OFFICIAL REPORT
AITHISG OIFIGEIL

Public Petitions Committee

Thursday 18 January 2018

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 18 January 2018

CONTENTS

PUBLIC PETITIONS COMMITTEE
1st Meeting 2018, Session 5

CONVENER

*Johann Lamont (Glasgow) (Lab)

DEPUTY CONVENER

*Angus MacDonald (Falkirk East) (SNP)

COMMITTEE MEMBERS

*Michelle Ballantyne (South Scotland) (Con)
*Rona Mackay (Strathkelvin and Bearsden) (SNP)
Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Ruth Christie (Scottish Government)
Dr John Mitchell (Scottish Government)
Jenny Simons (Scottish Government)
Maureen Watt (Minister for Mental Health)

CLERK TO THE COMMITTEE

Catherine Fergusson

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Public Petitions Committee

Thursday 18 January 2018

[The Convener opened the meeting at 09:01]

Continued Petitions

Mental Health Treatment (Consent) (PE1627)

The Convener (Johann Lamont): I welcome everyone to the first meeting in 2018 of the Public Petitions Committee. I hope that everyone had a good break, and I wish you all the best for the new year. I remind members and others in the room to switch phones and other devices to silent. We have received apologies from Brian Whittle.

The first item on our agenda is to take evidence on petition PE1627, on consent for mental health treatment for people under 18 years of age. As members know, the petition was lodged by Annette McKenzie. We last considered the petition on 7 December 2017, when we took evidence from Penumbra, the Scottish Association for Mental Health and Children in Scotland to explore the support that is available to people under 18 years of age who experience and seek treatment for mental ill health.

This morning, we will take evidence from the Minister for Mental Health, Maureen Watt; Ruth Christie, who is head of early interventions in the mental health and protection of rights division of the Scottish Government; and Dr John Mitchell, who is principal medical officer and psychiatric adviser in the Scottish Government. I welcome you all to the meeting.

Members will have a range of questions to assist us in understanding the support that can be offered to young people who experience mental health difficulties. However, before we get to our questions, I invite the minister to make an opening statement.

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

I start by offering my sincere condolences to Britney's mother, Annette McKenzie, and all her family and friends. Any death by suicide is a tragedy that has a devastating impact on family, friends and communities. It is a testament to her daughter that Ms McKenzie has raised the important issues in her petition for consideration by the committee. I thank all those who have given evidence.

Before we discuss the detail of the petition, I want to say that mental health is a priority for the Government. Our 10-year mental health strategy, which was published on 30 March 2017, sets out our vision to improve mental health in Scotland. A number of actions in the strategy are aimed at ensuring that children and young people have good mental health and that agencies act early enough when issues emerge and impact on young lives.

Early intervention and prevention are the cornerstone of our approach to mental health and wellbeing. Everyone needs to talk about mental health, and reducing stigma, promoting discussion and early action are vital to ensuring that Scotland is the best place for our children and young people to grow up in, especially in 2018, which is the year of young people.

Any suicide is a tragedy with a deeply distressing impact on family and friends left behind. We are currently developing a new draft suicide prevention action plan. The draft plan will be published for comment in spring 2018 and will be supported by a short series of engagement events, which are currently being planned. We will publish the final action plan later in 2018.

I agree with the view that committee members have expressed and with others who have given evidence, including the Scottish Youth Parliament, that young people have a right to confidentiality when seeking medical advice and a right to make informed decisions about consent. That is the case across a range of physical and mental health conditions, and it must continue. A change in the current system might deter children and young people from seeking help from doctors and other professionals and make them less likely to disclose the full facts of how they are feeling and their symptoms.

I am happy to answer any questions that the committee has.

The Convener: Thank you very much. I will start off by exploring the Scottish Government's views on the prescription of antidepressants. It has been suggested that the prescription of antidepressants to under-18s is an indicator of an increase in the number of younger people who are seeking help with their mental health. That has been seen as positive. Although we would support people of all ages becoming as comfortable with seeking assistance for their mental health as they would be with seeking it for their physical health, are you content that the rise in the prescription of antidepressants represents young people receiving the appropriate treatment?

Maureen Watt: Yes, convener. The rise in prescribing in Scotland is associated with reduced stigma and more people coming forward for

treatment. Antidepressants are effective, their use is evidence based, and there is currently no evidence that general practitioners are overprescribing them. In 2014, I think, Dr John Mitchell led a Scottish Government short-life working group of experts who concluded that the rise in the prescribing of antidepressants in Scotland was, for the most part, explained by better diagnosis and treatment of depression by GPs. The prescribing of antidepressants is in line with prescribing in general for physical illnesses. In all areas of health—physical and mental—there are higher prescribing rates.

Perhaps Dr Mitchell would like to add something to that.

Dr John Mitchell (Scottish Government): The document "Key Information on the Use of Antidepressants in Scotland", which was published on the Scottish Government website, was written to explore the rise in the prescribing of antidepressants when we were moving from a performance target that looked at antidepressant prescribing to one that was to do with psychological therapies. An expert group was convened to look into that, and the conclusions are available online.

The evidence from a variety of sources showed that, as far as we know, the prescribing of antidepressants in Scotland, particularly by GPs, is appropriate. In particular, a study of 1 million new prescriptions of antidepressants by Scottish GPs showed that, in general, they were being used for the right indications and they were being reviewed.

As the minister said, Audit Scotland did an investigation into prescribing in Scotland and found a 30 per cent increase in the prescribing of all medications. The rise in antidepressants is symptomatic of more people being treated for depression.

The Convener: The Government says that young people should not be prescribed antidepressants at the first visit and until everything else has been exhausted. Are you saying that there has been a 30 per cent increase in the prescription of antidepressants after all that work has been done?

Dr Mitchell: The 30 per cent increase was in all medications for all physical and mental health conditions across all ranges.

The Convener: So what is the figure for antidepressants?

Dr Mitchell: There has been a rise in antidepressant prescribing at a population level. The numbers for children and adolescents are much smaller, but there has been a consequential rise at the same time. The rise has run in parallel with the rise in people coming forward for treatment. Antidepressants are certainly not the first-line treatment for depression in children.

The Convener: Do you know that? On average, at what point are young people who visit a GP prescribed antidepressants?

Dr Mitchell: We do not have figures for that.

The Convener: So we do not know that.

Dr Mitchell: No.

The Convener: We know only that, as you say, more people are presenting with mental health issues and there is an increase in the prescribing of antidepressants. We do not know whether it is the first port of call or the last port of call. Would the Scottish Government be willing to examine that?

Dr Mitchell: We do not have those numbers. We have spoken to the Royal College of General Practitioners, which would say that prescribing would be at the very back of a GP's mind if a young person came forward with mental health problems. That is what it has told us.

The Convener: However, in this case, we know that the young person was prescribed tablets at the first visit. Obviously, we want to know the routine approach by GPs. You have said that people are willing to talk about mental health issues and that the prescribing of antidepressant drugs has increased, but we do not know whether that prescribing is at the end of a long process or at the beginning of the process. If there was evidence that young people were routinely being prescribed antidepressants at the first visit to a GP, would that concern you?

Maureen Watt: There is no evidence that people having greater access to psychological therapies will reduce antidepressant prescribing. We must talk in generalities. We do not know what conversation took place with the petitioner's daughter or what state she was in. If a doctor thought first off that a person was in such a state that they needed a combination of antidepressants plus psychological therapies that would not happen that day, they would not wait to start one while waiting for the other.

The Convener: Of course we cannot second guess the clinician or whether the young person was in crisis. However, our evidence suggests that good practice is that there should not be prescription initially, but it should be moved on to after everything else had been tried. I am concerned that you seem to see a positive correlation between increased prescriptions of antidepressant drugs and better attitudes to mental health. If young people were routinely given antidepressants on their first visit, that could equally represent poor medical practice. Would

you be willing to investigate whether there is an explicit policy that that ought not to happen routinely? I think that such a policy intent would be right.

Dr Mitchell: The study that I mentioned earlier was in the *British Journal of General Practice* in 2012. It looked at new courses of antidepressants that were being prescribed in Scotland.

The Convener: Does that report predate the figures that were presented to us as showing that we have a better positive attitude to mental health because there are higher levels of prescribing?

Dr Mitchell: That research and the research that is described in the 2014 report happened because of the rise in prescribing and the concerns that people had expressed.

Michelle Ballantyne (South Scotland) (Con): Good morning, everybody. I will pick up on the thread that the convener has been following.

I hear what has been said about appropriate treatment, and I will certainly look at the research, although research often depends on what questions were asked. If we ask GPs, "Are you making all the considerations and following the National Institute for Health and Care Excellence guidelines?" they will say, "Yes."

How does the Government ensure that GPs have adequate training, particularly to support young people with mental health issues? Does that training include how to make prescription decisions and ensuring that young people are properly informed about side effects and the real meaning of informed consent? We know from the recent audit of suicides that the majority of young women overdose—that is their first line of choice. The issue that Johann Lamont has explored is important. What evidence do you have and what confirmation can you give us that the training for GPs is adequate?

Maureen Watt: All GPs are fully registered medical practitioners who have completed undergraduate psychiatry. The Royal College of General Practitioners figures show that more than 75 per cent of current GP trainees in Scotland have completed postgraduate psychiatry posts and that more than 50 per cent have worked in paediatrics. About 30 per cent will have done both. Therefore, GPs who are coming through the system have a good level of knowledge and experience of mental health issues as well as paediatrics.

09:15

We know that one in three presentations to primary care has a mental health element, so GPs are very experienced in considering the mental health and wellbeing of their patients. In addition, GPs must undertake 50 hours of continuing professional development every year, and the Royal College of General Practitioners has free online e-learning modules on a variety of topics, which include child and adolescent mental health and depression in children and young people. The Royal College of Psychiatrists, NICE and NHS Education for Scotland also have resources available.

All the training modules and training are available for GPs to access, and I do not think that there is any evidence that GPs are not as well versed in mental health issues as they are in any other issues.

Dr Mitchell: GPs are expert medical generalists. As the minister said, they have followed general undergraduate medical training, which involves psychiatry. The training for all GPs would have information about communication, family dynamics, and children and mental health as part of the curriculum.

