OFFICIAL REPORT
AITHISG OIFIGEIL

Public Petitions Committee

Thursday 21 March 2019

The Scottish Parliament
Pàrlamaid na h-Alba

Session 5

© Parliamentary copyright. Scottish Parliamentary Corporate Body

Information on the Scottish Parliament’s copyright policy can be found on the website - www.parliament.scot or by contacting Public Information on 0131 348 5000

Thursday 21 March 2019

CONTENTS

Col.
CONTINUED PETITIONS ... 1
Mental Health and Incapacity Legislation (PE1667) ... 1
Mental Health Support for Young People (Inquiry) ... 16
Bus Services (Regulation) (PE1626) ... 32

PUBLIC PETITIONS COMMITTEE
6th Meeting 2019, Session 5

CONVENER

*Johann Lamont (Glasgow) (Lab)

DEPUTY CONVENER

*Angus MacDonald (Falkirk East) (SNP)

COMMITTEE MEMBERS

*Rachael Hamilton (Ettrick, Roxburgh and Berwickshire) (Con)
*David Torrance (Kirkcaldy) (SNP)
Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Maurice Corry (West Scotland) (Con) (Committee Substitute)
Clare Haughey (Minister for Mental Health)
Hugh McAloon (Scottish Government)
Kirsty McGrath (Scottish Government)
Teresa Medhurst (Scottish Government)
Dr John Mitchell (Scottish Government)
Philip Raines (Scottish Government)

CLERK TO THE COMMITTEE

Sarah Robertson

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Public Petitions Committee

Thursday 21 March 2019

[The Convener opened the meeting at 09:30]

Continued Petitions

Mental Health and Incapacity Legislation (PE1667)

The Convener (Johann Lamont): I welcome everyone to the sixth meeting in 2019 of the Public Petitions Committee. We have received apologies from Brian Whittle, and Maurice Corry is attending as a committee substitute.

Before we begin, I take this chance to congratulate Maria Lyle, who is part of our clerking team and is also a world para athletics championships and Paralympics medallist and has had great athletic success at European level as well. We are very proud of the fact that she won the young Scotswoman of the year award last week, and we want to pass on our congratulations—and take some of the reflected glory—as a committee.

We have one item on our agenda this morning, which is consideration of three continued petitions. The first is PE1667, by W Hunter Watson, which calls for a review of mental health and incapacity legislation in Scotland. When we previously considered the petition in October 2018, we agreed to invite the Minister for Mental Health to give oral evidence.

Members will be aware that, on Tuesday, in advance of today's evidence session on the petition, the Minister for Mental Health made a statement to the Parliament announcing an overarching review that will examine the full legislative framework that supports and protects people with mental disorders. The minister has written to the committee with further detail on the review. That appears to deliver the action that the petition calls for and to pick up on the concerns and regular comments of members of this committee about the number of petitions relating to mental health that have come to us recently.

The petitioner has indicated that he very much welcomes the minister's statement and he hopes to be given an opportunity to respond to the forthcoming consultation on reform of the Mental Health (Care and Treatment) (Scotland) Act 2003 so that he may raise the many issues that concern him. Members have a copy of the petitioner's email to the clerks to that effect.

Notwithstanding the minister's statement to Parliament and her letter to the committee, she is here to give evidence to the committee, which might allow us to draw out some further information on the review. She is accompanied by Teresa Medhurst, deputy director, adult mental health; John Mitchell, senior medical adviser; and Kirsty McGrath, head of the adults with incapacity review team. Thank you all for attending.

Minister, given that you delivered your statement to Parliament on Tuesday, do you wish to say anything further by way of an opening statement to the committee?

The Minister for Mental Health (Clare Haughey): Thank you, convener. With your indulgence, I will make an opening statement.

As you mentioned, I announced to Parliament on Tuesday that, in order to strengthen support for people with mental health conditions, we will undertake an independent review of the Mental Health (Care and Treatment) (Scotland) Act 2003. Taken together with the on-going work on the incapacity and adult support and protection legislation, we now have a comprehensive programme of activity that amounts to an overarching review of the legislative framework that affects people with mental disorders.

The vast majority of people who access mental health services do so on a voluntary basis. Relatively few people are ever treated for a mental disorder against their will. If they are, it is because it is necessary to protect them or other people.

People with a mental disorder may also be affected by the Adults with Incapacity (Scotland) Act 2000 or the Adult Support and Protection (Scotland) Act 2007. Depending on their needs, a person may be subject to one, two or all three of the acts. That may be confusing for the individual and their carers and create barriers for those who care for their health and welfare. Although there have been huge advances in relation to mental health in terms of treatment and changing social attitudes, we have also always been clear that we will continue to keep the changing context under review to ensure that our legislation is fit for purpose.

In recent years, there has also been an increasing focus in all areas of public life on the importance of protecting and promoting human rights and recognising the rights of people with disabilities, and that has provided us with an opportunity to look again at our legislation to ensure that the rights and protections of those with a mental disorder are fully respected.

The Scottish Government is committed to bringing change to people's lives and ensuring that mental health is given parity with physical health. The review of the mental health legislation

will take that a step further, reaffirming our commitment to creating a modern and inclusive Scotland that protects, respects and realises internationally recognised human rights.

I mentioned that we have already begun work to review incapacity law and practice as well as learning disability and autism under the mental health legislation, and that we will shortly be undertaking work on the adult support and protection act. The latest review will build on and be complementary to that on-going work, resulting in an overarching review of the legislative framework affecting people with mental disorder.

I want to take a minute to outline the principal aim of the review of the mental health legislation, which is to improve the rights of and protections for a person with a mental disorder and to remove barriers to those caring for their health and welfare. It will do that by reviewing developments in mental health law and practice on compulsory detention and care and treatment since the Mental Health (Care and Treatment) (Scotland) Act 2003 came into force and by making recommendations that give effect to the rights, will and preferences of the individual by ensuring that mental health, incapacity and adult support and protection legislation reflects people's social, economic and cultural rights, including requirements under the United Nations Convention on the Rights of Persons with Disabilities and the European convention on human rights, and by considering the need for convergence of incapacity, mental health and adult support and protection legislation.

We intend to announce the chair of the review shortly. Clearly, it will be for the chair to determine how the review is best taken forward. However, I want to be clear that the work will be stakeholder driven and evidence led. I am determined that, throughout the process, the views of service users, those with lived experience and those who care for them are at the front and centre of the work so that they can help us to shape the future direction of our legislation. For each stage of the process, an engagement strategy will have to be created, showing how the review will seek to gather views that are as wide ranging as possible, including from those who I have mentioned as well as professionals and people with a more academic interest. In particular, the third sector will be key to making that happen, as it has a wealth of knowledge and understanding concerning the impact of legislation on people's lives.

I very much hope that the committee will welcome the announcement of the review, which complements the work that is already under way and will ensure that Scotland's mental health legislation continues to lead the way in ensuring the rights of and protections for our citizens.

The Convener: Thank you.

In your statement on Tuesday, you announced the review of the full legislative framework that supports and protects people with a mental disorder, which includes the Mental Health (Care and Treatment) (Scotland) Act 2003, the Adults with Incapacity (Scotland) Act 2000 and the Adult Support and Protection (Scotland) Act 2007. You also referred to reviews or other work that will be undertaken that might improve practice without requiring legislative change. This has been addressed in your letter to the committee but, for clarity, can you confirm how many separate reviews or distinct pieces of work will be taken forward as part of the overarching review?

Clare Haughey: As you say, work is on-going that will feed into the overarching review. There is work on the mental health legislation in relation to people with learning disability and autism. There is also on-going work on the adults with incapacity act, and we anticipate work on the adult support and protection legislation. As I said in my opening statement, people often find their situation confusing because they fall under several pieces of legislation at one time. We need to ensure that those workstreams continue and that our work is clear and concise, in what is a very complex area. Under the chairmanship of the review of the mental health legislation, that work will feed into the overall review.

