definitely publish your report by January?

The Convener: Yes.

Maureen Watt: As long as you are not then going to criticise me for not publishing the strategy in 2016, I will certainly take that into account.

The Convener: Thank you.

Ivan McKee (Glasgow Provan) (SNP): I thank the minister and the other panel members for coming to talk to us. I want to explore the preventative agenda a wee bit. You mentioned it in your opening remarks, minister, but I want to know how you see the focus shifting to tiers 1 and 2. We have heard from witnesses—and I have heard this from constituents who are involved in the area, too—that many cases that end up on tier 3 waiting lists could have been addressed earlier had there been more resource, focus and training and a wider understanding of how to deal with the issue at that earlier stage. That would mean that the individual's needs would be addressed earlier and that the issues might not be as severe or would not get worse over time as a result of the individual being in a long queue at tier 3. How do you see resources shifting in that regard? What policies are there to effect that?

Maureen Watt: You have taken evidence on the different tiers. The strand that will run through the whole of our strategy is starting well, living well and ageing well mentally. We absolutely want to focus on tiers 1 and 2. As you have said, there has been much focus on tiers 3 and 4. Children are sometimes sent to tier 3 when in fact they do not necessarily need that kind of intervention, and we want to build up the workforce in tiers 1 and 2 to ensure that children, parents, health professionals and schools are more aware of what to do with children or young people who are beginning to show signs of mental distress.

Penny Curtis can give you some examples of that in more detail.

Penny Curtis (Scottish Government): Mr McKee, are you talking predominantly about children and young people or more generally? The same would apply to both.

Ivan McKee: I am mainly talking about children and young people. I have spoken to people about the mental health first aid training programme for teachers and to third sector organisations that are working on play therapy and so on. That kind of thing seems to have an impact, and it is also probably much more cost effective to do things at that stage rather than later.

Penny Curtis: Yes. There are already good examples of staff in schools being upskilled in areas such as mental health first aid. Indeed, some pupils have done the same in order to help their peers.

The need for the changes is partly driven by the impact that the waiting times standard has had on CAMHS. The level of demand has increased year on year, with a 10 to 20 per cent increase in the number of children and young people who start treatment every year. That is not just referrals coming in; it is children who are receiving some form of treatment when they are seen by CAMHS.

In part, that has been driven by the unmet need that has always existed in the system, and that is being much better picked up by general practitioners and by staff in schools and other children's services. Cases are now much more likely to be referred on. As a result of that increasing demand, CAMHS professionals now have to concentrate on treating those children and young people, which means that there is less capacity for those professionals to do early intervention work with other children's services.

We know that, in the next strategy, we need to look at how those connections can happen better so that CAMHS professionals are involved in supporting other children's professionals to make good decisions about the most effective early intervention and prevention approach to take. That is also about upskilling other services to deliver what the evidence base says is most effective for different problems emerging at different times. Another aspect is what we might call the population-based approach, which includes the things that go on to ensure that schools have a nurturing culture that supports good mental wellbeing and resilience in children and young people.

Ivan McKee: I would like to explore that a bit further. I understand what you say about a nurturing environment, but I am asking specifically about dealing earlier with individuals who have an identified issue. I think that I heard you say that resources are driven towards meeting the tier 3 target. In the medium to long term, that is inefficient; indeed, I imagine that the evidence would show that it is much more effective for resources to be deployed further upstream.

Penny Curtis: Absolutely. That is the downside of the target.

Ivan McKee: I am 100 per cent in favour of targets, but do we have the wrong target or, in fact, not enough targets? It might be helpful to have targets for tiers 1 and 2, too. I know that a target review is being carried out by Harry Burns, but would you like to comment on that?

Penny Curtis: Absolutely. The target has been extremely helpful. A target is always designed to drive improvement over a period of time and, in CAMHS, there was a clear case for why that needed to happen: the service was under capacity and waiting times of a year and more were common. The target has driven significant improvements.