On specific specialist knowledge, as the minister said, the vast majority of current GPs have done postgraduate psychiatry as well as their GP training. The minister has explained the revalidation process for doctors in the United Kingdom, which requires all doctors to do continuing professional development. Those 50 hours of CPD are a mixture of mandatory training and individual bespoke training, depending on the individual's needs.

Every doctor has an annual appraisal meeting in which there is an opportunity for them to talk to their appraiser about what training they have done in the past year and what training might be appropriate for them to do.

Michelle Ballantyne: Have any concerns ever been raised with you that GPs are not adequately trained in mental health and that they need to know more about non-pharmacological options? Have such concerns ever been brought to you?

Dr Mitchell: We are aware of parliamentary questions and ministerial correspondence expressing concerns about that issue, but, in talking to the RCGP and to primary care advisers in Government, GPs themselves say that mental health and mental health issues are very important to them. They take a keen interest in mental health, and they work hard to make sure that there is training available and that they are up to date with it.

The RCGP would say that, if a young person presents with a mental health problem, prescribing is the last option. The first thing that a GP would do is think about the child's social and family environments and about what community opportunities exist to reach out and help the child—including, potentially, referral to specialist

services and the provision of psychological therapies. GPs from the RCGP have said to me that they would not default to prescribing.

Michelle Ballantyne: However, as you identified earlier, you do not have figures to show that, which is one of the challenges that we face. Most of what we hear is anecdotal rather than evidence based, which is something that we may need to look at.

Where does safeguarding fit in among all the mandatory and optional training? Is there a mandatory annual or biannual renewal?

Dr Mitchell: The mandatory arrangements vary from place to place. On safeguarding, doctors know that the fundamental risk assessments that they perform on all sorts of issues and the fundamental issues of confidentiality and consent, which are part and parcel of all clinical encounters, are instructed by the principles of good medical practice that the General Medical Council lays out. There are places where aspects of that process are mandatory and places where they are not mandatory. However, generally in primary care we try to have as little mandatory training as possible to allow space for the individualistic training that is required. Most of the mandatory training tends to be on issues such as fire safety, child protection, information governance and health and safety issues such as hand washing. The GMC principles are the overarching way of guiding doctors on safeguarding, managing risk and thinking about consent and capacity.

Michelle Ballantyne: Most professionals have to break confidentiality to escalate information on a youngster who is considered to be vulnerable or at risk. How is that communicated? What training is there on that? There have been significant changes in the rules around child protection and safeguarding, and the manner in which information is escalated and shared has been a massive point of discussion. How is that communicated? How do GPs engage in it?

Maureen Watt: There is GMC guidance on that. It states:

"Respecting patient confidentiality is an essential part of good care; this applies when the patient is a child or young person as well as when the patient is an adult. Without the trust that confidentiality brings, children and young people might not seek medical care and advice, or they might not tell you"—

the doctor—

"all the facts needed to provide good care."

On disclosure, the GMC guidance makes it clear that disclosure without consent is permitted only if there is "an overriding public interest." For example, we know that, if someone who drives a vehicle is experiencing blackouts, they have to tell the Driver and Vehicle Licensing Agency. Disclosure is also permitted when it is in the best interests of a patient who does not have the maturity or understanding to make a decision. If a child was diagnosed with a serious illness such as cancer, the GP would inform the parents and carers, because the child would need treatment and support. In addition, disclosure is permitted when it is required by law for child protection reasons, as in cases of child abuse. All of that guidance resulted from the Age of Legal Capacity (Scotland) Act 1991, under which people over the age of 16 are considered adults.

Michelle Ballantyne: Under normal circumstances, if a child or young person was likely to take their own life, that would count as a situation in which there was a need to disclose information. That would be the case for every other profession, and I suppose that that is the nub of the question for us. For a GP, when is there a need to disclose? As a nurse in children's services, I was duty bound to disclose when I felt that a child was potentially at risk of taking their own life.

Dr Mitchell: I agree completely. For any clinician who believed that the person in front of them was expressing active suicidal ideas, the level of risk would trump any concerns about confidentiality.

Maureen Watt: I will add a point about the Scottish Government's direction of travel. The chief medical officer's report "Realising Realistic Medicine" sets out that treatment and prescribing is now much more the result of a conversation between the patient and the medical practitioner. In days past, we might have expected the doctor to know best about everything and we might just have accepted what they said. However, I can now think of times when I said that I did not want something, thank you very much. People need to realise that the relationship between the GP and the patient is now more about having that conversation. That is the direction of travel.

The Convener: We cannot talk about the specifics of any individual case, so let us imagine a person who is 16 years of age and is in such crisis that the GP goes against the usual presumption, which is not to prescribe on a first visit but to try other things, with prescription as last resort. The person is prescribed medication on their first visit and yet is deemed able to have a conversation, as you describe it. Do you think that that would happen in the real world?

To start with, a young person in those circumstances is not in an equal relationship with the doctor. By your definition, the person is in such crisis that the doctor has to override all normal presumptions. You said that, if the condition were cancer, the family would be told in order that they could give support. However, because it is a

mental health issue, the family is not brought in. In this case, the family feel that, if they had known about it, they would have been better able to support the young person, even if that was simply by managing the prescribed drugs for the young person.

Maureen Watt: As you have said, we do not know the circumstances of that case.

The Convener: In the imaginary case that I am describing, somebody is in such crisis that it overrides all normal practice such as prescribing only as a last resort. Surely, in those circumstances, with somebody in such crisis at 16 years of age who does not have an equal relationship with the doctor and has not been to discuss the matter before, you would put in a safeguard as has been done for cancer patients? The mental health challenges are so severe that the doctor is going against normal practice.

Maureen Watt: We do not know what went on in the specific case and we cannot surmise. There is obviously going to be an investigation.

The Convener: With respect, I am not asking you to do that—

Maureen Watt: I understand that.

The Convener: Let me finish the point. We are all very sensitive to the fact that the young girl's family is probably following this discussion closely. We are not talking about that specific case. We all have respect for that and understand that we do not know the individual circumstances.

I am asking you to think about a circumstance in which a young person of 16 is in such crisis that they cannot wait for other therapies and has to be prescribed drugs there and then. Do you seriously think that those are circumstances in which the patient will have a conversation about what meets their needs? If you think it appropriate for a cancer patient to have their family round about them, why would you not have family round the mental health patient when those drugs were prescribed?

Maureen Watt: We should not assume that the young person is any less aware of what is going on than an older person. Young people today talk much more about mental health problems than we ever did before.

Does Dr Mitchell want to take over?

Dr Mitchell: The principles of realistic medicine are about good communication on health between patients and clinicians. The specific situation that the convener describes, of urgency and great concern—

The Convener: It is urgent only because the doctor in the theoretical example has overridden all good practice of not prescribing immediately and of trying everything else first. There is almost a presumption against the prescription of antidepressants. That is how serious the situation is in the theoretical example.

Imagine yourself in those circumstances. Would you accept that the normal conversation would not apply? I am not saying that the situation was serious; however, it must have been for the doctor to override all those policies. What safeguards would you then put in place?

Dr Mitchell: I am trying to understand what the situation would be. If a young person presents to a GP for the first time and the nature of the conversation means that the GP is immediately concerned that the young person is severely mentally disordered, is in severe distress or poses a severe risk, the GP will not say that they are going to treat the person with an antidepressant and do no more. The GP will recognise the risk and will seek specialist help and support, which might be available through an emergency referral to a child and adolescent mental health service, for example. Guidelines and processes will not be breached or changed. If the level of concern rises, the GP will decide that they should not manage the situation on their own.

I cannot imagine a clinical situation in which any person presenting in acute distress and potentially mentally ill or suicidal would simply be given an antidepressant and that would be that. There would be much more concern, and support would be put in place around such a person, as an emergency measure, on that day.

09:30

The Convener: Do we know where that happens routinely?

Dr Mitchell: I see it happening in my clinical practice. I have worked in psychiatry for 25 years and I routinely receive referrals from GPs in exactly that situation, when somebody has presented to them whom they feel is a psychiatric emergency.

Rona Mackay (Strathkelvin and Bearsden) (SNP): Good morning. I will follow up on the issue of consent and confidentiality, because I think that that is at the core of the petition. The Government's submission mentioned a review of the consent process. Can you provide me with an update on that review?

Dr Mitchell: In "Realising Realistic Medicine", which was the chief medical officer's 2015-16 annual report, the CMO announced that there would be a review of consent in Scotland, which would involve working with the GMC and the Academy of Medical Royal Colleges. That review has been happening, and the intention is that the

product of the review will come out for consultation in March.

Rona Mackay: Is that March of this year?

Dr Mitchell: Yes.

Rona Mackay: Thank you.

One of the written submissions is from Fiona French, who states that she does not believe that the onus should be on the patient to give informed consent at a very vulnerable time in their lives. That vulnerability is magnified when it is a young person of 16. When the petition first came to us, every member of the committee was alarmed and shocked that a young person of 16 could be given drugs without anyone else's knowledge. What is your view on that, leaving aside the guidelines? What do you feel about the fact that a young person of 16 was prescribed those drugs? Do you think that she would have been capable of giving informed consent?

Dr Mitchell: I cannot talk about the individual circumstances of the case, but I agree with the evidence that you have received from many other parties, including the Scottish Youth Parliament and professional bodies, that young people are able to give informed consent to treatment for various conditions. In the same way as a young person has a right to confidentiality on the prescription of contraceptives, for example, they have the right to confidentiality on treatment for medical and mental health conditions.

We do not know the circumstances of the situation. Was the child prescribed a beta-blocker medication, which is not an antidepressant? That medicine has other purposes. It is used as a treatment to prevent heart disease and high blood pressure, because it maintains the pulse at a regular rate. If the child had presented for a physical health problem and been prescribed a medicine such as that, which is primarily a physical health medicine, universal opinion would be that children have the right to make those decisions with their GPs.

GPs have told me that, in all circumstances, they routinely think about whether the young person in front of them is capable—whether they have capacity to make the decision that they are weighing up. I think that it is possible for young people to give informed consent and that that should still be permitted.