Kirsty McGrath can say more about the on-going work on the adults with incapacity act, and how we envisage that the future work will fit in with the current workstreams.

Kirsty McGrath (Scottish Government): As the committee will be aware, we have been looking at the adults with incapacity legislation over the past year or so, and it is clear that there are distinct areas of crossover between the adults with incapacity legislation and the mental health legislation, namely the way in which capacity is assessed, the definition of mental disorder and the use of an individual's mental disorder as the gateway to intervention. Therefore the area could not be looked at in isolation through a review solely of the adults with incapacity legislation.

When we were out meeting stakeholders, we heard many calls for us to take a wider approach and to consider more holistically the crossover between mental health and incapacity law. That is what will happen through the review that was announced on Tuesday, which has been widely welcomed by all the stakeholders that we met over the past year.

From our meetings with stakeholders, it is also clear that, although there are concerns about some of the processes in the adults with incapacity legislation, there is a strong desire to ensure that we do not throw away the very good aspects of the 2000 act. When the act first came

into force, it was groundbreaking and, in many areas, it remains so, particularly with regard to the principles in it, which are, in summary, the principles of least intervention and of ensuring that the wishes and preferences of the adult are taken into account. We have been told by stakeholders time and again that, if the practice of dealing with adults with incapacity adhered more closely to the principles in the 2000 act, we would be far closer to achieving full adherence with the UN Convention on the Rights of Persons with Disabilities than might currently be considered the case.

While we await the outcome of the review, which will impact on possible legislative changes in the area of adults with incapacity, we will proceed with a comprehensive programme of non-legislative changes to practice and guidance. Principal among those changes will be the development of a strategy for supported decision making, so that people with impaired capacity have the support that they need to make their own decisions about their lives and care. Enabling people to exercise their legal capacity on an equal footing is a fundamental aspect of the UN Convention on the Rights of Persons with Disabilities.

In addition, we are seeking to improve the training for professionals across health, social care and the law, to ensure that those who require to know about the adults with incapacity legislation are fully aware of the range of options and the principles to which they need to adhere.

Our first priority is the revision of guidance and codes of practice on powers of attorney. That work will highlight the need for every adult in Scotland to consider appointing an attorney while they have the capacity to do so. The guidance will also provide information on the rights and responsibilities of attorneys, the safeguards that are in place to protect individuals and the sanctions that can be imposed for misuse of power of attorney.

If the committee requires any further information about that work, we would be happy to write with the details.

The Convener: We have questions that will tease out some of the details, but it would be helpful if you could provide further information after the session if you feel that we have missed anything.

Kirsty McGrath: I am happy to do so.

The Convener: The work seems very complex and complicated. How will it be co-ordinated and managed? Will the chair of the review manage all the work? Will there be some kind of timeline so that the committee or the Parliament can check on progress? What parliamentary engagement with the process will there be? Minister, in the chamber on Tuesday, I heard you say that you do not want to be—you did not use this word, but it is what I understood you to mean—constrained by setting a date for completion of the review, given that you do not want to be driven by that date if things become too complex. I completely understand that, but how will the work be managed so that we do not get overwhelmed by its complexity? How will you make it visible to everyone so that we can understand what you are trying to do? What parliamentary engagement do you envisage to allow us to see what progress is being made as the process goes on?

Clare Haughey: I completely understand your concerns about the complexity of the work, because it is very complex and several workstreams are going on currently. As Kirsty McGrath indicated, it has become evident that we cannot have those workstreams working in isolation; we need to pull together all the legislation and have an overview of mental health and incapacity legislation. That is what has brought us to this point.

We will have in place processes and regular reporting from the workstreams to ensure that they are co-ordinated. With your indulgence, convener, Teresa Medhurst can explain exactly how we will manage the process.

09:45

Teresa Medhurst (Scottish Government): Each workstream will be provided with a briefing on the work of the different elements, so that people fully understand what is happening. That is particularly important for the new chairperson who will come in for the mental health legislation review. Through officials, we will maintain oversight of where each workstream is and provide informal opportunities to meet and share information. We will also put in place a structure of more formal engagement for critical stages of each pathway for the reviews that are being conducted.

Clare Haughey: We are aware that we are spinning lots of plates, so we are keen at the outset to have in place structures and processes to ensure that communication is good and that everyone's work is co-ordinated.

Angus MacDonald (Falkirk East) (SNP): The Scottish Government published its consultation paper "Adults with Incapacity (Scotland) Act 2000: Proposals for Reform" last year. The paper stated that, at the same time as the consultation,

"a scoping exercise is being carried out to find out what is currently happening across Scotland by way of support for decision making for those who need it",

as part of supporting people to exercise their legal capacity. The paper also said:

"working groups with a range of stakeholders will be set up with the aim of establishing a strategy for support for decision making that will underpin"

the adults with incapacity legislation. For clarity, and further to your statement this week, will you provide further information about the consultation and its outcomes? Will you confirm that it will be included in and will help to inform the overarching review?

Clare Haughey: Regrettably, the work that you referred to was delayed because of difficulties last year in recruiting staff to undertake it. We have now resolved the staffing issues, and I am pleased to report that, this week, Scottish Government officials met People First (Scotland), which is a learning-disabled people's organisation, to learn about the work that its law and human rights group has been doing to support decision making.

We are in the early stages of planning workshops with a range of stakeholders at which we will learn from them what support is needed to exercise legal capacity. Following that, we will look for volunteers to support us in further developing and testing the strategy. I assure the committee that that work is a priority for us this year.

Angus MacDonald: In your statement, you stressed the need to engage with stakeholders, including many in the third sector, so it is good to hear that you have met People First. How will you achieve the level of engagement that you have committed to?

Clare Haughey: Far be it from me to tell the chair how to conduct the review—we will appoint them to do that—but I have been clear from the outset that the voices of lived experience from service users, their carers and their families must be front and centre of the entire review. When a chair is appointed, I will be clear that that is the expectation from me and the Scottish Government. When reviews have been commissioned, we have made it clear that the voice of lived experience must be at the heart of them.

Teresa Medhurst: There will be engagement, and stakeholder strategies will form part of the work packages that will be in place to deliver the review. We will ensure that the chair is provided with appropriate support not just to inform the different engagement strategies, but to have oversight of the work. Through informal and formal engagement with the chair, we will ensure that there is engagement at the programme level to fully understand the appropriate evidence, whether that is academic or otherwise. We will also ensure that the engagement strategies that are in place involve not just organisations but people with lived experience and carers.

Angus MacDonald: That is encouraging to hear.

In May 2017, the Mental Welfare Commission for Scotland and the centre for mental health and capacity law published the report "Scotland's Mental Health and Capacity Law: the case for reform". One recommendation is that

"There should be a long-term programme of law reform, covering all forms of non-consensual decision making affecting people with mental disorders."

Can you confirm that that will be included in the review? How might that look?

Clare Haughey: Yes, I can confirm that that area will be covered by the review. John Mitchell might be able to add a bit more about that.

Dr John Mitchell (Scottish Government): Those sentiments echo the original Millan committee report, which, I think, foresaw the need to create what we are calling convergence in the different laws and to look at how they protect the rights of people as well as at the fundamental idea of how we protect decision making and involve people in their care. The most recent report talks about a longer-term vision, and that is a fundamental aspect of what we would expect from the review. As the minister explicitly said, the third purpose of the review is to look at the convergence of the legislation on decision making.

Maurice Corry (West Scotland) (Con): We understand that the UNCRPD rights are not legally enforceable in Scotland in the same way as ECHR rights are. You have referred to that as providing

"impetus for this increased focus."