There are always unintended consequences, or consequences that can be accepted for a point in time, but it is necessary to track some of the other important things that are happening. In CAMHS, for example, we have what is called the balanced scorecard, which looks at activity across a range of indicators and gives a more balanced picture of the whole service. Our use of data in the new mental health strategy means that we will look right across the system at the most important things.

Ivan McKee: Maybe those indicators should have the same profile as the tier 3 waiting time target. That way, we might be able to drive resources to the right place.

Maureen Watt: We need to be careful, because tiers 3 and 4 relate to medical interventions by medical professionals such as psychologists and psychiatrists. With tiers 1 and 2, we envisage much lower-level intervention, such as the basic counselling that is now offered in many schools. That is the kind of early intervention and prevention that we are talking about. All teachers are responsible for literacy, numeracy and wellbeing, so it is a case of making sure that more teachers and other professionals have mental health first aid training, and that use is made of the counselling service that is often provided by the third sector through integration joint boards, in schools or through GP practices.

Dr Mitchell: We need to use data in a very smart way. You are right that we need to get a handle on what we are doing and whether it is making a difference at all levels, from population level through to specialist services. We are going through an exercise of thinking about how we can collect data that evidences meaningful change in not just the clinical but the personal outcomes that the minister mentioned in her opening statement in a way that is not a burden to services. We do not want to have data that measures only specialist services; we want the data to cover a much broader range of services and to relate to the health and wellbeing indicators and the care standards. We want to take a total-population approach.

The Convener: Minister, you said that many schools have access to counselling. What percentage of schools have that on tap if they need it?

Maureen Watt: I do not have the figure to hand, but both the local authorities that cover my constituency have counsellors available for secondary schools. We want to make sure that people who work in nurseries and primary schools have mental health first aid training, so that they can recognise when children are beginning to show signs of mental distress.

The Convener: Yes, but you said that many schools have access to that service. It would be good if your officials could provide the committee with that information at some point.

As a parent, if my son or daughter had a rejected referral to CAMHS, I would want to know why. If the rest of my children were rejected as well, having gone through that process, I would want to know why. As a corporate parent, what is the Scottish Government doing to check on the almost 6,000 young people—20 per cent of the referrals—whose referrals are rejected? West Lothian Council called for a review of those rejected referrals. Would you support such a review to find out what is happening to those children?

10:30

Maureen Watt: I do not want to build in any unnecessary delays to children getting access to services. We have already put £54 million into a support package for mental health services for children and adults to make sure that they get the appropriate support that they require.

Of the allocated money, £4.8 million has been awarded to Healthcare Improvement Scotland to establish a mental health access improvement support team. That team will work with boards to improve access to mental health services.

We have also increased the workforce in mental health services and put money into training to upskill those already working in those services.

I will ask John Mitchell to talk about the rejected referrals—

The Convener: Do you support a review of the rejected referrals to find out what is going on, which West Lothian Council has called for?

Maureen Watt: What I said to you in my initial response was that I do not want to introduce any unnecessary delays into the system—

The Convener: I am not asking about any delay; I am asking about a review.

Maureen Watt: But if we have a review, it might introduce a delay and I think that we are beyond that stage.

Dr Mitchell: All specialist services have admission criteria and all specialist services will, from time to time, decline referrals. Whether that is child and adolescent mental health services or general psychiatry or physical medical specialties, the referrer is given an explanation about why the specialist service is not necessarily the best place to meet the needs of the person being referred. It is up to the service to explain to an individual why a referral has not been accepted and what alternatives are available.

The Convener: Is there a problem in the system that explains why almost 6,000 children are apparently being referred inappropriately in the first place?

Dr Mitchell: For every specialist service, there are always referrals that are inappropriate. That is common to every specialty in medicine.

The Convener: Almost 20 per cent of referrals are rejected, though.

Dr Mitchell: I think that you would find the same in general psychiatry.