Angus MacDonald (Falkirk East) (SNP): I will broaden out the questioning by turning to the issue of CAMHS, which has been touched on. We understand that the scope of CAMHS differs between NHS boards, which creates the risk that some people might fall through the gaps in certain areas. When we took evidence a few weeks ago, SAMH suggested that CAMHS should be extended up to the age of 25 for those who are already in the system and that, in the longer term, a specialist service for 16 to 25-year-olds should be established. What are your views on those suggestions?

Maureen Watt: In this year's programme for government, we announced that we are committed to exploring the potential for those who are aged 18 to 25 to continue their care and treatment within CAMHS. Work to explore the extension of CAMHS to the age of 25 is under development and will form part of the remit of the youth commission that will be led by Young Scot, as was announced on 6 December. The young people who are involved in the commission are going to do their own research to identify the issues that are important to them, and they will speak to experts, policy makers and service providers about areas for improvement. They will then present recommendations to ministers.

The general direction of travel will be to extend the specialist CAMHS to age 25. Earlier this week, I had discussions with some year 5 medical graduates who are doing CAMHS psychiatry, and, from that conversation, I think that the system needs such flexibility. Yesterday, I was at the Junction, a youth project in Leith, to meet children. A girl who has an eating disorder said that children who have eating disorders might feel quite childlike and unable to go into adult services, so extending CAMHS to age 25 might be appropriate for them. However, other children, such as those who have anger management issues, might feel that they are more adult and might want to move on. The system needs such flexibility, but we will wait and see what the research shows.

Angus MacDonald: Am I correct in understanding that there is to be an increase in the funding for CAMHS as part of the 10-year mental health strategy? I am sure that I saw that somewhere.

Maureen Watt: Yes. The direction of travel of the mental health strategy is towards early intervention and prevention, and the emphasis on children and young people is part of that.

As we set out in the draft budget, we intend to increase the direct support for mental health innovation and improvement to £17 million, which represents a 32 per cent increase. That includes the money for CAMHS transformation and our commitment to increase the mental health workforce by 800 workers over the next five years.

CAMHS targets have a high profile and, as I have said on many occasions, I am not happy with boards that do not meet their targets. The mental health improvement team at Health Improvement Scotland is working with a number of boards to redesign their services, if necessary, to upskill

those who are already working in CAMHS and to increase the number of people who are working in CAMHS. That work is on-going, and I hope that it will result in improvements. NHS Forth Valley, for example, was one of the first boards to work with the health improvement team, and we saw an immediate increase in the number of children who were being seen. However, a couple of people left that team and the number fell back again. There is a fragility in the system that we need to work out.

Angus MacDonald: We know that CAMHS is intended to be a four-tiered system. However, the statistics and targets exist only for tiers 3 and 4, which are the more intensive sectors. Does the current data provide a comprehensive representation of mental health demand in relation to young people in Scotland? If not, does the Government have any plans to develop data in that area?

Maureen Watt: It would be extremely difficult to capture data on tiers 1 and 2, because that service is provided by a wide range of organisations including schools and youth groups—anywhere, really. However, the direction of questioning is right. We want to ensure that children are given help at an early stage rather than having to wait for tiers 3 and 4. As John Mitchell said, there will be people who need to go directly into tiers 3 and 4. However, by increasing the number of people who have, for example, mental health first-aid training, we can identify people who are showing signs of depression or stress and ensure that they have lower-intensity counselling sessions at an early point, and we can perhaps prevent people from having to go into tiers 3 and 4. That is why one of the other streams of work on the mental health strategy concerns the review of personal and social education in schools.

Angus MacDonald: You are probably aware that the Scottish Youth Parliament noted that its members favour an increased focus on social prescribing opportunities such as peer-to-peer support, youth worker discussions, information centres and counselling either as alternatives to medical intervention or as a complement to it. What is your view of that suggestion? Have you undertaken any work to develop those alternatives?

Maureen Watt: Absolutely. We are all on the same page on this, as that is what we all want to achieve. As I said, we are working closely with youth groups to take that work forward.

Angus MacDonald: Can you give us any examples of what is happening?

Maureen Watt: The Scottish youth commission that I mentioned earlier is part of that work. Young Scot and SAMH are doing joint work on the issue of rejected referrals, collecting statistical data on rejected referrals and recruiting young people to give us an idea of what the journey has been like in this field. Such work is not new—the previous mental health strategy also had such actions. The work is on-going; we just have to keep at it.

Dr Mitchell: The previous mental health strategy contained a commitment to try to improve social prescribing opportunities, particularly as options for primary care. As the minister said, the audit of rejected referrals will provide us with rich data about what happens to young people if they are not taken on by specialist child and adolescent mental health services. We will therefore get quite detailed information about the alternatives to those services, such as peer support and services that are provided by other community agencies.

The Convener: Will you be examining the reduction in support in community and school settings? The Education and Skills Committee was out and about on Monday and took part in a number of focus groups. The group that I took part in was made up of headteachers, who spoke with one voice about their frustration with the difficulties involved in getting a CAMHS referral and about the fact that the support that is available within schools is reducing. Has there been a discussion in the education department about the importance of increasing rather than reducing that support?

09:45

Maureen Watt: We are working together with education colleagues on the review of PSE in schools. On Tuesday evening, when SAMH had its annual reception in Parliament, it launched its campaign—going to be—to make sure that children and young people have access to early intervention.

As I said, we want to ensure that a wide variety of people working in the education service and youth service have the skills to be able to identify people who are showing signs of anxiety and depression, and that they know where to direct them to, for example for counselling. Good examples are happening already—the one that you may have seen in the news is at Wallace high school in Stirling.

The Convener: Dr Mitchell said that the beta blockers mentioned in the petition were not antidepressant drugs. Is it the case, however, that they are seen as an anti-anxiety treatment for mental health presentations?

Dr Mitchell: Yes.

Maureen Watt: Do you want to give an idea of what the different categories are?

The Convener: So it was a mental health issue rather than a physical problem that the medication was provided for?

Dr Mitchell: I assume that that was the case. I do not know the circumstances of what happened.

Propranalol is a beta blocker that is used primarily for treating high blood pressure and for preventing heart attacks. It is used in treating anxiety because it has the symptomatic effect of holding the pulse at a steady rate. For example, if you knew that you had to come and give evidence at a parliamentary committee, and tachycardia or rapid pulse rate was something that was hugely problematic for you, you might use it to keep your pulse at a steady rate and reduce that. It is used in treating anxiety, but is not used in treating depression.

The Convener: So it would not be prescribed to somebody who was in crisis.

Dr Mitchell: I do not imagine so, because it does not have an immediate function beyond the one that I described of reducing symptomatic feelings of rapid heart rate and therefore subjective feelings of anxiety. It would not be an emergency treatment except in cardiac health.

Michelle Ballantyne: That is interesting. As we go through this, I see some discrepancies between some of the commentary and what I find on the front line. CAMHS have been reduced where I have been working. Evidence shows that most mental health problems begin in adolescence and, if they are not caught early, continue into adult life and cause tremendous problems.

During the evidence that we have taken so far, a number of concerns have been raised that there is not enough clear emphasis on early intervention and tackling problems in adolescence. How do you respond to that?

In addition, we have been given evidence that only about half of GPs indicated that they were familiar with the Scottish intercollegiate guidelines network guidelines on mental health. That does not concur with some of what you have said about GPs' knowledge and understanding. There seems to be a discrepancy in people's experience in some of the evidence we have been given so far.

Maureen Watt: In earlier answers, we were talking about anecdotal evidence. As the mental health lead in the Scottish Government, Dr Mitchell gets a better picture overall and has more conversations with GPs and people working in this field throughout the country.

In answer to previous questions, we referred to the guidance that GPs have access to, their continuous professional development and the fact that one in three people presenting to GP practices will have a mental health problem. As a result, GPs and health practitioners are as well versed in dealing with those issues as they are with physical health problems.

You are absolutely right that most mental health problems occur in adolescence or even earlier, which is why 14 of the actions in the mental health strategy are concerned with early intervention and prevention to ensure that Scottish people can expect to have good mental health and wellbeing. They are key to minimising the prevalence of poor mental health and the severity of its lifetime impact. It is important to stress that recovery is possible; managing the condition is key.

Michelle Ballantyne: Dr Mitchell said earlier that he could not imagine a situation in which a doctor would just prescribe, rather than seeking help, if somebody presented in crisis with suicidal tendencies. We know that GP appointments run for about 10 minutes, which is generally the allocated time. A psychiatrist or psychologist would not do a 10-minute appointment. Mental health is not similar to a lot of physical illnesses in being diagnosable by a test, so the diagnosis is much more of a judgment call.

You said earlier that prescribing is a positive indicator that people are seeking help. If your strategy works, would you expect the prescribing rate to plummet as an indication that it has been successful? If we treat mental health effectively with an emphasis on early intervention, should prescribing not disappear, to a great extent?

Dr Mitchell: The success of our strategy will be about whether people are able to access the treatment that they need when they need it. Depression can happen to anyone; premorbid mental health in a person's development can be a significant contributing factor, but mental illnesses can happen de novo, out of the air. For example, a person's experience as a child may not have any implication for whether they later develop schizophrenia, dementia or a severe mental illness.

Pharmacological, psychological and social treatments can work for mental illnesses. We treat physical illnesses with medications that we know work, and an increase in people's access to those treatments does not necessarily mean that the usage of medications and prescribing would fall. In that sense, we should think of mental illnesses in the same way that we think of physical illnesses. We would not expect a success in people's access to health and an improvement in all health to lead to a drop in the prescribing of all medications, so we should not expect such a drop in prescribing to follow improvement in mental health.

Michelle Ballantyne: There is a stumbling block for me—and the general population—as we explore this issue and you are grilled about it. When a GP is presented with a patient, particularly

one who is young, how do they make the decision about whether the problem is clinical depression, which may require pharmacological intervention, or a normal course of life? You would probably agree that everybody will suffer from depression at some point in life, but most people do not require pharmacological intervention.