Will the review look at the enforceability of that range of rights in Scotland?

Clare Haughey: As I said in my statement, we are looking again at the legislation to ensure that the rights and protections of those with mental disorder are fairly respected. The review will make recommendations that will give effect to the rights, will and preferences of individuals, making sure that the legislation on mental health, adults with incapacity and adult support and protection reflects people's social, economic and cultural rights, including the requirements of the UNCRPD and the ECHR.

Maurice Corry: The legal standing of personal advocates for people with mental health incapacity is an issue. Will that be covered in the review?

Clare Haughey: All the legislation on mental health and incapacity will be reviewed. Kirsty McGrath will be able to give you more specific information about adults with incapacity legislation and that issue.

Kirsty McGrath: The consideration of independent advocacy and its place in supported decision making is part of our development of the supported decision-making strategy. We are well aware of the importance and value of independent advocacy and of the very positive difference that having an independent advocate can make to a person. Yes, it is part of our work.

Maurice Corry: I have one concern about that subject. I want to drill down on the legal standing that advocates have in relation to decision making. That seems to be a big grey area at the moment.

Kirsty McGrath: Yes, I agree—it is a grey area that requires clarity.

Maurice Corry: That issue will be looked at.

Kirsty McGrath: Yes, absolutely.

David Torrance (Kirkcaldy) (SNP): The petitioner refers to article 12.4 of the Convention on the Rights of Persons with Disabilities. He considers that

“appropriate and effective safeguards to prevent abuse, in accordance with international human rights law”,

as set out in that convention, are lacking in Scottish mental health and incapacity legislation. How will that be factored into the overarching review?

Clare Haughey: As I said in my opening remarks, it is worth noting that most people who use mental health services receive that treatment voluntarily and that very few people are subject to an order or certificate under the 2003 act. However, compulsory treatment is used to provide some individuals with the medical treatment that they need to alleviate suffering and for their protection and that of others. Compulsory treatment is allowed under mental health legislation in Scotland only in a strictly defined set of circumstances, and there are a number of safeguards including independent advocacy and the independent Mental Health Tribunal for Scotland, which grants and reviews orders for compulsory treatment.

There is also the independent Mental Welfare Commission for Scotland, which monitors the use of Scottish mental health law, including in compulsory treatment. The commission has the power to intervene in cases if there is evidence of improper care, treatment or practice. Under the 2003 act, any service user has the right to support from an independent advocate and the right to appoint a named person to represent their interests. They also have the right to make an advance statement, setting out what treatment they would and would not like when they are unwell. The Mental Health (Scotland) Act 2015 introduced further changes to ensure that people with a mental disorder can access effective treatment quickly. It also strengthened support for decision making and promoting rights.

Rachael Hamilton (Ettrick, Roxburgh and Berwickshire) (Con): It is widely recognised that people living with dementia are, in certain circumstances, denied their human rights and are sometimes physically or chemically restrained. The petitioner considers that

“the lives of some elderly people with dementia will be shortened in breach of Article 2 ECHR if they are subjected to chemical restraint”.

With that in mind, does the Scottish Government intend to amend Scotland’s health and social care standards so that they would no longer condone the use of “chemical restraint”, to use the petitioner’s words? Could that be addressed without legislative change?

Clare Haughey: Improving care and support for people with dementia and those who care for them has been a major ambition for the Government. Our legislation follows a rights-based approach, and the code of practice that accompanies the Adults with Incapacity (Scotland) Act 2000 explains that the use of covert medication is permissible in certain limited circumstances—for example, to safeguard the health of an adult who is unable to consent to the treatment in question when other alternatives have been explored and none is practicable.

John Mitchell is best placed to explain how that works in practice and some of the difficulties that families, carers and clinicians face in providing appropriate care and treatment for people with severe dementia who require medication but who cannot give consent for that.

Dr Mitchell: That issue is a real concern, and I am grateful to Rachael Hamilton for raising it. There is a fundamental challenge in balancing the protection of people’s rights with protecting them from ill health and its consequences. The legislation makes it clear that nobody should be forced to have medication without their consent if they have capacity, and that is the practice. The challenge is when people do not have capacity. Currently, the 2000 act allows treatment for physical disorder when capacity is not present, and the 2003 act does the same in relation to mental disorder.

All medications have side effects. For example, there is concern about an increased risk of falls and an effect on blood pressure when antipsychotics are used on elderly people. Those are very real risks. As with any treatment, on a day-to-day basis, clinicians have to weigh up the side effects versus the benefits. If, for example, somebody with dementia is in a psychotic, distressed and agitated state, there might be more

risk to their health from falls, so they might not be treated rather than treated.

10:00

Rachael Hamilton: Obviously, the clinician must take a very important decision in making any intervention. However, the petitioner has asked, in particular, whether Scotland's health and social care standards could be amended without going down the legislative route in order that we do not condone the use of chemical restraint.

Dr Mitchell: As the minister said, the use of chemical restraint is authorised under certain circumstances. There is very clear guidance for clinicians. The Mental Welfare Commission for Scotland has explicit published guidance on the use of covert medication, as do the Royal College of Nursing and the Royal College of Psychiatrists. Very detailed guidance for practitioners on consent and capacity considerations and the use of covert medication, which people are aware of, is already available in Scotland, and I am not aware that any further amendment would be needed beyond the necessary consideration of that guidance as part of the total review.

The Convener: Is there a difference between giving someone medication for their medical condition without their consent and chemical restraint? Anecdotally, we have heard it called the "chemical cosh". It is about managing people. Is the petitioner trying to address that? How do you respond to that? A person not being able to consent to the medication that they require for their condition is quite different from a person being managed.

Dr Mitchell: Yes. The petitioner raises two issues. There is a discussion about covert medication and, as the convener has rightly said, there is a discussion about what clinicians might call rapid tranquilisation. It may be quite clear that a medication is being administered against the wishes, or without the consent, of the individual. That might not necessarily involve dementia; a young, psychotic and dangerous individual who may have to be in hospital may be involved. The two situations are different, and there is different guidance on the principles for both.

Situations that involve emergency tranquilisation with medicine are very common. Unfortunately, that is required in some circumstances, and the Mental Welfare Commission for Scotland lays out explicit guidance on that. The 2003 act also contains particular safeguards so that if, for example, a patient is subject to compulsion and medication is administered without their consent—that is a section 243 issue—there is a legal responsibility on the clinician to document why they did that and to inform the Mental Welfare Commission for Scotland, which is the overarching watchdog that is independent of Government and that promotes and protects the rights of people in Scotland who have mental health problems.

The Convener: Okay. The next question is maybe more a question for the minister. At the heart of the petition is concern about the human rights of the person who may be treated against their will. The petitioner has asked why the minister made

"no reference to the absolute right of ... patients not to be subjected to inhuman or degrading treatment"

and referred to the case of Robert Napier v the Scottish ministers. He said:

"Will the Scottish Government study the definition of inhuman and degrading treatment provided by the European Court of Human Rights in paragraph 52 of its judgment in the Pretty v UK case and consider whether forced treatment might at times fall into the prohibited inhuman category",

as he believes it did in an example that perhaps provoked or prompted the petition. There is a slightly different issue to do with human rights legislation. Is such treatment in itself inhumane or degrading? Has the Government taken that into account?

Clare Haughey: Certainly, convener, our legislation is compliant with the European convention on human rights and fundamental freedoms. It has never been found—in part or in whole—by the European Court of Human Rights to be incompatible with the convention.

We are commissioning the review to take account of developments and changes in human rights legislation, so it will look at current human rights legislation, whether it be European or United Kingdom human rights legislation—none of us knows where we are going to be at that time.