Maureen Watt: It goes back to Ivan McKee's question about appropriate referral. Someone may not require a tier 3 intervention and that is why there is a referral back to tier 1 or 2.

Maree Todd (Highlands and Islands) (SNP): I have a supplementary question about eligibility. A couple of people gave evidence about how the age of eligibility varies across the country. Are there any thoughts about standardising that? As a pharmacist, I know that there is some evidence that, physiologically, your brain is probably not adult until you are about 25. The impact of these illnesses at a time when someone is trying to fulfil their educational potential, form relationships or get into work can be devastating. There is quite a good case for a very specialised service for children and adolescents, probably covering adolescents who are older than the age range that is currently covered. What are your thoughts on that?

Maureen Watt: We are aware that there are discrepancies between health boards as to when young people are referred on to adult services. Some health boards refer people on at the age of 16 and are very rigid about that; others refer people on at the age of 18 and are not so rigid.

The main priority is to make sure that the transition from child and adolescent mental health services to adult services is smooth. There are examples of good practice for that transition. John Mitchell can comment on that as a medical specialist.

Dr Mitchell: The transition period is always a period of risk and concern. The difficulty of having separate services for children, for adolescents and for older adults is that there are then two transitions rather than one.

Your argument is best applied in relation to early intervention in psychosis. The early intervention in psychosis services that exist in Scotland cover a broader age range, from adolescence right into young adulthood. That is completely for the reasons that have been mentioned about the developing brain and the social position of a child becoming an adult and having to think about living on their own, employment and relationships. As is covered in the engagement document, we certainly support further work to improve early intervention in psychosis services for that age range.

Richard Lyle (Uddingston and Bellshill) (SNP): Good morning, minister. I wish to move on to waiting times. In your introduction you said that we were the first to introduce a waiting time target for mental health. The most recent figures on performance against the waiting time target for CAMHS shows that only seven out of the 14 health boards met their target. Across Scotland as a whole, 77.6 per cent of people were seen within 18 weeks. Are you happy with that performance? Could it be improved on? What are you doing to ensure that it is improved on? What are you doing

to ensure that the other seven health boards get their finger out?

Maureen Watt: I am absolutely not happy with that. I keep a very close eye on the statistics when they come out. Not only that, the extra £150 million is being used to help boards to meet their targets. For example, in the first tranche for health boards, some are quite close to meeting their targets or are meeting their targets. Two that are further away from their targets are working with Healthcare Improvement Scotland to see how they can reconfigure their services so that they start to meet their targets. We are seeing some initial evidence that that is working. John Mitchell or someone else can give the exact statistics.

I think that you had someone from NHS Forth Valley before the committee. I speak to health board chairs and chief executives on a regular basis, and all the boards have a keen eye on their mental health waiting times. That is very much at the forefront of their minds. The extra money that we have allocated to us is being used to help with that improvement.

It is possible that there will be a further dip in waiting times as boards reconfigure their services, but other boards are making big strides. For example, NHS Tayside has taken measures to meet its targets. As I say, every board is offered those services from Healthcare Improvement Scotland to help them reconfigure their services, employ more staff and retrain staff, if necessary, to bring them up to meeting their targets.

I am not happy about the situation, but I am quietly confident that we are moving very much in the right direction to ensure that all boards will meet their targets.

Richard Lyle: So there is more money going into mental health and we have a dedicated minister, whom I respect highly. We can now move things forward, and a new strategy will come out in January. Now that you are the minister, are you and your officials going to be driving the health boards to improve on a daily or weekly basis to ensure that they can deliver more? I am sure that Penny—Mrs Curtis, sorry—will tell me yes.

Maureen Watt: My answer is yes, but Penny will tell you how we are doing.

Penny Curtis: Picking up what the minister has said, I think that it might be helpful to set out in a little bit more detail the improvement package that ministers have put in place. Through the data that we were seeing and the engagement that we had with the clinical and managerial leads in each health board, we recognised that different things were happening in each board. Some boards had made reasonably good progress towards meeting the targets, but others were struggling with particular and very individual things. Sitting in the Scottish Government and looking at the national data or even health board data, I think that it is very hard to understand exactly what is happening under those headline figures.