When somebody walks into the surgery and talks about how they feel, how does the GP decide whether they require pharmacological intervention? I am struggling slightly with that, and I am sure that my colleagues are. Surely it requires more investigative conversation to ascertain the kind and level of depression and, therefore, what treatment is needed. Is it appropriate to make that decision about pharmacological intervention at GP level?

Maureen Watt: We know that poor mental health and wellbeing are related to poverty and deprivation. People who live in poor communities are more likely to experience mental ill health and depression. Many of them just accept it as a way of life instead of coming forward. We must ensure that more people feel able to come forward about living with poor mental health.

That is precisely why more general practices are becoming multidisciplinary teams and we are expanding the link worker programme to ensure that there is a link worker in every general practice, starting off with those in the deprived areas. As you say, we have to get to the root cause. That is where the link worker will come in. They will have the longer conversation and find out why people are feeling depressed and what the root cause is.

As John Mitchell said, that does not necessarily mean that such patients should not be prescribed antidepressants but we also need to ensure that we take an holistic approach to people's conditions and find out how they can be helped in other ways. It might be that the link worker ensures that the person receives all their benefits, that their financial situation is improved or, if there are signs of adverse childhood experiences, that we get to the root cause, which may be childhood sexual abuse, and then the person is given the right help in those areas.

A multidisciplinary intervention is required, but we should never forget that poverty and deprivation are huge problems for people's ill health.

Dr Mitchell: What you say is absolutely right, Ms Ballantyne. Mental illnesses are difficult to diagnose because we cannot do a blood test or a brain scan to confirm them. That is why there is a medical and clinical training to allow practitioners to identify them.

When people who are unhappy or perceive themselves to be depressed present in distress, clinicians will not necessarily jump to a diagnosis of clinical depression. They consider the person's social environment. However, to try to aid diagnosis, it is generally clinically understood that there are some hallmark features of clinical depression. They are more than just the pervasive lowering of mood but encompass sleep disturbance, early-morning wakening, a typical diurnal variation of mood being worse in the morning than in the evening, a change in concentration and a change to more pessimistic thinking. Those hallmark features are diagnostic characteristics that a GP would know in the same way that they would know how to go about diagnosing rheumatoid arthritis when somebody presents with joint pain and what features would point them towards a physical diagnosis.

We also have some rating scales that assist with that. For example, in screening for postnatal depression, we nationally use the Edinburgh postnatal depression rating scale, which assists clinicians in identifying people who are above a threshold that is likely to require a clinical intervention, which might not be a pharmacological intervention.

Michelle Ballantyne: Would it be reasonable to say that identifying depression in an adolescent, with all the issues that adolescence entails, is more complicated than identifying it in a mature adult?

Dr Mitchell: Yes, it is. It requires a sensitive understanding of what it is like to be an adolescent nowadays and an understanding of the developmental pathway that we all go through as we grow into an identity of ourselves. On top of the other hallmark features that I described, that requires a certain degree of subtlety. In the conversations that I had with the RCGP, it said that GPs see people turning to them routinely when they are in distress and have problems. The GPs are used to starting off thinking not in a medical way but in a social environmental way and exploring the problems in people's lives and what they can do about them without necessarily thinking about medical interventions and diagnosis.

10:00

Michelle Ballantyne: Is there therefore a gap in the SIGN guidelines on dealing with adolescents with mental health problems who come to a GP? Do the guidelines and instructions to GPs need to be strengthened, particularly on what to do when prescribing for young people?

Dr Mitchell: The guidelines are guidelines. The fact is that a GP who is treating all physical and

mental health conditions has recourse to hundreds of different forms of guidelines, whether they be SIGN guidelines, UK-wide NICE guidelines, local guidelines from their own health board or best practice information that royal colleges, such as the RCGP or the Royal College of Psychiatrists, will have on their websites.

Looking at the material that is available for treating depression, there is a detailed and thorough UK-wide NICE guideline that was last revised in 2016. It reviews the evidence to that date on all aspects of treating depression, including antidepressants, and treating children and young people. The SIGN guidelines in Scotland are about non-pharmacological treatment for depression. They are available and they are current.

The short answer is that I do not see that there is a need for revision of the extant guidelines that are available to clinicians.

Rona Mackay: Do you or does the General Medical Council have any way of monitoring GPs who do not appear to be following the guidelines? Does that have to come about as a result of a complaint from a patient or from a patient's family?

Dr Mitchell: The monitoring of a doctor's practice is done through the process of peer review to appraisal to revalidation and relicensing, which is laid out in the GMC and is a UK requirement for doctors.

Rona Mackay: Let me just stop you there. What does "peer review" mean?

Dr Mitchell: The checking of the 50 hours of continuing professional development—checking whether a doctor has done what they said they would do—and the conversation about what might be sensible for them to do next year is done through a doctor meeting a group of peers, usually organised at the health board level. That group looks back at what the doctor has done and forward at what they will do, and it takes the time to check that what is being said is accurate. That information is given to the royal college and sent to the annual appraisal meeting. The annual appraisal has to cover that information, as well as information from other sources.

GPs receive information about their prescribing, for example, that might or might not be discussed. Any complaints would be discussed at appraisal. There would be reflection on the complaints and any action that an individual took. That material then feeds into a GMC revalidation process.

Rona Mackay: The system is sort of self-governing.

Dr Mitchell: It is only self-governing at the level of the peer review, which is looks at the continuing professional development. The actual appraisal is a national process and it is independent. It is not local peers who do that; it is a nominated appraiser who has special training and is allocated people to appraise annually.

Rona Mackay: Does any sampling of case reviews occur?

Dr Mitchell: I am not aware of that, no.

Rona Mackay: I want to return to school-based counselling. In your review of counselling, are you giving consideration to systems of school counselling that have been developed elsewhere, such as in Wales?

Maureen Watt: We hope to get the findings from the review of PSE towards the end of the year. We will look at what happens in areas such as Wales. Wales may not have the sort of system that we want to introduce in Scotland, but we will be looking at what we can learn from other areas as part of the review.

The current position is that it is for local authorities to decide what support services fit the needs of their local schools and circumstances. Not all schools will need the same services, and different schools will use different approaches. Some will use school nurses, some may train teachers and some may take in counsellors. It would not be appropriate to advocate a one-size-fits-all approach. We will wait and see what the review of PSE produces and we will have a workshop to develop recommendations. We can also learn from the best practice that is happening already in Scotland.

Rona Mackay: On the one-size-fits-all point, from my experience in my constituency, the problem that people and families have in accessing mental health care is that the system can be very confusing and they do not have a single point of contact. There may be four or five people dealing with a specific case, and the communication can be poor.

Will you consider streamlining the process so that families know who to contact and when, and are not dealing with four different people?

Maureen Watt: It depends on what the problem is. If it is a problem with school work—

Rona Mackay: The problem is referral to mental health services.

Maureen Watt: In the first instance, the port of call is the GP practice.

Rona Mackay: I am talking about beyond that, once it has been established that a referral is needed. There can be half a dozen people to contact, and there does not seem to be a single contact point.

Maureen Watt: That will depend on the services available in the local area. There may be a variety of youth groups or third sector organisations that have different ways of dealing with different aspects. We have a plethora of organisations working in the field in different local authority and health board areas. It is important to ensure that GP practices are aware of all the organisations that work in the field, have had conversations with the people running those organisations and know where best to refer individuals.

For example, as I said, I was at the Junction in Leith in Edinburgh yesterday. GPs, schools and youth groups all refer people to the Junction.

Rona Mackay: Is it down to the local authority to organise the best provider? Can you understand why, for someone who does not know the system and has never had to enter it before, it can be confusing when all of a sudden all those people are involved? They wonder who to contact.

Maureen Watt: A link worker in a GP practice would be the person with oversight of all the different organisations available. Do my colleagues want to add anything?

Ruth Christie (Scottish Government): Getting it right for every child is the system that is being rolled out in Scotland, and through that there should be single points of contact and ways of ensuring that all the professionals involved in the entirety of a child's life are co-ordinated and that there is a single child's plan if the child requires that.

Rona Mackay: It is not happening in my area, but I hope that it will come.

Maureen Watt: That is one of the reasons why a named person has a big role to play.

Rona Mackay: Exactly.

The Convener: It might be a challenge to have one person as the named person responsible for 400 young people. You said that it would not be about one size fits all, but would it be reasonable to expect that there should be a minimum standard at school level? I was quite surprised that you said that access to the third sector or whatever would be through a GP. That would seem to be a massive burden.

Going back about 20 years, I ran what was called a joint assessment team in which teachers, family, whoever was around a child and the child themselves worked to identify what support they needed and then accessed that support. It seems to be a medical model to go to a GP for further referral. I am not convinced by the school-based counsellor model, but there should be counsellors in schools. Of course, it is a different matter for young people who are outside the school system.

Do you accept that, if such expertise was properly funded at school level to direct young people to the appropriate support in the community, that would give certainty? It is not about one size fits all, but about having a minimum standard that any young person in Scotland could expect.

Maureen Watt: I did not say that everybody should go through their GP; I said that it would depend on the level of severity. As John Mitchell has said, some people will experience anxiety and distress but might not have a clinical diagnosis or be clinically depressed. What we are getting back is that there is already good practice in some schools and in some areas, and that schools have access to a variety of people through school counsellors and educational psychologists. It will not be for us to prescribe, because that is not within our remit, but after local authorities have seen the result of the review that we are carrying out, they will be able to decide what is best practice for them and their schools.

The Convener: But you said in response to Rona Mackay that the point of contact was the GP.

Maureen Watt: That is one of the points of contact.

The Convener: It does not answer the question of where to go when there are three or four points of contact. There is the idea that somebody in the school setting, for example, has absolute responsibility for taking young people through their journey. The first point of contact would therefore not be the GP.

Maureen Watt: In my view, if a child goes to their school guidance teacher, the teacher should have the skills through mental health training, first aid training and the training that they do for their guidance role to consider, in conjunction with the child and perhaps the parents, what the best course of action would be for the child. That could be counselling or something else. We need to ensure that everybody in a local area knows where the available services for the child are, whether that is the third sector, the voluntary sector or the local authority.