We also abide by the appropriate case law emanating from the European Court of Human Rights. I hope that the petitioner will be assured that the Scottish Government takes cognisance of article 1 of the convention in ensuring that everyone within its jurisdiction has the rights and freedoms that it provides.

The Convener: So, the review will look specifically at the question of whether some of the treatment that is being used falls foul of the absolute right not to be subjected to inhuman or degrading treatment.

Clare Haughey: As I said, our legislation has not been found, in part or in whole, to be in breach of the ECHR. I might be wrong in saying this—the lawyers in the room will tell me if I am—but I think that the specific case that is cited related to slopping out practices in Barlinnie and not to mental health issues.

The Convener: The petitioner's point is that, if that case can be founded on the idea of inhuman and degrading treatment, will the review at least consider the possibility that—in the view of the petitioner and others, I am sure—some things that happen to folk who are in treatment could also fall within that category? What reassurance can you give us that the review will look at that? I do not have a view one way or another of what the review or consideration would establish, but it is clearly an issue for the petitioner, and I ask you to reflect on that.

Clare Haughey: Absolutely. I understand that concern. I have met the petitioner and have heard his views and concerns. I expect the review to look at all human rights legislation. Dr Mitchell wants to come in at this point.

Dr Mitchell: Thank you, minister. Absolute and qualified human rights is a complex area. I am not a lawyer, and I think the evolving story of human rights is why we are having this review, to some extent.

Article 2 of the ECHR, which is the right to life, is an absolute right. That means that there is a duty not to take away anyone's life and a duty to take reasonable steps to protect life. Article 14 is the right not to be discriminated against, which could be interpreted in terms of people having the right to the same effective treatments as other people. Article 25 is the right to the highest attainable standard of physical and mental health. Those are illustrations of the counterpoint between the different articles, and protecting an individual while still protecting absolute rights is challenging. We have now had two decades of the current legislation, so an expert consideration of the issues around the experience of human rights in a review is timely.

The Convener: You accept that, as we have said, there is a distinction between effective treatment of an individual and the means by which the system manages patients.

Dr Mitchell: Yes.

The Convener: Therefore, when you are looking at those situations, you will look at them differently in terms of human rights.

Dr Mitchell: Yes.

The Convener: Thank you.

Maurice Corry: My question follows on from the previous question and response. Will the review consider the advice on the informed consent of people with disabilities that should be given to psychiatrists and other medical practitioners?

Clare Haughey: We are developing a strategy for supported decision making to give people with impaired capacity the support that they need to make their own decisions about their lives and care. We will provide a comprehensive training programme for professionals across health, social care and the law. We are improving the provision of support for guardians and attorneys, and we are revising current codes of practice and guidance to provide clarity on the law as it stands.

The Convener: I have two final questions. Do you have an idea, in general terms, of what the outcomes of the review might be? Is it possible that we might have consolidating legislation as opposed to new legislation?

Clare Haughey: I am glad that you caveated your question, because I do not want to pre-empt the outcomes. There certainly could be convergence of the mental health and the adults with incapacity legislation, as I said in my statement in Parliament, but I do not want to prejudge what the outcomes of the review will be or what work will be recommended.

The Convener: You have said that the chair of the review will be announced soon. A ministerial definition of "soon" can sometimes be quite flexible. Can you indicate when that might happen? You also said that the work will be supported by a short-life working group. What is the anticipated lifespan of the short-life working group?

Clare Haughey: I appreciate your point about "soon". When I ask my officials for something, "soon" means yesterday. We need to get the right person for what will be a complex and important review. You can be assured that I will not rest on my laurels and that we will appoint a chair as speedily as we can.

The short-life working group will include representation from patients, service users, people with lived experience of mental disorder, relatives, the Mental Welfare Commission for Scotland, third sector organisations, the Scottish Human Rights Commission, the Mental Health Tribunal for Scotland, health boards, local authorities, our principal medical officer, the Scottish Prison Service and the Scottish Courts and Tribunals Service. A wide range of people with a wide range of views will contribute to the group, and we anticipate that the initial stage will last for about 12 months.

As I said, other work is continuing. We expect to have the recommendations from the review of how the mental health legislation affects the learning disabilities and autism populations by the end of this year, and that will feed into the working group's work. Lots of different work streams are under way.

Rachael Hamilton: I would like to clarify something with John Mitchell. You mentioned that article 2 of the ECHR gives individuals an absolute

right to life. If the review of the legislation took into account the full field of human rights, would it be the case that doctors could no longer prescribe drugs concealed in food, for example? Would there be a change to the current practice?

Dr Mitchell: That is a matter for the review and for legal interpretation. I would not be able to anticipate the outcome of the review.

The Convener: The committee has done a lot of work on the use of mesh. There was the issue of the independent review of mesh implants, and then Professor Britton considered the review's effectiveness. Will you look at her report for guidance on how to ensure that high standards are applied in how the review operates?

Clare Haughey: Absolutely. We will look at best practice in carrying out a review, as you would expect us to do.

The Convener: With the mesh review, the big issue was the extent to which some of the stakeholders felt excluded. That is a huge challenge; even determining the membership of the short-life working group is challenging.

Clare Haughey: Absolutely, but I hope that the committee, the Parliament and the wider community have heard me say that service users and people with lived experience and their families will be front and centre when it comes to the review. They will be at the heart of what we do.

The Convener: Thank you very much. It has been a very useful session. Of course, the committee takes full credit for the timing of the announcement. [*Laughter*.] I am sure that the petitioner and people more broadly will welcome the minister's decision to take forward the proposed work.

We must think about what we want to do next with the petition. It has been suggested that we should reflect on what has been said today, which will afford the petitioner and anyone else who wants to comment the opportunity to do so. We can decide how to manage the petition at a later stage. It seems to me that the petitioner's request has been met, and I am sure that he is pleased about that, but we can decide what to do about the petition at a later stage. Do members agree?

Members *indicated agreement.*

The Convener: I thank the minister for her attendance.

10:15

Meeting suspended.

10:20

On resuming—

Mental Health Support for Young People (Inquiry)

The Convener: The next evidence-taking session relates to the committee's inquiry into mental health support for young people in Scotland. As members will know, the inquiry was launched in connection with PE1627, by Annette McKenzie, on consent for mental health treatment for people under 18 years of age. The committee wishes to understand where young people can seek help from at an early stage before they reach the point of crisis, the extent to which young people are aware of how they might support their peers, and how we can increase public awareness of what I think we have established is quite a complicated landscape.

At its meeting on 21 February 2019, the committee considered a thematic analysis of the responses to the call for evidence. We are very grateful to all those who responded and for the wide range of evidence that we received. From that evidence, it is clear that the Scottish Government is undertaking a wide range of work in the area of children and young people's mental health services. To assist the committee in determining where it could focus its work in the inquiry, we have requested an update from the Minister for Mental Health on the progress of Scottish Government policies. The minister is here today to give evidence to the committee to that end. She is accompanied by her officials from the Scottish Government: Dr John Mitchell, senior medical adviser; Hugh McAloon, deputy director, children and young people's mental health; Philip Raines, head, children and young people's mental health delivery unit; and Lyndsay Wilson, senior policy lead, suicide prevention. Welcome.

I invite the minister to make a brief opening statement of no more than five minutes, after which we will move to questions.

Clare Haughey: Thank you very much, convener. I am happy to set out the Scottish Government's approach to improving support for our nation's mental health and to address any issues that the committee might raise.

I start by describing our vision and how it has shaped the work that we have set out. My vision for the mental health of children and young people, which was presented in the "Mental Health Strategy 2017-2027", is about ensuring that children and young people

"get the right help at the right time, expect recovery, and fully enjoy their rights, free from discrimination and stigma."