We recognised that what we had to do to support boards to improve was to do something bespoke for each area that allowed us to have much more genuinely collaborative engagement with them. Instead of sitting with a very hard-hat performance management look—which, of course, the minister would also take in demanding that chief executives take improvements to mental health services seriously—we also went in and worked closely with a board to understand the local barriers. Quite often, they were very simple things such as access to good analytical support or good systems improvement, or particular redesign issues that they were struggling with.

That is the work that Healthcare Improvement Scotland has been doing, but it is also very closely tied to NHS Education for Scotland's work on and investment in ensuring that the workforce supply is right and is being used sensibly to meet the needs of boards in a strategic way. That said, we recognise that there have been other issues to address. For example, there was not enough capacity in the system, which is why money has gone out to the boards and health and social care partnerships to support investment in more staff to deliver more services and therapies in CAMHS.

Richard Lyle: I have one more question, convener.

The Convener: Okay, but I must ask for brief questions and brief responses now.

Richard Lyle: I am not sure whether the response to this question will be brief, convener. Given that the Scottish Government and Government ministers get blamed when other organisations fail, what work are you doing to ensure that, when the new strategy comes out in January, all the boards work to it and do not fail?

Maureen Watt: The work on meeting targets is on-going and is not necessarily going to change significantly as a result of the strategy. In other words, we are not waiting for the new mental health strategy to come out in order to meet waiting times targets. Healthcare Improvement Scotland and NHS Education for Scotland will, where necessary, work with boards on redesigning services to start meeting the targets using best practice from other boards. Healthcare Improvement Scotland is involved with the redesign, while NHS Education for Scotland is, as Penny Curtis has said, seeking to ensure that boards have the right workforce in place to start meeting their targets. As I have said, any redesign of a service might cause initial hiccups, but I am

confident that that work will lead to all health boards meeting the targets better.

The Convener: You have said that things will not change too much because of the strategy. However, I hope that they do. After all, that is why we need a strategy that works.

Maureen Watt: I was talking about the redesign of services. As I have said, that work is already going on.

Donald Cameron (Highlands and Islands) (Con): Good morning. First, I just want to make an observation. Unusually, there is a huge degree of cross-party support for mental health—it is an area of great consensus. However, if this strategy is not right or ambitious enough, that support will be squandered, and I just hope that you accept that the stakes are very high here.

Secondly, I have a question about the right-based approach that Lucy Mulvagh referred to last week and which the minister mentioned in her opening statement. Such an approach is clearly a good thing as a general principle, but how do we achieve it in practice? How do we enforce someone's rights in this respect?

Maureen Watt: I agree with your observation. Given that the issue of mental health has been raised not just by my appointment but as a result of the keen interest that all parties are taking, the stakes are high. I realise that I will not satisfy everybody with the strategy when it comes out, but I hope that everybody acknowledges the importance of the vision and the direction of travel. On governance, we will put in place a strategy reference group to ensure that we are going in the right direction. Although it is a 10-year strategy, we will ensure that there are outcomes that have to be achieved along the way.

10:45

A rights-based approach will be embedded in the strategy, which will focus on the delivery of rights through the PANEL—participation, accountability, non-discrimination and equality, empowerment and legality—principles. We will try to make the provisions in mental health legislation meaningful to everybody. Rights will be intrinsic to the actions in the strategy, and we will ensure that people with enduring mental health problems in particular are empowered to have a say in their treatment. We will try to encourage more people to make use of advocacy and have a written statement of their treatment, which they can work on when they are well. John Mitchell is involved in that area.