The Convener: Michelle Ballantyne has the last question.

Michelle Ballantyne: What has just been said leads us on nicely to the fact that, during the evidence session that we had with the voluntary sector, the committee heard that a target previously existed that 50 per cent of front-line staff should receive mental health training through applied suicide intervention training and skills-based training on risk management. The good news is that that target was achieved, but the bad news is that there is no longer a target in place

and that, if only 50 per cent received the training, 50 per cent have not. We also know that there is a turnover of GPs, with new ones coming and old ones going. Where are you with that? What assessment has been made of the outcomes that are being achieved by the delivery of the training? Is there any intention to review the target and bring in another one to ensure that training takes place?

Maureen Watt: In general terms, HEAT—health improvement, efficiency, access to treatment and treatment—targets are reviewed all the time. To ensure that there is not an overload of HEAT targets, the priorities change from time to time. The former HEAT target for suicide prevention training for key front-line staff ended in 2010 because the target had been exceeded in all board areas and at least 50 per cent of front-line staff across Scotland had been trained in suicide prevention awareness techniques. As a matter of good practice, NHS boards continue with that work in order to maintain at least 50 per cent of front-line staff being trained in suicide prevention awareness techniques.

10:15

NHS boards that are interested in suicide prevention training should always contact NHS Health Scotland. We are discussing with NHS Health Scotland its plans to refresh and reinvigorate its suite of training programmes for suicide prevention and wider mental health awareness. As I said, we are preparing a new draft suicide prevention action plan and will undertake public engagement in the spring with a view to publishing the final version in the summer. The engagement process will afford stakeholders the opportunity to contribute their views and aspirations on action to support suicide prevention. We should recognise that suicide figures have reduced by 17 per cent in Scotland, and we want to continue that trend. The action plan will be reviewed and revised to reflect what needs to be done.

Michelle Ballantyne: You are probably aware that inspections of children's services have changed to look not just at a school but across the board at associated services in, for example, the voluntary sector. Case sampling includes looking at social work inspections to see whether the decision process and the handling of a child's case were correct and to give an idea of the quality of the services that have been delivered. You said in response to Rona Mackay's question that, to your knowledge, there is no routine case sampling for GPs. Is that a gap when looking at GPs' decision-making processes and treatment decisions?

Dr Mitchell: All GPs, as part of their appraisals, have to write reflective commentaries on things that have happened in their practice. The expectation is that any complaints, critical incidents or adverse events would be subject to those reflective considerations and discussed at appraisal. That is an opportunity to provide the time and space to GPs and specialists to reflect independently on things that have not gone as well as they could have done.

Michelle Ballantyne: That is what I would call clinical supervision, which allows GPs to reflect on their own practice, but that is different from an independent sample review of case management. With reflective practice, a person has the choice to look at things that they have noticed that have not been good or that have been bad and to consider how they feel about those. My query is about an independent review of case management, which is different. My question is whether you consider that there is a gap there.

Maureen Watt: There will be a review of situations like the one that we are describing—

Michelle Ballantyne: I am not talking about complaints.

Maureen Watt: Let me finish. Health boards review individual GPs' prescribing practices. If there are outliers, they are identified, as are GPs who send more people to hospital and to consultants. That is all monitored and boards can bring up issues at the annual appraisal.

Dr Mitchell: Sampling case management would be challenging. If we were talking about the case management of all mental health presentations of people of a certain age, that would be difficult to define. As we said, a case could involve someone seeking help about problems in life, a mental health contact or a mental disorder contact. For me, the problem is with the definition of exactly what we would be sampling.

Michelle Ballantyne: Fair enough.

The Convener: Thank you. We have come to the end of our questioning, although I have a lot of questions left in my head to reflect on, based on the evidence that we have heard.

In a moment, I will invite members to discuss what we should do with the petition, but I first want to thank the petitioner again. I recognise that we are talking about a general issue, but she and her family are talking about the death of a daughter, which has had a massive and devastating effect on all of them. If Annette McKenzie and her family are able to provide another response, that would be extremely helpful. We are aware how painful that must be for her, but I think that the purpose of her raising the petition was to try and inform

thinking so that other families do not have to suffer in the same way.

I am interested in members' views on what we should do now. We should contact the petitioner in the first instance. Is there anything else?

Michelle Ballantyne: There is no doubt that it is an extremely complicated subject, as Dr Mitchell has pointed out. The decision making on mental health at the point of contact is particularly difficult. The decision on whether someone is in crisis and whether to resort straight away to a pharmacological intervention is challenging, but I wonder whether that needs more exploration and whether there should be a requirement to have some sort of specialist consultation, particularly before a young person is put on a prescription.

The Convener: In conversations that I have had with GPs in the past, although not on mental health issues in particular, they have said that, because of the way that the system operates, they can give a prescription but they cannot give time, because the pressures are massive. I am interested in whether there is evidence, or whether we should get evidence, on the correlation between the first visit by someone with anxiety and distress, and prescription. Is that a short process or does prescription come at the end of a longer period? That would tell us something.

I am concerned about simply viewing an increase in prescription as a positive because it means that people are talking about mental health. I am old enough to remember when people talked about the housewives' little helpers—women went to the doctor and were routinely given Valium or whatever. GPs have moved on from that, thank goodness, and we would be concerned if there are pressures that bring that back. I am interested in establishing how we get that kind of evidence.

Michelle Ballantyne: To be clear, we are in no way implying that GPs are not doing their job, but we have to recognise that the time in which they have to see a patient and draw conclusions is about 10 minutes per visit. Therefore, even if a GP saw a person four times, they have less than an hour to make a judgment call. As Dr Mitchell said in response to my question, a psychologist or psychiatrist would not expect to make a judgment in such a short period. The rise in mental health issues and in the number of people seeking help—which is important and positive; I accept the minister's comments on that—means that the lack of time for GPs needs consideration. We cannot just walk away and say that 10 minutes is an adequate diagnostic time.

The Convener: I am interested in the point that, although we can see the logic of a young person who has been diagnosed with cancer having their family around them and immediately putting support in place, there is a question of confidentiality in relation to mental health issues. I understand that. I have worked with young people who did not want their families to know what their concerns were, because some of those concerns were enmeshed with family issues. However, I would be interested to explore further with the medical profession the difference between the two cases.

Rona Mackay: That was my point. Part of the core of the petition is about confidentiality in mental health cases. With a physical illness, the family would be involved. We need to ask whether the General Medical Council would consider looking again at the issue of GPs taking a decision on whether the family should be involved based on the seriousness of the mental health issue. There seems to be a disconnect between the two cases, although I respect a young person's right to confidentiality. We need to explore that, because the issue of confidentiality is at the heart of the petition.

Michelle Ballantyne: The issue is not necessarily about the young person's family knowing; it is about there being a responsible person who they can talk to and who can oversee and be aware of what is going on.

Rona Mackay: Yes—a relevant person.

Michelle Ballantyne: There is also an issue about informed consent. It is not possible to give informed consent without knowing all the potential consequences and side effects. In my experience, and in most people's experience, people do not get a complete run down of what a drug might or might not do to them when a prescription is handed over. That is a big issue.

Angus MacDonald: We clearly need to reflect further on the evidence that we have heard today at a future meeting. One of the salient points that has come out of the evidence session is that we need statistics on when, or at what stage, antidepressants are prescribed. If, as seems to be the case, those statistics do not exist, we need to ensure that they are available in the future. If there are any statistics at present, they need to be shared with us.

The Convener: I suggest that we ask the clerks to draw together the issues that we have highlighted, having reflected on the evidence. We can then look at what that means for our taking further evidence. That would be worth while. We are grateful for the time that the minister has taken to answer questions this morning, but there are further questions that we would like to explore.

Do members agree to that approach?

Members *indicated agreement.*

10:26

Meeting suspended.

10:31

On resuming—

Prescribed Drug Dependence and Withdrawal (PE1651)

The Convener: Our second item is evidence on PE1651 by Marion Brown. We last considered the petition on 7 December 2017 and agreed that we would seek oral evidence from the Minister for Mental Health.

The minister and Dr Mitchell have remained with us for this item, and I welcome Jenny Simons, policy officer in the mental health and protection of rights division of the Scottish Government.

As members will know, we have received a large number of submissions on the petition, primarily from people who wish to let us know about their experiences of prescribed drug dependence and withdrawal. I extend our thanks to all those who have taken the time to provide their views.

Our role is not to look into the circumstances of any individual case, but the submissions that we have received convey the strength and depth of feeling that exists on this issue for a range of people. I am sure that I speak for everybody on the committee when I say that reading through the submissions in preparation for the committee had a significant impact. We are genuinely grateful because we know that people are not writing about something theoretical; they are writing about their own direct experience.

I invite the minister to make some opening remarks before we turn to questions from committee members.

Maureen Watt: I start by thanking the petitioner, Marion Brown, who submitted the petition on behalf of Recovery and Renewal.

Prescribed drug dependence and withdrawal is an important issue, and that is, as the convener said, demonstrated by the level of response to the petition. I am grateful to those who have taken the time to share their personal experiences, many of which I have also read. Psychological therapies have an important role to play in helping people who have mental health problems, who should have access to effective physical and psychological treatment, and I welcome the opportunity to discuss the issue in more detail.

The Scottish Government will continue to emphasise the importance of parity in physical and mental health services. People who have a mental illness should expect the same standard of care as people who have a physical illness, and they should receive medication if they need it, just as someone should receive medication for a physical illness.

The Scottish Government has worked hard with partner organisations to reduce the stigma that is faced by people who have mental health problems, and that has been reflected in the rise in demand for mental health services across Scotland. As the stigma declines, we see more people coming forward to seek help from their GPs for problems such as depression. As a consequence, more people have been prescribed antidepressants, but that has been accompanied by better diagnosis and treatment of depression by GPs.