We know that in order to achieve that vision a decisive change is needed in the support for children and young people.

Audit Scotland's report "Children and young people's mental health" highlighted that there is often too great a focus on crisis and specialist services at the expense of early intervention and prevention. You will have seen the Public Audit and Post-legislative Scrutiny Committee's recent report on that Audit Scotland report. We welcome that committee's report and recommendations, just as we welcomed the report from Audit Scotland.

We are taking action in several areas. First, we acknowledge that performance in specialist services needs to improve. Although recent statistics show that improvement is happening, I am clear that we need to remain focused on driving sustainable and faster improvement, and steps are being taken to drive that change. We have invested £4 million in improving the capacity of child and adolescent mental health services by recruiting 80 additional staff; discussions are under way to support performance as part of the development of the annual operating plans of national health service boards; we are increasing resources to support improvement in health services in every part of Scotland; and, finally, I have established and chair a new strategic board for mental health to monitor and drive the necessary improvements.

Secondly, sustainable performance will be possible only if we drive wider system change. Our mental health strategy set out the key framework for achieving that; that has been backed by ambitious commitments to action and resources in the 2017 and 2018 programmes for government, and we are committing a quarter of a billion pounds to that work. We have set out our detailed plans in "Better Mental Health in Scotland", which was published in December, and key to our approach is improving the capacity of not just our health services but all services that can support mental health. That is why we are making significant investments in the capacity of education to support children and young people.

Thirdly, we are looking to key independent groups to highlight where reform needs to go in future. The work of the children and young people's mental health task force, chaired by Dr Dame Denise Coia, will be vital for the issues that we are discussing today. The task force will set out detailed recommendations to the Scottish Government and the Convention of Scottish Local Authorities that will drive our future work. Similarly, the national leadership group for suicide prevention, chaired by Rose Fitzpatrick, will make recommendations on how we can be more effective in making suicide everybody's business. Both groups set out their delivery plans last December. At the same time, we are undertaking major reviews of key mental health issues. For example, we have in the past month announced a major review of forensic mental health services as well as a wide-ranging review of the Mental Health (Care and Treatment) (Scotland) Act 2003.

Lastly, I highlight the critical importance of reducing the stigma around mental health issues and ensuring that young people are comfortable with speaking out if they experience poor mental health. Mental health is one of our key public health priorities, and we will work with the new public health Scotland body and other partners on how to drive that priority across all our work.

The Convener: Thank you, minister. A focus of the committee's interest is the early interventions that can be made in a young person's life and the support that they can draw on, and I note that a number of the announcements made on mental health services in the Scottish Government's programme for government for 2018-19 had the same perspective. Can you update the committee on the progress that is being made towards the goal of having a counselling service in every secondary school, an additional 250 school nurses and the offer of mental health first aid training for teachers in every local authority? Moreover—I know that this was not a commitment—would the Government consider offering mental health first aid training not just to teaching staff but to other staff in schools?

Clare Haughey: If you will allow me to, convener, I will take those points individually.

On the provision of counselling services in every secondary school, our commitment in the 2018 programme for government was to ensure that every secondary school had access to such services. The work on introducing counselling in schools is progressing well, and we are continuing to work in partnership with COSLA on establishing a delivery model for that commitment. As you will expect, my officials have been working very closely with officials in the education portfolio on that, and officials are also continuing to work in partnership with COSLA and local authorities on establishing a formal joint agreement, with two of the four required stages now completed.

Further work is being undertaken on establishing the appropriate funding model for the distribution of resource to education authorities, and it is anticipated that the model will be considered by COSLA in April. A key issue that perhaps has not been highlighted so far is the fact that the counselling service that we are putting into secondary schools is a year-round, not term-time, service. After all, young people's needs do not stop when the school closes for the school holidays.

Our first step in rolling out our 2018 programme for government commitment to put in place an additional 250 school nurses was a survey of the existing school nursing capacity in every NHS board area. That survey has now been completed, and it might well inform the development of an action plan for rolling out additional capacity and the necessary upskilling of the existing workforce, which is due in late spring. The relevant training and coursework materials have been developed to ensure that the existing workforce has the necessary skills to carry out what is a different role.

With regard to training teachers in mental health first aid, the current mental health first aid programme has been offered to six local authorities, where staff working with children and young people are undertaking the training, and we are on track to ensure that the offer is made to all local authorities within the original timescales that we outlined. We have also convened a joint project to design and develop a specific training course that will be made available to all school staff. I hope that that answers your final question, convener.

The Convener: That all sounds interesting, but it is clear that, when you talk about, for example, setting up the funding model or getting an agreement, it is all about process. When can we reasonably expect a school to have one of those counsellors, and when we can expect all schools to have one?

10:30

Clare Haughey: I answered a question similar to that in the chamber not so long ago. We have committed to having the first tranche of counsellors in schools by the start of the 2019-20 academic year.

The Convener: What proportion is a "tranche"?

Clare Haughey: We anticipate that it will be 50 per cent. I appreciate what you said about a lot of this being about process, but we need to ensure that the mechanisms are there to deliver the interventions on the ground.

The Convener: Systems sometimes create busyness that is without outcomes. However, if you are asking for things to happen yesterday, minister, that will move things along a little bit. People can take comfort in process, but we really want there to be a difference in our schools as a consequence of the policy.

Clare Haughey: Absolutely—I do not disagree with that. We need action, and I hope that action is what will be demonstrated.

Angus MacDonald: Minister, you will be aware that, last week, the convener of the Public Audit and Post-legislative Scrutiny Committee stated:

> "The absence of basic data in relation to a whole range of factors in mental health provision for children means that it is not possible to say whether public spending is making a difference to young people's mental health."

The Scottish Government has made additional funding commitments, such as the £60 million investment in the school counselling service. In the absence of basic data on young people's mental health services, how are the impacts of that and similar investments to be measured?

Clare Haughey: The children and young people's task force has a dedicated workstream to address finance and data issues. It might be helpful if I ask Hugh McAloon to give you some details about how the task force will carry out that work.

Hugh McAloon (Scottish Government): In its delivery plan, which was published in December, the task force laid out how it will carry out its work on finance. It is seen as a complex area because it looks across a range of different services and players, but the task force broke it down into three fairly simple tasks.

The first task is to identify the full investment in children and young people's mental health. The difficulty of measuring that has come up before—it moves beyond the health service to universal children and families services, including schools. However, that is the first task that the taskforce has set itself.

The second task is to ensure that the investment lands where it is intended. When money is invested in children's and young people's mental health, we need to ensure that we have a way of tracking that, so that it lands where it is meant to land.

The third—and probably the most important—task is to develop a consistent and agreed approach to ensure that the investment delivers for children and young people, their families and the taxpayer, and that there is a return on it.

That is a simple way of describing the work of that workstream. It is helpful that it is so simple, because it cuts to the core questions.

There are significant shared elements and interdependencies between the finance and data workstreams, so all those questions can only really be answered by an improvement in the quality of data in the entire system. It is an area that I am reasonably new to, but it seems that, although there is no shortage of data, it is hard to pull information out of it. There are also gaps in the data, so the task force is looking at the bits beyond the NHS in which the data—although

there is a lot of it on what is going on—does not tell the full story because it does not reach into universal services. The interaction between the data and the finance workstreams will be really important for the task force.

I anticipate that a lot of that work will be informed by other workstreams, such as the workstream that is looking at universal generic services in communities, which will consider bringing together health and other integrated children and families services. That has probably not been done before. The data requirements to monitor the effectiveness of that will probably emerge as the recommendations of that workstream emerge.

Similarly, the work that is going on in the specialist workstream, which is looking at a new and reformed approach to CAMHS, will throw up questions about how we measure progress and the effectiveness of that different approach.