Dr Mitchell: I was going to give examples of PANEL. Participation is about how people are involved in their own care plans. We have done work on anticipatory care plans and advance statements. Accountability is about measuring outcomes and data and showing that what we do matters for people. Non-discrimination and equality are about parity of esteem, and looking at and trying to face the issue of premature mortality. On empowerment and legality, we have the Millan principles that the current legislation sits on, which guide clinical decision making in terms of protecting people's rights when their ability to give consent to decisions is impaired.

Miles Briggs (Lothian) (Con): Good morning to the panel. One of the aspects of the strategy on improving mental health services in the community is the role of links workers in GP surgeries. When will all 250 links workers be in position?

Penny Curtis: None of us is the policy lead for that so, if it is okay, we will write to the committee with further information about that.

Miles Briggs: We heard evidence last week on that issue, which is why I wanted to know whether the minister is involved in it. The fairer Scotland action plan suggests that only 40 of the 250 will be in position by 2018. That is not good enough. If we are really going to make a huge difference, those 250 should be recruited and trained now. I ask that you look at this and ensure that we consider how we are going to recruit those people early on so that they are in place across Scotland. Just 40 links workers by 2018 is completely unacceptable. If the funding is in place, we should be recruiting those people now. Will the minister comment on that? Can we look at how we can transform services with the links workers?

Maureen Watt: We can certainly take the query away and get back to you on it. Although we aim to recruit links workers to every practice, that does not mean that there is not already someone with training in mental health available in the GP practice. It is more than likely that someone is already available; we have to ensure that GPs and other people in the practice are aware of all the services that are available in their communities as well as CAMHS.

Miles Briggs: As the minister responsible, when do you think that the 250 links workers—it was in your manifesto, which we are all signed up to delivering—should be in place?

Maureen Watt: As I said, we will get back to you on when we expect that to happen.

Alex Cole-Hamilton: In reflecting on Richard Lyle's question and the minister's response, it strikes me that the reason why half our health boards have failed to meet their CAMHS target is not want of a Government minister breathing down their necks and saying, "You must work harder", but the profound question mark over investment.

I will ask specifically about autism. This week, three families have come to see me, all of whom have children with autism who are at various stages in the CAMHS process. None has had a diagnosis within six months and some have had to wait more than a year. With that delay comes failure to connect with other services: for example, they cannot get benefits, including disability living allowance. There is, for those families, massive uncertainty about what life holds.

The Convener: A question.

Alex Cole-Hamilton: What can we do to disaggregate autism from the CAMHS system to make sure that such families get the care and treatment that they need as quickly as possible?

Maureen Watt: I am not sure that autism necessarily needs to be disaggregated. The number of psychiatrists who specialise in learning disability has doubled in recent years. I accept your point that in some cases people wait too long for a diagnosis, but every local authority has to have an autism strategy and many of them work with third sector organisations that work in autism in order to ensure that families get the support that they need.

I am not happy with the situation as it is at the moment in some areas. However, autism and mental health in general now have much higher profiles. Some cities, including Aberdeen in my constituency, are working towards becoming autism-friendly cities. I work closely with the Minister for Childcare and Early Years on the issue.

Alison Johnstone (Lothian) (Green): My first question is on perinatal services.

The Convener: We can come to that at the end. Can you ask about health and inequalities?

Alison Johnstone: Okay. The minister is aware that evidence on health inequalities and mental health shows marked differences between people who experience mental health problems and those who do not. People with long-term mental health problems typically have poorer physical health and shorter life expectancy than the general population. Will the new strategy aim to close the life-expectancy gap and how will it achieve that? How will the new strategy respond to inequalities through preventative measures?

Maureen Watt: As Alison Johnstone does, I think that it is unacceptable that life expectancy among people who have enduring mental health problems is shorter by up to 20 years. That will be key in our strategy; the situation has to change and the strategy will focus on improving care of the physical health of people who have mental health problems; we will make sure that when people present with mental health problems, their physical health is looked at, as well.