The responses to the petition highlight the issue of appropriate prescribing. As far as guidance on the prescribing of mental health drugs in Scotland is concerned, the SIGN guidelines provide evidence-based clinical practice guidelines for the NHS in Scotland. SIGN guidelines are designed to bring new knowledge into action to meet our aim of reducing variations in practice and improving outcomes. They are produced in collaboration with patients, carers and members of the public. SIGN guideline 114, which is on non-pharmaceutical therapies, encompasses psychological therapies, structured exercise and lifestyle interventions, and a range of alternative and complementary treatments in the management of depression.

Prescribing often involves not just drugs. Although we will ensure that people who need medication will continue to receive it, we are committed to improving access to psychological therapies that increase choice and best accommodate patient preference. As part of our 10-year strategy, we are taking a range of actions to transform mental health services in Scotland to respond to that need. Those actions include work to improve access to services, the development of new models of care within primary health services and a national roll-out of cognitive behavioural therapy, as well as the development of interventions for people in crisis through the distress brief intervention pilots that are being funded across Scotland.

Furthermore, although medical student teaching now emphasises that medication has an important place in treatment, it should not be overused or continued indefinitely, and decisions should always involve the patient so that they understand the potential benefits and risks of deciding to take medication. That process needs to take place within an enabling environment, in which support and a range of information sources are readily accessible to patients.

Our guiding ambition for mental health—that we must prevent and treat mental health problems

with the same commitment, passion and drive with which we treat physical health problems—is simple but, if it is realised, it will change and save lives. We want to create a Scotland in which all stigma and discrimination related to mental health is challenged, and our collective understanding of how to prevent and treat mental health problems is increased. We want our nation to be one in which mental healthcare is person centred and recognises the life-changing benefits of fast and effective treatment.

I am happy to answer questions.

The Convener: Thank you very much, minister. A theme of the submissions that we received was people's concern about being prescribed drugs without adequate explanation of the consequences of that and without having access to any other support, and then being left on them for a long time without being given support to come off them. That is the underlying concern that has been identified by the petitioners and others.

In the previous evidence session, we discussed the issue of GP training in relation to prescribing decisions, and I would like to ask a related question on PE1651 about the training that is available to GPs. The petitioner has commented that GPs are being held responsible by everyone, but that they do not have the expertise, knowledge or training to support people to safely come off such prescriptions. How would you respond to that?

Maureen Watt: As I said in relation to PE1627, in 2014 the Scottish Government published key information on the use of antidepressants in Scotland, which illustrated that the quality of antidepressant prescribing appears to have improved in recent years. Too often, a less than effective dose was prescribed for too short a period of time. Now, higher average doses are prescribed for longer, more appropriate periods. That is a more effective approach, which reduces the risk of recurrent bouts of illness in the long term.

As the briefing paper highlights, the rise in the prescription of antidepressants in Scotland is explained, for the most part, by the better diagnosis and treatment of depression by GPs. Research that has been carried out in academic centres in Scotland confirms that antidepressants are being prescribed in line with the endorsed clinical guidelines and that such improvements will continue.

There is consistent evidence of undertreatment of depression and we know that the personal and economic costs of having it are high. We need to continue to work on ways to improve the recognition and effective treatment of depression.

The use of antidepressants by an individual is a dynamic process and varies due to the relapsing and remitting nature of the illness and individual treatment preferences. It does not work for everyone but, for those who respond to it, the evidence for antidepressant treatment reducing relapse is strong. There is no evidence that having greater access to psychological therapies will reduce antidepressant prescribing. Rather, access to appropriate and effective treatments, which will include antidepressants, is improved.

The Convener: I am concerned by that response because you seem to be saying that the problem is being addressed by giving people stronger drugs and leaving them on those drugs for longer. The petitioner says that people are being given drugs without the appropriate information about the consequences and being left on them without other supports, and that the GPs do not have the expertise to support them through the withdrawal of those drugs. That is the core of the petition. I asked you specifically what support GPs have been given on the matter. What expertise do they have to support people through the withdrawal of those drugs?

Maureen Watt: That is a more clinical question, so John Mitchell will answer it.

Dr Mitchell: The drugs that we are talking about—the ones that can cause withdrawal problems—include the painkillers, particularly opiate medications, that may be prescribed not only by GPs but by specialists in hospitals in, for example, cancer care, and the sleeping tablet drugs such as benzodiazepines and the Z-drugs, which are antianxiety and sleep medicines and which may also be prescribed by GPs and specialists.

Those two classes of drugs cause dependence, in that the body of a patient who stays on the drug becomes tolerant of it and the dose has to be increased if it is to continue to have the same effect. When they stop taking the drug, they get withdrawal symptoms. That is the definition of dependence. Antidepressants have withdrawal side effects—they have discontinuation reactions—but they do not cause dependence in the same way as other drugs do. That is, tolerance is not associated with them—we do not have to keep pushing the dose up to get the same effect.

The point that you made first, convener, about the decision-making relationship between the patient and the prescriber is at the heart and soul of realistic medicine and the work that is going on through that. Not only is there the work on consent that we talked about in our previous evidence, but there is the health literacy action plan for Scotland, which is about how we have conversations with people about the treatments that we provide for them and which is being revised.

I will address the point that you made about GPs being on their own with the issue. It is not so much the GP as it is the prescriber who is responsible—the prescriber is responsible for the prescribing of all of those drugs, the potential side effects and the potential withdrawal problems. There is now a variety of different prescribers. Obviously, there are specialists in hospitals, who may be doctors or pharmacists. There are also prescribers in primary care. Indeed, advanced nurse practitioners prescribe for some conditions. Therefore, I do not think that we expect GPs to be left feeling that they are on their own in managing the complications of prescribing across that range. However, a GP who initiated a medication would certainly be responsible for that treatment.

The Convener: Will you and the minister clarify whether you accept the premise of the petition that there are people who were not given proper advice about the consequences of taking these prescriptions, with the result that the idea of informed consent is a challenge? They are put on those drugs, not given other supports and left on them. Do you also accept that the GP does not know how to support them through the withdrawal of the drugs? That is the petition's fundamental premise. Do you accept that that has happened and continues to happen? Does it concern you that it happens?

Maureen Watt: I would not accept the premise that it happens routinely. Obviously, the petitioner feels that it has happened in some cases.

The Convener: Does it happen?

Maureen Watt: As I have said, the petitioner feels that it has happened.

10:45

The Convener: Do you think that it happens? It does not have to happen routinely for us to be concerned about it. Do GPs have the right support? If you do not accept that it happens, that is fine, but if you accept that it happens, what is the Government's response in addressing the concerns highlighted by the petitioner? We cannot continue to prescribe stronger drugs for longer.

Dr Mitchell: I am happy to accept that as people's description of their care.

The Convener: Do you believe them?

Dr Mitchell: Yes.

The Convener: There is a difference between saying that somebody thinks that they feel something and saying that they feel something that is legitimate.

Dr Mitchell: Yes.

The Convener: So you accept that it is a legitimate concern.

Dr Mitchell: Yes. I recognise and accept the descriptions that people have given of the problems that they have had with prescribed medicine, although those descriptions do not represent the normal or average experience. They are situations that people have chosen to tell us about.

In respect of people's feelings about the quality of the consent and information conversation that they had with the prescriber, I am happy to accept that there will be occasions when those conversations are not as good as they could be. However, other conversations, in which the prescriber explains what a person's options are and discusses the pros and cons of those, might be extremely good.

GPs are in a primary care team and have access to guidance, as we discussed earlier. They can pick up the phone and speak to specialists if they want to. They have the opportunity to talk to other GPs—they describe doing that regularly—about clinical situations that they are involved with.

Specifically in relation to prescribing, we are rolling out improved pharmacy, both in the community and in primary care. Health boards tell us that by March 2018, we will have 200 new whole-time equivalent pharmacists in addition to 50 pharmacy assistants in practices across Scotland. GPs are not isolated in having to struggle with complicated prescribing issues—the support is there for them and they tell us that they are using it.

Maureen Watt: Jenny Simons can add something about the matrix.

Jenny Simons (Scottish Government): NHS Scotland has developed a psychological therapies matrix, which is an evidence-based resource that highlights different combinations of therapies and approaches to treating a range of different conditions. The guidance on depression forms a large part of that and is about how medications and different approaches to therapies and other sources of support can be combined, and doctors have that available to them. That is worth highlighting, as is the SIGN guidance, which has been developed in Scotland for GPs and other practitioners and clinical staff to refer to.

Rona Mackay: Do we have statistics on the number of people suffering withdrawal from antidepressants or prescription drugs?

Dr Mitchell: We do not have a unified number that describes that. The Royal College of Psychiatrists did some research into discontinuation reaction to antidepressants, which

it published on its website. I can find those numbers for you.

I think that the experience of discontinuation reactions from antidepressants is quite common: they are pretty much effects of every antidepressant from every class. However, in general, the actual discontinuation reactions—the symptoms—are mild and self-limiting.

We cannot really define how severe or challenging the issue is, but—as I say—the Royal College of Psychiatrists has information from a survey and we are perfectly happy to accept that. These are real symptoms that people are having. Certainly for people who are on the dependent drugs such as opiates and benzodiazepines, without careful handling, almost 100 per cent of people would have withdrawal reactions. That is why there is clinical guidance and information available to help people work out how to cut down and reduce drug doses.

For antidepressants, the Royal College of Psychiatrists says that tapering should take place over four weeks in order to allow the body to adjust to those medicines.

Rona Mackay: Do you feel that the patient is being given enough information about the possible side effects, including the effects of withdrawal? Is it down to the GP to manage that?

Dr Mitchell: The prescribing of a medicine and then what happens with that medicine is the responsibility of the person who does the prescribing. The GMC is quite clear about the responsibilities of doctors in that respect.

Clearly, those who have given evidence have described feeling that they have not been listened to, involved or properly informed. However, in my clinical experience and from talking to other doctors, whether or not they are representatives of professional bodies, I know that we want the best for our patients. No clinician wants a patient to suffer, either because of a disease or because of a problem with the treatment for that disease.

Doctors will work hard to try to make sure that they are delivering information in a way that is understandable and of a tolerable amount so that people can come to a true decision about what they want.