The whole thing fits together, and the three key questions—about identifying the level of investment, making sure that it lands where it is meant to land and developing a consistent approach to the return on it—run right through the task force's work. We anticipate that the recommendations that we will get on them will provide clear direction on how to take that work forward.

Angus MacDonald: Okay. That all sounds like quite a task, but we will clearly monitor it as it progresses. Thanks.

Maurice Corry: The report on mental health services for children and young people that Audit Scotland published in September 2018 highlights that mental health referrals for children and young people increased by 22 per cent over the five years to 2017-18. Minister, you made a very important statement about making suicide prevention, for example, everybody's business. What are the factors that have driven such a significant increase in referrals?

Clare Haughey: As Dame Denise Coia noted in her initial recommendations, which were published in September and which led to the formation of the task force, the rise in referrals signals an increased demand for services from those with emotional distress. The rising demand partly reflects the success of campaigns and the increased awareness of mental wellbeing. It is important that we recognise that, as a society, we are much more willing to admit that we are not feeling well but are in distress, and to seek help.

However, the increase might also reflect some of the increasing pressures that we hear about from young people—I hear about them when I go into schools, when I talk to young people and when I talk to my family. Not the least of those pressures seems to arise from social media and the pressures that it puts on to that generation. I do not think that our generations appreciate those pressures, as we grew up in a different world. Mitigation of them is a fundamental rationale for the programme for government investment in the work of the task force and the drive to increase the range of early intervention and prevention services that we need to ensure are in place to help children and young people.

We have spoken about the work to ensure that our schoolteachers have mental health first aid training and adequate skills, and we are putting in an increased number of school nurses with a focus on mental health and wellbeing. School counsellors are being introduced in every secondary school, and the task force is working to look at early intervention, community wellbeing and so on. All those things are really important in terms of getting that early intervention in there.

Maurice Corry: We are talking about young people, who are looked after by their parents, hopefully. What are you doing in your review in connection with parental guidance on the issue? Sadly, that is missing at the moment. There is a lot of peer pressure on children at younger and younger ages regarding mobile phone use, social media and so on, but I do not see anything about the parents and how you might help to educate them.

Clare Haughey: You might be aware that the four chief medical officers around the UK issued guidance for parents last month on screen time and social media. Much of that is also about modelling good behaviour, including things like not using mobile phones at the dinner table, keeping screen time out of the bedroom, emphasising the importance of sleep and so on.

John Mitchell might be able to add a little bit more on the specifics of the guidance that the CMOs put out.

Dr Mitchell: As the minister said, there is specific guidance about social media. The other aspects of our interventions with parents are at very early ages in terms of psychology and positive parenting programmes.

With regard to the emerging concern about distress in young people, and the finding that something new is happening among our adolescent female population to do with their presentations and expressions of distress, we are expanding the distress brief intervention programme from the summer of 2020 to include people under the age of 18. We are already thinking that that will involve work with families and not just with individuals and young people on their own.

Maurice Corry: It is good to hear that.

Clare Haughey: Would it be helpful for you to hear about how we are involving parents in the task force?

Maurice Corry: Yes.

Hugh McAloon: Joanna Murphy, who is the chair of the National Parent Forum of Scotland, is a member of the task force. With Joanna's input, the task force is establishing a parents network to reach out to parents groups across Scotland. The network is at an early stage, but the task force will use it to inform the development of its recommendations. Young people and parents are at the centre of the task force. Dame Denise Coia talks a lot about that.

We are looking at the potential for some form of digital platform to provide advice and support to not just young people and children, but their parents. That is key. The task force will look at how that can fit in with other services out there that parents use and how we can integrate the advice and support on mental health that we provide into those services.

Finally, there is Denise Coia's work and that of the task force on community hub-based approaches to earlier intervention and support around mental health. It is very much at the forefront of Denise Coia's mind that we should look at support for parents. She has spoken to a lot of parents, particularly of children who were rejected for CAMHS, and the constant message from them is that they need someone to talk to, to help them through their situation. Parents are very much at the heart of the recommendations that I would expect to come out of the task force.

Maurice Corry: I think that you are on the right track, if that is the case. As a parent, it is music to my ears.

The Convener: We are mindful that the petition was prompted by Annette McKenzie losing her daughter, having been unaware that her daughter was on medication. There is the whole question of when something should be confidential and when it is wise to ask someone to share what they are doing with the people around them. We are very conscious of how difficult this has been for the family.

David Torrance: According to the chair of the children and young people's mental health task force, Dame Denise Coia, the following changes are required

"to reform and improve the system of children and young people's mental health services:

- A stronger focus on prevention, social support and early intervention;
- A wider range of more generic, less specialist interventions to free up specialist services to see those in most need of them; and
- Better information and understanding for the public, and all agencies and services, of where emotional distress and mental health and mental wellbeing problems are best supported."

Do you agree with that assessment?

Clare Haughey: Absolutely. Those are the themes that underpin the task force's work. They are what Dame Denise set out in her initial recommendations and they have informed our commitments in the programme for government.

David Torrance: What current mental health policy initiatives address Dr Coia's recommended reforms and what more needs to be done to do so?

Clare Haughey: We have spoken about the on-going work. We have a commitment to put a school counsellor in every secondary school in Scotland and to provide additional school nurses. Teachers in every local authority are being offered mental health first aid training. We must not look at schools in isolation. We do not train someone in first aid and expect that they will use their skills only within the work environment or when they are volunteering. The training that we are offering will equip a whole population of people with skills that they will be able to use in their everyday lives.

There are a broad range of policies and on-going commitments that will help to improve the knowledge and skills that people have to deal with mental wellbeing and mental distress, and to raise awareness of those issues throughout the population. Hugh McAloon might want to talk about specific aspects of the task force.

10:45

Hugh McAloon: It might be helpful if I say a little bit about the process that will be used with the task force. A team within our division is exclusively providing support to the task force, but the task force is independent of Government, and we are well used to carrying out such work.

I have been involved in similar work in relation to youth employment. It took a more traditional approach, in that the independent group came up with recommendations and the Government and COSLA considered and then implemented them as a whole.

This time round, the approach feels a bit more interactive, which is important because we are looking at a set of live issues for children and young people and their families. In some ways, the work is similar, in that independent recommendations will be made for the Government and COSLA to consider and—if there is agreement—implement. However, rather than waiting until the task force finishes its work in 2020, we anticipate that it will provide

recommendations for consideration at various intervals as it does its work. Rather than waiting until everything is ready, the task force will make recommendations in specific areas as they are ready.

We probably all agree on what needs to change. Dame Denise Coia describes well why there needs to be a wider-ranging and easier-access approach that is built on prevention and early intervention. Those aspects are underdeveloped at the moment. Waiting times are too long. The level of rejected referrals is far too high and should not be a feature of the system at all, and that results in distress and anguish for children and young people and their parents. Those are the reasons why we are doing the work.

The task force's role is not about endlessly describing the situation, but about how we change it. I expect the task force's recommendations to be challenging, because it would be surprising if they were not. We know that the status quo needs to be challenged. As we go, I hope that we will be able to work with our colleagues in local government in taking forward some of the recommendations, even as the task force continues its work. I anticipate that feature of our approach to be evident over the next year and a half.

Rachael Hamilton: Earlier, we talked about social media, which is an important strand of work in the committee's inquiry into mental health. Dr Mitchell mentioned the chief medical officer, Catherine Calderwood, who has said:

"There's no evidence of causation of harm"

but that there has been

"a rise in children's depression rate"

and that children say

"that their quality of life is lower if they are using screen time for long periods of time."

We welcome the Government's recent announcement about the new guidance on the healthy use of social media and screen time. What work is being undertaken on the development of the guidance? Has the Scottish Government done any work on the impact that social media is having on young people's wellbeing?