When I am out and about, I talk a lot about parity of esteem, which means looking at the whole person and not just at their mental health in one silo and their physical health in another silo. It is incumbent on all of us in the healthcare sector to make sure that the total person is looked at and that healthcare is provided. We will expect people who deal with individuals' mental health problems to look at their physical health as well, including support for smoking cessation, for alcohol and drugs problems and for obesity problems. We have made huge strides on smoking cessation, but we now have to drill down to look at specific groups. A focus on smoking cessation for people with mental health problems is one obvious area.

We have given £1 million to SAMH for improving the physical health of people who have enduring mental health problems. The see me campaign has been a huge part of everything that we do in mental health and is a great success story about reducing stigma among people with mental health problems.

Alison Johnstone: I appreciate that response. Will you advise what action the Scottish Government is taking in other policy areas to improve mental health? We know that housing has an impact, as do education and the lack of a decent environment to exercise in, for example.

Maureen Watt: Making sure that people are resilient and grow up with the capacity to deal with such problems is important. All the other ministers feed into our work to ensure good mental health for all. That involves policies including the fairer Scotland action plan, and it includes ensuring that people live in good housing, get the right education, have places to walk and get fresh air, and stuff like that.

Miles Briggs: My question is about finance for the strategy: you mentioned a figure of £150 million. Is that amount set in stone or could more money be found if other services need to be developed?

Maureen Watt: Obviously, everybody would like more money to be found, but it is not there on a tree to be plucked. It is important to remember that the £150 million is money in addition to what is already spent on mental health services, which is about 11 or 12 per cent of the total health budget. As we have discussed, this is about reconfiguring services to ensure that money is used wisely and that we are meeting the population's demands.

Miles Briggs: The First Minister has suggested in the chamber to a number of colleagues from across the parties that the £150 million is not capped and that money could be found for additional projects that are in need of funding. Do

you believe that that is the case? Could money be brought forward relatively quickly? We have met a lot of organisations that have suggested that projects that are not currently included in the strategy might in the future make a huge difference in helping to improve mental health.

Maureen Watt: I have not heard of any new money. Have you, Penny?

Penny Curtis: No.

Maree Todd: On mental health legislation, in the previous session of Parliament there was agreement to consider how learning disabilities are regarded in law. I think that a particular issue was going to be looked at. Will you update us on that?

Last week, the chap from the Mental Welfare Commission for Scotland who gave evidence said that the first mental health legislation that was passed by the Scottish Parliament was world leading, but we are now probably behind the rest of the world in respect of our approach to mental health law. Is a general review being considered that would take into account the more modern view of human rights standards and disability law?

Maureen Watt: I will answer the second question first. The Mental Health (Scotland) Act 2015 builds on the Mental Health (Care and Treatment) (Scotland) Act 2003 and ensures that rights are embedded in everything that we do. Penny Curtis will expand on that and respond to the first question.

Penny Curtis: The commitment to review learning disability was made by the minister at the time, Jamie Hepburn, when the 2015 act was passed. There was a long-standing commitment to review the definition of mental disorder in mental health legislation. We have asked a number of organisations to scope what the review should cover and we have made it clear that it should be inclusive. That process is pretty much concluded, so we will consider its outcome and offer ministers advice about the next steps over the next few months. That will be part of the context of the mental health strategy.

11:00

As the minister said, mental health legislation in Scotland is part of a complex set of legislative provisions that have built up over time and concern not only mental health but get into issues such as adults with incapacity. As the provisions have built up over time, issues have emerged that suggest that the legislation does not work as well as we might like it to work. At this stage, we have committed to initial consideration of measures that are not working and of how they can be improved. No sensible Government would undertake lightly a wholesale review of mental health incapacity legislation, but with a 10-year strategy it is absolutely right and helpful that we can revisit how Scottish legislation operates in the context and experience of what is happening around the world.

Clare Haughey: I declare an interest in that I worked in perinatal mental health for more than a decade before I was elected. I am going to ask a question about the subject, which is close to my heart.