Rona Mackay: Clearly, the people who have given us submissions were not aware of the possible side effects, including the effects of withdrawal, because I imagine that no one would agree to take a drug that would have such effects when they came off it. They just would not do it. Either they were not told or it was not explained clearly enough to them. Would you accept that?

Dr Mitchell: I do not know what happened in individual conversations. If you are put on any opiate painkiller, you would expect to be told that the painkiller is very strong and that when you stop it or come off it, that will need to be done carefully.

I think that people have a general understanding about painkillers and probably also about sleeping tablets—and certainly about antidepressants. It is the responsibility of the people prescribing to make sure that individuals are aware of potential side effects, including the withdrawal side effects.

Should a member of the public want to find out more about that, there is a leaflet about coming off antidepressants on the Royal College of Psychiatrists website, for example. There is also information on the NHS inform website that gives quite a lot of detail for people with medication problems about coming off medicines. People need to know that that information is there. That is good clinical practice, as described by the GMC, in terms of the relationship that the clinician has with their patient and how they are mutually following a course of action to the betterment of that patient's situation.

Rona Mackay: Clearly, there is a problem. Presumably, only a small percentage of people experience severe, life-limiting side effects, but it happens, so the system is not perfect.

Dr Mitchell: No system is perfect—I accept that. The life-limiting consequences are rare. If a person had on-going major and severe difficulties as a consequence, support is available to help with that.

Rona Mackay: This is another case where statistics might be useful in order to get an idea of how many people suffer from severe symptoms.

Dr Mitchell: Again, it would be difficult to set a threshold for that. As I have said, we know that discontinuation reactions are common. The issue is deciding when the effects are self-limiting, which people will manage through good communication with the prescriber, and when there is an unusual situation in which more help is needed. It is difficult, because where would you draw the line across that spectrum of experience?

Rona Mackay: Minister, when you talked about the 10-year mental health strategy, you mentioned the new models of care in it. Will you expand on that aspect of the strategy?

Maureen Watt: It is about making sure that people have a range of therapies available to them. As we discussed in relation to the previous petition, that might mean that people are not immediately put on antidepressants. Instead, following a discussion with their GP, they might be prescribed something from a range of therapies that includes psychological therapies, such as computerised cognitive behavioural therapy, or

more exercise, given the correlation between exercise and depression.

I do not know whether you have spoken to the Scottish recovery network, but it has a range of treatments and interventions that are useful in helping people to recover from mental illness. That aspect of the strategy is about making sure that all the different combinations of treatments are available to the increased number of people who are presenting with mental illness.

The Convener: I give my usual early warning that, because of the rules of the Parliament, we must close the meeting by 20 to 12. I want the questioning to finish by half past 11. I ask members to focus so that we can cover all the areas within that time—although I should say that I am the only member who has strayed from our line of questioning so far.

Michelle Ballantyne: How does the strategy relate to the delivery of the national performance framework and the mental wellbeing indicators? What we have heard so far has sent me into a bit of mental confusion. You stated that the 2014 review showed that the quality of prescribing has improved, that we are moving to longer, higher doses and that there is consistent evidence of undertreatment. However, you then said that the use of antidepressants is a dynamic process and that there is no evidence that greater access to psychological therapies reduces pharmacological prescribing, although you have just been talking about the importance of having alternative treatments available. Where is the strategy going? What are you trying to achieve? There seems to be a contradiction in the statements that you have made.

Maureen Watt: As we discussed earlier, the short-life working group that Dr Mitchell chaired came to the conclusion that, in the treatment of depression in certain mental illness conditions, it is better to prescribe a higher dosage for longer, and the same conclusion has appeared in various articles and journals. I am not the clinician here. Furthermore, we know that medical prescribing, when used in combination with other therapies, may result in a better outcome. Therefore, the Scottish Government must ensure that those alternatives are available.

Michelle Ballantyne: If I understand you correctly, you are suggesting that non-pharmacological options should be combined with prescribing and that you do not see the strategy moving us towards reducing prescribing.

11:00

Maureen Watt: It is not for a strategy to do that. That is a decision for clinicians, given their knowledge.

Dr Mitchell: It was not me but my predecessor who chaired the expert group. We are saying that we want people to get the treatment that they need for their condition. As I explained earlier, my predecessor set up the expert group and wrote the published report because of concern about the rising number of prescriptions and because we were in the changeover from HEAT targets for the prescribing of antidepressants to targets for psychological therapy delivery.

At the time, there was a question about whether the increase in the use of psychological therapies meant that there would be a reduction in antidepressant use. The available evidence, which the group found from a variety of sources that were cited in the paper, did not support that. It implied that, in the better treatment of a condition such as depression, there should be more people taking medication, because medication works for some types of depression; there should be more psychological therapy, because there is a strong evidence base for cognitive behavioural therapy treating depression well; and there should be more social therapies and social support, because we know that they improve the condition. All those things go hand in hand towards improving access and treatment. Getting one thing does not mean that someone gets less of another; in fact, they get an uplift in all of them.

Generally, when adults present with depression, before a GP reaches for a prescription pad they think about the social, occupational and family environments of the person and about what the person could do through sport or through reducing their alcohol consumption—if alcohol is problematic—to improve their mood. They start by asking, “Might you want to talk to somebody about this?” and saying, “We have these resources available for you” before they tell the person, “I think you need to go on an antidepressant.” The only situation in which that would be trumped is in specialist care. For example, if I had a referral from a GP of somebody with depression who was not eating or drinking and who was actively suicidal and psychotic, I would say that that person needed to be on medicine. In some situations, medicines are life saving.

Michelle Ballantyne: What does the mental health strategy say about the physical wellbeing of people with mental health disorders who are put on antidepressants? Was any consideration given to the link to people’s physical wellbeing?

Maureen Watt: Absolutely. One of the key threads throughout the whole mental health strategy is that doctors and others should look at the whole person. They should look, for example, at whether a mental health condition is the result of a physical condition that is not being treated and at whether a physical condition is the result of

someone having a mental health condition. We know that people with mental health conditions are likely to have their longevity reduced by 15 to 20 years, which is a health inequality that we must address. That is one reason for the thread that runs through the mental health strategy about doctors and others having the time and space to look at the person as a whole. It is hoped that the new GP contract will give them that time and space.

Michelle Ballantyne: We have heard it suggested that tests such as quantitative electroencephalographs or SPECT—single-photon emission computed tomography—scans of the brain can assist people who have been on antidepressants and have experienced problems with withdrawal. Can you tell the committee anything about that?

Dr Mitchell: I am not aware of any published evidence that brain scanning has any therapeutic effect on medication withdrawal.

Michelle Ballantyne: Are there any options for managing withdrawal or recommendations about what should be done? If the recommendation is that people should be on those drugs for longer and should take higher doses, is there anything in the strategy about what needs to be done to bring people off them?

Maureen Watt: That information is not in the strategy, which is at a higher level than telling doctors how to do things. Jenny Simons mentioned the matrix, which was produced with NHS Education Scotland as a stepped guide to planning and delivering evidence-based psychological treatment. It has sections on depression and attention deficit hyperactivity disorder. For each medicine, there is a leaflet that tells us how to use it, the recommended dosage and what to expect. A lot of people might not read the leaflets, but they are available. I have had cause to read some with regard to antidepressants. NES has produced a booklet for the general public that is titled "Psychological Therapies in Scotland: Information for Service Users and Carers", and the matrix sets out those therapies.

A GP will hold review consultations at stages with a patient who is on antidepressants, and any decision to take a person off them will be taken by the patient in conjunction with the prescriber.

Angus MacDonald: The British Medical Association has recognised that there is an issue with prescribed drug dependency and has called for policy changes that include a national 24-hour helpline. The Scottish Government stated in its written submission that, although such a helpline has merit, the resources to help people who have addictions have already been allocated. What engagement has the Scottish Government had with the BMA on the establishment of a helpline? What services are in place to help people who are addicted to prescribed medication?

Maureen Watt: We are aware of the BMA's call for a helpline. However, in discussing the petition, we would indicate strongly that the best person to help with withdrawal from antidepressants is the person who prescribed them in the first place. They will know the clinical history of the person who has been on the drugs.

That said, if people want to seek other advice, NHS 24 and NHS inform operate in Scotland, and community pharmacists are in a position to give advice. Problematic withdrawal is best managed by the day-to-day services rather than through a helpline whose operator does not know the history of the caller—that is our strong recommendation. John Mitchell has been in touch with NHS 24 about that specific issue.

Dr Mitchell: We have seen the BMA's evidence to the committee, and we are aware of the work of the all-party parliamentary group for prescribed drug dependence at Westminster, to which the BMA has written a detailed letter in response to the Department of Health's proposal that telephonic support should be provided through its 111 NHS telephone service. We have read with interest the BMA's comments about the English 111 service and the English NHS choices website and information service.

We have discussed the BMA's comments with the Department of Health in Scotland and have asked NHS 24 in Scotland what our response would be if a person who was struggling to come off medication of any sort phoned NHS 24 for help. NHS 24 has said that it receives such calls and points out that it has a nursing telephonic service and material on the NHS inform website as well as pharmacy advisers to provide a higher level of advice. However, it has also said that, beyond the call being made, it would advise a Scot who phones up to discuss the matter first and foremost with the original prescriber of the medicine, as the minister has said, and, if need be, to seek advice from a community pharmacy or the pharmacy supporting the primary care team or centre.

Angus MacDonald: Have you had any discussions with the BMA to that effect?

Dr Mitchell: We have not spoken directly to the BMA. I tried to contact the Scottish secretary this week, but he is on annual leave.

Angus MacDonald: Nonetheless, attempts have been made.

Dr Mitchell: Yes.

Maureen Watt: The Royal College of Psychiatrists has recognised the issue, and a

leaflet that it has issued on coming off antidepressants is available on its website.

Angus MacDonald: The Scottish Government's written submission refers to alternatives to medication being referenced in SIGN guidelines. However, the petitioner has stated:

"Waiting times for availability of non-pharmacological treatment make a mockery of the application of this existing SIGN guidance."

How do you respond to that concern?