Clare Haughey: I think that Rachael Hamilton would agree that we grew up in a very different world from the one in which our children are growing up. Sometimes, as parents, it is quite difficult to understand the pressures that young people are under.

With regard to the Scottish Government's commissioned work, we are developing advice on social media use, which will be produced by young people, for young people. That is really important for the credibility of the guidance, as well as to help us to understand the landscape and the world in which young people live. If the committee is interested, we would be happy to inform the committee of further timelines as they become available.

Research on the impact of social media was commissioned last year, and we will publish it very soon.

Rachael Hamilton: Has the Scottish Government had any collaboration or discussions with social media platforms such as Facebook and Instagram? There are recommendations that age verification could be improved and that the sharing of data might be useful. I presume that those issues are part of the research that you have undertaken. The industry has a duty of care, too, and there has been a suggestion that a voluntary code of conduct should be developed. I presume that those will be some of the points that come out of the work that has been going on with young people.

Clare Haughey: Those sound very much like some of the things that would have been considered as part of the background preparation for the commissioning. I do not have the exact detail of that to hand, but I am happy to write to the committee to provide you with that information, if you are interested in it.

Philip Raines (Scottish Government): Many of those issues start to move into the territory of the UK Government, so we will have to work closely with it. UK Government colleagues are doing a lot of work in the area and discussions on many of those issues are on-going. We need to pool our efforts to ensure that there is a collective effort across all the nations in having discussions with the relevant platform providers or others. I guess that the question is about where we can best lend our efforts to support that work.

The Convener: A number of the submissions that the committee received as part of our inquiry into mental health support for young people in Scotland referred to a need for a change to the approach of mental health services, from a biomedical model that is based on medicating children and young people to an approach that is based on levels of psychological distress and trauma and recognising the social, psychological and biological factors. People are advocating a different approach from that of thinking that there is something wrong and we need to fix it.

Do you agree that such a change of approach would be helpful? What policy initiatives are planned or are under way that would encourage such change, which is partly about mindset?

Clare Haughey: We need to recognise that the issues around young people's mental health

extend across a spectrum, from wellbeing to mental illness, just as they do for all of us. As we have heard, the task force's intention is to have a whole-system approach to change and improvement right across that spectrum from wellbeing to treatment for illness.

We would challenge the idea that there is a single biomedical model. The few children who have mental illness must be able to access evidence-based treatment, which must include medication. We would not question the need for some children to receive medication for a physical illness, so we have to be careful about how we approach the issue of mental illness. However, I absolutely recognise that people have concerns about the use of medication for children.

The 2017 UK National Institute for Health and Care Excellence guidelines on treating depression in children and young people clearly state:

> "Antidepressant medication should not be used for the initial treatment of children and young people with mild depression."

The guidelines provide information on the use of that particular medication in more severe conditions. That is the prescribing guidance that we expect clinicians to follow.

John Mitchell might be able to give a bit more information on the safeguards and the guidelines on the use of medication. It is an important issue that is raised each year when we publish the figures on the number of children who are prescribed medication. I absolutely understand why that can cause some people alarm, but the vast majority of children have a psychosocial intervention or a talking-based or play-based therapy to treat their illness or condition.

The Convener: Is that being monitored? One of the questions at the core of the petition is about the point at which people are prescribed medication and the extent to which general practitioners and others are under pressure. Medication should not be the first port of call, but there are pressures that can lead to that happening, although I am not saying that that is a universal experience. Has any work been done on what happens when the straightforward option is prescription but the guidelines say that it should not happen until further down the line?

Clare Haughey: Yes; a lot of work has been done over recent years. John Mitchell will provide the committee with the detail on that.

Dr Mitchell: It is thanks to the energies of the petitioner that, as the committee will be aware, I wrote to all general practitioners in Scotland and to the royal colleges on this very important issue. My very detailed letter explained the issues in the petition and the importance of being aware of the guidelines and following them, as well as issues to do with consent and capacity.

As part of the specialist task force sub-group's work, we have had conversations with the Royal College of General Practitioners about the prescribing of medication by GPs. That on-going conversation is looking at whether there might be an opportunity for the emerging single national Scottish formulary for medicines to lay out—if there are shared care arrangements—who should be prescribing what and when. Those conversations are happening.

As the minister has said, we have an annual publication that gives us data on the prescribing of medication for mental health problems in adults and children, which is broken down by health board. Primary care data is also produced for discussion at practice level about prescribing not just mental health medication, but other medication.

The Convener: On the question of whether prescribing medication is the first port of call or whether that happens further along the line, is that monitored? I am not a clinician, but there may be circumstances in which a GP feels prescribing medication at the first stage is the most appropriate decision. Is that monitored?

Dr Mitchell: As the minister has said, the NICE guidelines are clear that antidepressant medication should not be used for the initial treatment of children and young people with mild depression—

The Convener: The NICE guidelines may say that, but we know that such prescribing happens. Is that monitored?

Dr Mitchell: We monitor the use of antidepressant prescribing in children—

The Convener: Does that monitoring establish the point at which the medication was prescribed in the journey of a child?

Dr Mitchell: It does not go into that detail, but we would expect the prescribing of antidepressants to be supervised by specialists in specialist child and adolescent mental health services. As I said, part of the work of the specialist group—

The Convener: I am sorry to interrupt, but does that mean that you would not expect a GP to prescribe antidepressants for children at all?

Dr Mitchell: No.

The Convener: Not at all?

Dr Mitchell: No. We would expect the initiating of prescribing to be a specialist function. GPs would be asked to do the on-going prescribing—the provision of a prescription—hence the

conversation with the Royal College of General Practitioners about the precise arrangements for that.

The Convener: Is that specifically for antidepressants rather than other related medication that might be used for somebody experiencing anxiety?

Dr Mitchell: As happened in the tragic case that the petitioner has come to us with, the medicine used was not an antidepressant—

The Convener: But it was a medicine prescribed for anxiety.

Dr Mitchell: Yes, but with a primary function for another purpose. The information on prescribing in primary care is, as I have said, generic; there is not a specific measurement for children and young people of exactly what is prescribed for those conditions.

The Convener: Does that mean that you would not know whether—I am not saying that they are—young people are routinely prescribed antidepressants at the first appointment?

Dr Mitchell: They would not be prescribed antidepressants at a first appointment with a GP, because the NICE guidelines are clear that they would not be. If a child or young person presents to a GP with moderate or severe depression, the expectation is that that GP would seek specialist help and involvement, and any prescribing would be initiated through that process.

The Convener: The system would not identify prescriptions for anxiety that were not antidepressants but something else.

Dr Mitchell: Not across the total range of medicines—it does so in the same way as it identifies physical health conditions.

Rachael Hamilton: On that point, is data on the pathway collected? For example, in a case in which the GP prescribes tablets for anxiety, is data collected about any previous recommendation that that young person be treated through a different form of therapy? That would enable us to see a correlation between which pathways are working and which are not, before they are referred to a specialist.

11:00

Dr Mitchell: We would expect that, if a young person in distress presents to a health service, the GP's first order of business would be to use their clinical skills to consider support and social prescribing opportunities. That information would be documented in the primary care records. However, there is not a national amalgamation of that information, as such.

Rachael Hamilton: Do you think that it would be useful to do that so that, in extreme cases in which suicide happens, we could see whether a distinct pattern emerged in the pathways that GPs have recommended?

Dr Mitchell: When a serious incident such as a suicide happens, critical incident processes mean that there will be a detailed exploration of the previous historical narrative leading up to what has happened with that person, and that will lead to recommendations being made. We have a lot of information on suicides and the prodromes to suicide. The challenge is more in the generality of ordinary practice, as it must be recognised that presentations of distress, not only to primary care but to schools and other services, as well as to employers and so on, are relatively common. The hard data on that story is not present and it is not possible to pull it together.