The number 1 ask in the Royal College of Psychiatrists in Scotland's manifesto this year was that we improve the health of mothers and babies throughout Scotland. I note that, last week, NHS England announced a £40 million investment in perinatal mental health services, with a further £20 million next year specifically for mother and baby units. What investment is being made in perinatal mental health services in Scotland? How does the minister envisage those services developing over the next few years?

Maureen Watt: A focus on perinatal mental health is key to our programme of starting well, living well and ageing well, as a focus on pregnant mothers' mental health and the health of the newborn baby is key to starting well. As you will know, along with the new mental health strategy, there is currently a review of maternity and neonatal services. Perinatal mental health will be a key part of that review. I also recently agreed that £170,000 should be spent on setting up a managed perinatal clinical network. That will happen in the next few years to enable collaboration between people who work in the field to ensure that they have the right focus and are taking the right way forward.

Clare Haughey: I was not aware that a managed clinical network is being set up. That was going to be my next question. The services have been calling for that for some time, so I am really pleased to hear that news.

Alison Johnstone: I may be behind the curve, but I understand that the application to establish a managed clinical network was unsuccessful at a meeting of the national specialist services committee. Why was that and what alternative routes will the minister pursue?

Maureen Watt: We are pursuing alternative routes. John Mitchell will tell you why the application was unsuccessful.

Dr Mitchell: The application went to the national specialist services committee. Although the committee members all agreed that it is an important area of care, they had anxieties about funding being made available through boards top slicing money to fund the network. We took the matter to the minister to ask whether we could fund it centrally, which she confirmed only last

week. We have let stakeholders know quickly, so they are aware of that. We still have to take the business case for the proposal back to the national specialist services committee because NHS National Services Scotland would manage the perinatal managed clinical network and, therefore, needs to set up the machinery to enable its doing that. The problem was funding, which we have now resolved.

The Convener: The drug and alcohol services budget was cut significantly this year. Earlier, you said that there is no tree from which to pluck money. It appears that the integration joint boards have had to find a tree from which to pluck money to fill the gap in the drug and alcohol services budgets. Was that the right approach? What impact will that cut have on mental health services?

Maureen Watt: Alcohol and drug partnerships are meeting our targets on alcohol and drugs. The Cabinet Secretary for Health and Sport wrote to health boards about the funding of alcohol and drug partnerships, making it clear that they should find the money from their own resources to ensure that alcohol and drug partnerships are funded—

The Convener: Where were they to find that money?

Maureen Watt: It comes from their own resources. The alcohol and drug partnerships—

The Convener: The money tree?

Maureen Watt: As I have said, the alcohol and drug partnerships are working well—they are meeting their targets. The boards were told in a letter from the Cabinet Secretary for Health and Sport that they must ensure that the alcohol and drug partnerships are adequately funded.

The Convener: So, if you were asked to find the same extent of additional money for mental health services from your budget, would you be able to find it?

Maureen Watt: The thread that has run through all the evidence from me and colleagues today is that reconfiguring of services to meet new demands and to ensure that money is used wisely goes on all the time.

Alex Cole-Hamilton: The Audit Scotland report absolutely shows that we are meeting our targets on critical-care drug and alcohol treatment, but the cut to alcohol and drug partnerships' funding is £1.3 million a year in Edinburgh alone. There is no way that we will meet our on-going targets if we have to absorb that kind of cut. The reconfiguration will be measured out in lives.

Maureen Watt: As I said, the targets are being met. It is not just about medicalised treatment.

Alex Cole-Hamilton: The cut has not come in yet.

Maureen Watt: This is about alcohol and drug partnerships on the ground. As Minister for Mental Health, I have visited a number of partnerships, including in Edinburgh, and the work that they are doing is meeting the needs of their communities.

Alex Cole-Hamilton: But the partnerships will lose £1.3 million this year.

Miles Briggs: The minister said that she has visited the Edinburgh partnerships. I have, too. People in those partnerships have told me that a person with an alcohol or drug dependency issue cannot access mental health services. What are you doing to change that?