Maureen Watt: We have recognised that problem in the mental health strategy. Just a couple of months ago, I gave NHS 24 an extra £500,000 to develop its online services, which include computerised cognitive behavioural therapy. We are aware that some—though not all—people prefer to use online services, and we are trying to ensure that they are more widely known about and available. Moreover, NHS 24 has an on-going telephone counselling service as part of its overall service, which many people have found extremely helpful. There will be a further expansion of online services, and there are funding packages in the mental health strategy for developing and enhancing the supply and training of the workforce for evidence-based therapies.

Angus MacDonald: An issue that has come up in a number of submissions is the off-label prescribing of medication, which I take to mean the prescribing of medication for the treatment of symptoms or conditions outside the terms of the licence for that medication. I am curious about whether you recognise that issue and, if you do, whether the Scottish Government can take any action on it.

Maureen Watt: I think that that is a clinical question for John Mitchell.

Dr Mitchell: In the United Kingdom, the licensing of medication is carried out by the Medicines and Healthcare products Regulatory Agency, and its decisions translate into the information in the British national formulary, which is the UK-wide go-to book for prescribers. It says that a certain drug should be used for certain conditions and not for others, and it provides information in that respect.

The best practice for clinicians is to follow the British national formulary and licensing arrangements. However, research on the circumstances in which a certain medicine might work is sometimes behind the curve, because medication trials require huge numbers of people and, in order to be valid, need to compare the drug in question with a placebo or the usual treatment. There are clinical situations in which it is simply not possible, because of a lack of numbers or other issues, to do the research.

11:15

A good example of that is antidepressant use in children. Because antidepressants are prescribed to children so seldom, and because we use 20-odd antidepressants, if we conducted a randomised controlled trial in which we randomly compared the use of a particular medication to treat a child with depression with the use of a placebo or a different treatment, we would not have sufficient numbers to enable us to know whether we had got a true finding. There would also be huge consent and ethical issues in our doing that.

As medications become more widely used, academic centres and experts might well try out medicines in situations in which they are not licensed to be used, because there is no evidence base to show that they work in treating a particular condition, but in which experts and academics have found anecdotal evidence that they work. Specialists often manage complex situations, and they apply their expertise in determining how best to help their patients. They would, of course, seek to use medications that were first-line British national formulary products. However, if those medicines did not work, there might be situations in which they would say to the person concerned, "This medicine is not licensed for treating your condition, but there is evidence that it might help. Do you want to try it?" It would be best practice for that conversation to be open and transparent. Any prescriber who wants to use a medicine for an off-licence indication should make very clear to the person concerned what they are doing and should record the fact that they are doing it—including why they are doing it—in the case notes. Such situations are unusual, but they are far from rare.

Angus MacDonald: Thank you for that interesting response. Perhaps we can look at how it relates to another petition that we are considering, which is on thyroid hormone replacement treatment, at some point in the future.

Rona Mackay: My question relates to an issue that Dr Mitchell touched on in answer to Michelle Ballantyne. The petitioner has commented on what she calls the catch-22 situation that doctors face, whereby they sometimes feel under pressure to prescribe drugs when someone is contemplating suicide, on the basis that non-pharmacological treatments cannot be immediately accessed and because there is a perception that prescribing medication is more defensible than not doing so. In other words, GPs take a safe route in the treatment of such patients.

Could you expand on your concerns about that comment?

Dr Mitchell: I do not think that I recognise that description. If a doctor had a patient whom they

felt was actively suicidal, they would seek emergency specialist help for them. They would not think, "I'll give them an antidepressant and put them out the door."

Rona Mackay: I am sorry. I thought that, in response to Michelle Ballantyne, you said that, in extremely serious cases, you would prescribe.

Dr Mitchell: As a consultant psychiatrist, I would do that in a situation in which somebody was an in-patient in a psychiatric hospital. A person's safety trumps everything. In a situation in which a patient was not eating or drinking and whose life was at immediate risk, I would prescribe a medication for them, but I would admit them as an in-patient and would give them that medicine in a controlled and safe place.

Rona Mackay: If you were a GP and a patient came to you saying that they could not take any more and were feeling suicidal, are you saying that you would not prescribe, but would signpost them elsewhere?

Dr Mitchell: I am not a GP, but my experience is that a GP would contact the local community mental health team and say that this person needed to be seen now. The community mental health team would respond to that.

Rona Mackay: Are you confident that the response would be quick enough and that there would be no delay?

Dr Mitchell: That is the nature of community mental health teams. They do a lot of routine, scheduled work, but they also do a great deal of work that is considered to be urgent or emergency. Community mental health teams work on the basis that an emergency referral means that they must drop everything and deal with that immediately, and an urgent referral means that someone must be seen within 24 hours. More often than not, the referral form from the GP will be explicit about the level of intervention that they are seeking.

In a situation in which a GP is with a patient who is saying that they are actively suicidal, no community mental health team would be waiting for a typed up referral letter, but would deal with the practicalities of the situation there and then. It would be nice to get some information, but one would deal with the risk in the moment.

Rona Mackay: To summarise, you do not believe that GPs are generally using prescribing as a safe option or that they are prescribing just in case things get out of hand.

Dr Mitchell: No. I do not recognise that behaviour. A GP might argue the reverse. If a GP has someone in who gives them concern about their level of suicidality and they ask that person whether they were thinking of ending their life, but the person says, "No, I'm not," the GP would wonder whether they could trust what the patient was saying. That is a common situation. The GP's gut feeling might be that the patient was high risk, even though they were saying, "No, doctor, I'm not suicidal and I am not thinking of ending my life." The GP's concern might be that if they decided that that person was not actively suicidal and they gave them an antidepressant and sent them away, it might lead to greater criticism than not prescribing an antidepressant.

Maureen Watt: I want to mention two things. First, we are running distress brief intervention pilots in six areas across Scotland, which give access within 24 hours to counsellors for anyone who presents to accident and emergency or who becomes known to the police or is in police custody. The pilots started in October—I went to visit the Lanarkshire pilot—and have already had some good feedback.

Secondly, the commitment to an extra 800 mental health workers is to address those issues, so that we can ensure that if someone presents out of hours they can get immediate help.

The Convener: I have one final point. You mentioned earlier that many drugs come with a little leaflet. Do you accept that a little leaflet has no authority in comparison with the authority of the GP? Should the GP humanise what the little leaflet says, so that people know what the consequences are?

Maureen Watt: Yes. We all know that when we go to the GP, if the doctor prescribes something, they tell you what to expect from the prescription. However, I accept that there may be cases where that is not happening.

Michelle Ballantyne: Could you comment on whether you accept the following statements that were given to us in evidence? The first statement is:

"Ten per cent of the population of Scotland takes an antidepressant on prescription. Of those between 80 and 90% are on treatment for more than a year - many for over a decade."

Is that because it is good treatment, or because people are dependent?

The second statement is:

"At present rates of antidepressant use among adolescents in Scotland, especially among women, is rocketing. These drugs are or are on their way to being the most commonly used prescription drugs by Scottish adolescents."

Do you recognise and agree with those statements?

Dr Mitchell: I do not recognise much of that. Antidepressants are certainly a commonly used medication. The guidance for treating depression

says that if someone who is experiencing their first depression goes on antidepressants and the medication works for them, they should stay on it for six months before they come off it. If they have a recurrence of the depression, they should stay on the medication for two years. That guidance is internationally accepted and based on evidence.

For effective treatment of people with depression, if people respond to the drugs, they should be on them for that sort of timescale. They are not effective if they are used only for a month or for two months.

I grant that the study that was done on the prescribing of antidepressants is now six years old, but it indicated that the longer and more appropriate periods of time were being applied by GPs. It was new prescriptions of antidepressants and what happened to them that were being examined.

The Convener: I thank the minister and her officials for their evidence. I appreciate that you have done a double shift today, but it has been really useful.

I emphasise to anyone watching that we recognise the importance of mental health and that progress has been made, but the petitioner is presenting the challenge that there are issues that we need to address.

I am grateful for the witnesses' attendance today. I am happy for you to remain for the final few minutes while we have a conversation about how we take the petition forward, but I am happy for you to leave if you have other commitments.

The committee needs to think again about the petition. I assume that we do not want to close it, and I am interested to hear members' views.

Angus MacDonald: We need to reflect on the evidence that we have heard today. Given what we heard from Dr Mitchell, I would be keen to hear what the BMA's current position is with regard to the helpline. Dr Mitchell explained that NHS 24 discussions have highlighted that there is a service but I am still keen to get a response from the BMA.

The Convener: Perhaps the most effective thing to do would be to ask the clerks to reflect on the evidence and where we have highlighted that we want more information. Even in those final points that Michelle Ballantyne made, there is quite a lot around the prevalence of antidepressants and the length of time that people are on them. If the petitioner's contention is that people are put on antidepressants but not supported, we want to explore that further.

Again, we also hope that the petitioner will reflect on the evidence and that she will, if she so chooses, provide us with more evidence.

Rona Mackay: The important thing is to get the petitioner's response and to pick out the individual issues that have come up during evidence, such as statistics and so on, that we have asked for. That would be useful.

Michelle Ballantyne: We need to hear from GPs about their experience of what we hear from both sides about a gulf in the evidence. We need to reflect on how we can do that.

The Convener: We also need to find out the extent to which there is a pressure. We have spoken about this in another context altogether. Defensive practice is where people feel that, for the want of a guarantee, they will do something else, and that is perfectly understandable. We might want to take that forward but, underneath all this, we recognise the challenges that health practitioners face in terms of pressure and managing their time.

Michelle Ballantyne: There is also the disconnect that many GPs feel now in that when they are seeing a patient, trying to look at them holistically is now much more difficult than it was because they used to know their patients within the context of the society in which they lived and worked. Now, they only see them as a patient for 10 minutes. They do not know the family or other circumstances or how they live. The process has become much more complicated.

The Convener: Those are all useful comments, so I will ask the clerks to bring all this together. Any further responses from the petitioner will be welcome in informing our further action.

Once again, I thank the minister and her officials. I very much appreciate their input. I also thank all those who responded to the petition.

Meeting closed at 11:30.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

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

The Scottish Parliament
Pàrlamaid na h-Alba