As I said, we are working with the Royal College of General Practitioners on the issue of prescribing to try to get a better handle on that information. However, I cannot give you comfort about whether a narrative around the young person in distress, which would show that the environmental supports that are available to someone have been explored, has been clearly documented and measured. The situation is the same with, for example, middle-aged men with high blood pressure who have an earlier narrative that involves advice about their weight and smoking and recommendations that they take out sports memberships. That narrative is not necessarily measured to the same degree as the data that we have about antihypertensive prescribing in Scotland.

The Convener: Do you think that the process that says that antidepressants must be prescribed only by a specialist should apply to other forms of medication that are being given to address mental health issues, such as something for anxiety that is not an antidepressant? Is that something that you should be considering?

Dr Mitchell: We have to allow fundamental clinical decisions to be made according to clinical judgment. A wide range of medical treatments are used. Some of those are reserved for specialists and some of those are not. Fundamentally, which treatment to use is up to the clinician who is assessing the situation and initiating the prescribing of medicine, if that is what is judged to be the correct course of action.

To say that all prescribing of everything under any circumstances for mental health problems should be done only by specialists would not be possible, because that sort of approach is not possible in relation to physical health. We also have to remember that prescribing is not necessarily done by doctors.

The approach has to be proportionate. We have to accept that, for someone who is saying that they are anxious and that the problem that they have is that their heart is beating so fast that it is troubling them, a GP might choose to use a medicine that would maintain their heartbeat at regular level rather than choose to prescribe an antidepressant or a sedative medicine. It would be impossible to limit the ability of clinicians to prescribe the broadest range of medicines.

The Convener: Yes, although I suppose that the question is whether physical distress is a consequence of emotional distress; a clinician would be able to identify that and to apply the same kind of caveats or precautions that apply to the prescribing of other medicine, which goes to the heart of what resulted in the petition being lodged.

I thank all the witnesses for what has been a useful session that has given us a lot of information about how to progress our inquiry into mental health support for young people in Scotland. We will reflect on what has been said. The minister offered to provide more information on a number of occasions. We would welcome any information that you think would be useful to us. We might want to look further at Dame Denise Coia's work. We will have an opportunity to reflect on what we have heard. Are there any specific points that members would like to make at this stage?

The inquiry is not work that we have decided to undertake lightly. We want to think about which aspects of the issue we should focus on to strengthen the work that is being done elsewhere. I am very conscious of the work that Dame Denise Coia is doing and how substantial that is. At a later stage, we will have an opportunity—

Rachael Hamilton: I am sorry, convener. I just want to make the point that it might help with our inquiry if we could get a bit more information about the digital platform that Hugh McAloon talked about, if that would be possible.

Hugh McAloon: We can provide that separately, if that would be okay.

Rachael Hamilton: Yes—not today.

The Convener: I am not saying that you have outstayed your welcome, but you have certainly provided us with a substantial amount of your time and given us plenty of food for thought, which we appreciate. We are conscious of the need to do work that bolsters the existing work and assists in what is a very challenging area.

We will have an opportunity to reflect further on how we should proceed with our inquiry but, for now, I thank all the witnesses very much for their attendance.

11:07

Meeting suspended.

11:10

On resuming—

Bus Services (Regulation) (PE1626)

The Convener: Our final petition for consideration this morning is PE1626, on the regulation of bus services. The petition was lodged by Pat Rafferty on behalf of Unite Scotland.

At our previous consideration of the petition, in April 2018, we agreed to write to the Scottish Government, asking it to respond to questions that were raised by the petitioner. As the clerk's note sets out, the Government responded to the effect that it would introduce the Transport (Scotland) Bill in due course and that the petitioner would be able to participate in that process. The bill has now been considered at stage 1 by the Rural Economy and Connectivity Committee, which recently published its report on the bill, identified concerns and provided recommendations for the Government to consider in advance of stage 2. We have not received a further response from the petitioner.

Do members have any comments or suggestions for action?

Angus MacDonald: It is unfortunate that we have not received a response from the petitioner, given the importance of the petition. To be honest, I would be loth to close the petition, considering its importance and given that the Transport (Scotland) Bill is before the Rural Economy and Connectivity Committee. Rather than close the petition, we should refer it to that committee for consideration as it goes through stage 2 of the bill process.

Rachael Hamilton: Would the petitioner have the opportunity to submit a further response to the Rural Economy and Connectivity Committee when the petition was passed over to it?

The Convener: Individual members would lodge amendments at stage 2. The petitioner would be afforded the opportunity to make the case in writing to that committee or to lobby on specific amendments, and there would be an opportunity for members of that committee to reflect on what the petition says and decide whether they wanted to lodge amendments.

My understanding is that, if we referred the petition to the Rural Economy and Connectivity Committee, it would not come back to us—that would be it. That committee would then deal with the petition.

I am conscious that the issues that are highlighted in the petition are of interest to people in Unite Scotland, but members might remember a number of other campaigns, including the Co-operative Party's people's bus campaign. I know that people across the parties have highlighted issues relating to bus services, such as their frequency, reliability and costs. The issue is of interest across the Parliament, and I do not think that it would be lost in the process or the system if the petition were referred to the Rural Economy and Connectivity Committee, because many of those issues will be addressed at stage 2.

Angus MacDonald is on the Rural Economy and Connectivity Committee.

Angus MacDonald: No, I am not.

The Convener: I keep thinking that you are. You should be on it, to assist our deliberations.

Rachael Hamilton: The situation with bus transport, the squeezing of local authority budgets and the subsidisation of transport in rural areas, in particular, are incredibly important issues. I think that the Rural Economy and Connectivity Committee would be the best committee to look at the petition, considering the nature of the geographical locations.

The Convener: My understanding is that that committee is addressing a lot of those issues and has addressed the matter in its stage 1 report. I think that there are some recommendations on it.

It is a rural issue, but it is also an urban one. In my city, for example, there are areas where the key commuter routes are sustained but the routes within communities stop at 6 o'clock at night. In Glasgow, there are places where it is not possible to get a bus after that time, partly because of the way in which the funding operates. It is simply not possible to run the number of subsidised routes that we might argue for. There is a question about the industry and how we regulate it.

11:15

The issues will be addressed by the Rural Economy and Connectivity Committee. In referring the petition, we are perhaps just flagging up some of the issues that the Scottish Government has not taken on board with regard to the level of regulation by local authorities, the powers that would be given to them and the resources that they would have for taking on that role.

My sense is that we do not want to close the petition, because we recognise the importance of the issues and feel that it would be useful to refer it to the Rural Economy and Connectivity Committee.

Maurice Corry: I agree entirely with that, convener, and with your point about it being an urban issue, which I have seen in my area, too. Little routes are being lost that are key to older people—I dealt with a case of exactly that in Ralston, near Paisley. Perhaps that observation could be flagged up to the Rural Economy and Connectivity Committee, as it is important and might get lost.

The Convener: In referring the petition, we would expect the Rural Economy and Connectivity Committee to be aware of the deliberations of this committee and of the original statements by the petitioner.

Maurice Corry: As long as that is the case, I am quite happy.

The Convener: Are we agreed that we will refer the petition to the Rural Economy and Connectivity Committee for consideration at stage 2 of that committee's scrutiny of the Transport (Scotland) Bill?

Members *indicated agreement.*

The Convener: We thank the petitioners and others who provided submissions on what is clearly an important issue for many of our communities.

I thank everyone for their attendance.

Meeting closed at 11:17.

This is the final edition of the *Official Report* of this meeting. It is part of the Scottish Parliament *Official Report* archive and has been sent for legal deposit.

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