Maureen Watt: That is very much about cross-working, and alcohol and drug partnerships will have access to people who work in the mental health field.

Miles Briggs: The partnerships cannot refer people, though.

Maureen Watt: Do you want to take this over, Penny?

Penny Curtis: One of the key things that we are looking for in the mental health strategy is recognition that it is probably the first major strategy in health and social care since the integration of health and social care. We will be looking to empower the health and social care partnerships to use their accountability and responsibilities to work across boundaries. That means that we must be very clear about where flexibility exists in respect of the money that goes to the partnerships and about their responsibility for delivery.

Alcohol and drugs services and mental health services are a really good example of why integration was put in place and of where opportunities exist. Responsibility for meeting an area's local needs is with those who deliver those services. If there is a gap between them, the services are responsible for filling it. We are looking to make that accountability clear while providing flexibility such that areas' needs can be met in their own local context.

Miles Briggs: I hear what you have to say about empowerment, but partnerships cannot currently refer people to services. I have not seen moves to change that. Is it likely to change? Is that what you are trying to say?

Dr Mitchell: Substance misuse services are mental health services. They all include consultant psychiatrists, junior psychiatrists, psychologists, mental health nurses and social workers in their multidisciplinary teams. Mental health expertise is available in substance misuse services. There are

sometimes, in the relationship with general mental health services, barriers between services, which should not exist. Services have tried to develop local comorbidity arrangements to ensure that links are made.

The Convener: Can we expect the same to happen this year? Can we expect a further budget cut? Will people be asked to shake the money tree again?

Maureen Watt: We are waiting for the budget to be delivered next week or the week after. I have not had sight of the budget.

The Convener: Have you been scrapping and fighting on behalf of the service that you manage and saying that you will not accept a cut like that again this year?

Maureen Watt: The budget will be delivered next week or the week after.

The Convener: Okay.

In its submission, NHS Health Scotland claims that three out of four people with significant mental health problems are not getting the treatment that they need. We have found that that evidence does not refer to Scotland. The way in which it was presented was disappointing—although that may have been to do with how I and some of my colleagues interpreted it.

Do we know the figures for Scotland? How many people with a significant mental illness are being treated and how many are not being treated? Is three out of four way off the mark?

Dr Mitchell: In mental health, it is very difficult to try to work out prevalences and incidences, because mental health—the spectrum from mental wellbeing to illness—

The Convener: People seem to be doing it elsewhere. Are we doing it?

Dr Mitchell: The best information that we have is from the Scottish health survey. We know that, at any time, about 16 per cent of the population has a mental health disorder, but that includes minor disorders that primary care would manage, as well as more serious mental disorders.

The Convener: Is the term "significant mental illness" used, as it is in the research that I mentioned?

Dr Mitchell: We would not necessarily recognise the significant mental illness figure of 25 per cent. The population prevalence in Scotland of severe mental illness—for example, schizophrenia—is 1 per cent. Only a third of those people are in on-going treatment with services. It is very difficult to identify population need and then to give an exact estimate of how much of that need is being met in primary care or secondary care.

The Convener: England and Scandinavia seem to have a method to assess that. Is it a standard assessment method?

Dr Mitchell: There are proxy measures, as I said. We know from our questionnaire studies in Scotland that about 15 per cent of the population would meet a level of symptom announcement that suggests that they have a mental health problem.

Early on, when we started the process, NHS Education for Scotland thought that about a third of the population who require psychological therapies were actually accessing them. We have improved our performance against that. Psychological therapies represent such a wide spectrum of treatment that we are comparing apples with oranges. It is difficult to say, across the breadth of all mental health problems, exactly what the penetration of service response is.

The Convener: Are there internationally recognised comparative data?

Dr Mitchell: There are no data that are any more precise than what I have described.

The Convener: Could you write to the committee to advise us of what data you have and do some comparative analysis?

Dr Mitchell: Certainly.

The Convener: Thank you for your attendance today.

11:14

Meeting continued in private until 12:02.

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