HEALTH AND SPORT COMMITTEE

Wednesday 4 June 2008

Session 3

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16th Meeting 2008, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
*Rhoda Grant (Highlands and Islands) (Lab)
*Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

COMMITTEE SUBSTITUTES

Joe FitzPatrick (Dundee West) (SNP)
Jamie McGrigor (Highlands and Islands) (Con)
Irene Oldfather (Cunninghame South) (Lab)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

Dick Fitzpatrick (NHS Lothian)
Delia Henry (Royal National Institute for Deaf People)
Dr Deborah Innes (Royal College of Psychiatrists)
Lilian Lawson (Scottish Council on Deafness)
Willie Macfadyen (British Society for Mental Health and Deafness)
Andy McDermott (National Centre for Mental Health and Deafness)
Mandy Reid (Scottish Council on Deafness)
Linda Sharkey (LINK Scotland)

CLERK TO THE COMMITTEE

Tracey White

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

David Slater

LOCATION

Committee Room 1

Scottish Parliament

Health and Sport Committee

Wednesday 4 June 2008

[THE CONVENER *opened the meeting at 10:02*]

Mental Health Services for Deaf and Deaf-blind People

The Convener (Christine Grahame): Good morning. I welcome everyone to the 16th meeting of the Health and Sport Committee in this session of Parliament. I remind all present to ensure that mobile phones and BlackBerrys are switched off. No apologies have been received.

The first item on the agenda is mental health services for deaf and deaf-blind people. We will take evidence from our first panel. I remind members that today's evidence sessions arise out of the committee's consideration of public petition PE808, which calls on the Scottish Parliament to urge the Scottish Government to develop and establish a specialist in-patient mental health unit for deaf and deaf-blind people and to provide resources such as training for mainstream psychiatric services in the community to make them more accessible to deaf and deaf-blind people in Scotland.

I refer members to the papers for this meeting, which include a briefing by the Scottish Parliament information centre and submissions from today's witnesses, some of which were received later and circulated separately to members. I welcome the petitioner, Lilian Lawson, who is the director of the Scottish Council on Deafness. She is accompanied by Mandy Reid, policy and research officer for the Scottish Council on Deafness; Willie Macfadyen, vice chair of the British Society for Mental Health and Deafness; and Linda Sharkey, who is the manager of LINK Scotland and is substituting—but that is no mean thing—for Drena O'Malley. I welcome you all, and I invite Lilian Lawson to make some opening remarks.

Lilian Lawson (Scottish Council on Deafness): (*simultaneous interpretation from British Sign Language*) First, I thank the committee on behalf of the panel for inviting us along to give evidence and for giving the petition serious consideration.

The Scottish Council on Deafness is a Scottish umbrella organisation representing 90 organisations that support deaf and deaf-blind people throughout Scotland as well as their families and carers, and the professionals who work with them. The organisations include those for people who are deaf and deaf-blind, local authorities, social work departments and professional organisations. We all work together to raise awareness about issues that affect deaf and deaf-blind people. We also campaign for a better quality of life for deaf and deaf-blind people in Scotland.

One of our main shared concerns is mental health. In response to that concern, SCOD set up a task group in 2000 to campaign for specialist mental health services for deaf people and a training programme for mental health professionals so that deaf and deaf-blind people would be able to access mainstream psychiatric services. Eight years later, we are still campaigning, because deaf and deaf-blind people have language, culture and communication needs that the health sector is not addressing. That affects their mental health and wellbeing. For example, communication difficulties lead to misdiagnosis and mistreatment. General practitioners do not refer deaf and deaf-blind people to psychiatric or counselling services and usually just give them medication. There is no funding for specialist counselling services or for access to mainstream services because the health boards refuse to pay for the interpretation that would allow deaf people to access those services. There is a shortage of British Sign Language interpreters and other language service providers, such as deaf-blind communicators, note takers and lipspeakers, and they have no experience of working in a mental health setting.

If deaf people are on the wards for treatment, there is nobody to communicate with them. The staff cannot communicate with them and interpreters cannot stay there all the time, which means that deaf patients become frustrated and that any treatment response is delayed. There is a lack of rehabilitation resources and care services for deaf and deaf-blind people. That has an effect on their mental health and means that they have to stay in accommodation longer than need be.

There are no appropriate services for young deaf and deaf-blind people in Scotland. They may experience a breakdown in family relationships and friendships because they may have to go down to the John Denmark unit in Manchester. Young deaf and deaf-blind people cannot access helplines and mental health information is not accessible to them. It is not appropriate that the only accessible mental health services are in England.

I will give you an example that I have had from West Scotland Deaf Children's Society. Somebody there received a phone call about a boy who had mental health issues and about whom there were concerns. The doctor had seen him and had treated him by giving him Prozac. West Scotland Deaf Children's Society contacted the John Denmark unit regarding the assessment of that young child. The staff there were deeply shocked to hear that he had been given Prozac without a proper assessment. GPs do not know how to assess deaf adults, never mind deaf children. That boy had been failed.

Deaf children can lack self-esteem and can suffer from inconsistent discipline, which affects them mentally and physically. They are more likely to have been abused. The lack of communication within the family leads to family breakdown, which in turn leads to children having mental health problems.

I will not give you all the facts and figures because they are all in the written submission already, but it is invaluable for you to know that deaf, deaf-blind and deafened people have individual needs; they are not all the same. Somebody might become deaf or deaf-blind later on in life. Their needs may depend on when they have acquired language and which communication method they prefer to use. Deaf, deaf-blind and deafened people are not alike; they are all different. That is why we need training on deaf issues and BSL, so that professionals have the knowledge and skills to match each person they meet. We need training to ensure that professionals have the right language skills and that we have the right mental health services for deaf people.

I ask Willie Macfadyen to talk about the lack of processes in Scotland in comparison with England and Ireland.

The Convener: I would like the committee to ask questions to elicit information, if Mrs Lawson does not mind. Thank you for your interesting introduction.

If the interpreters find that we talk too quickly or are unclear, please feel free to let us know.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I declare that I am a fellow of the Royal College of Psychiatrists. However, my professional training does not make me any better prepared for dealing with people who are deaf or deaf-blind.

The previous Government provided £40,000 for research into mental health services. Can the witnesses give us any clue as to the likely outcome of that research?

Lilian Lawson: *(simultaneous interpretation from British Sign Language)* Delia Henry, who is sitting behind me, is from the Royal National Institute for Deaf People in Scotland. The RNID was given the £40,000 for the research, so perhaps you could ask her about it later.

The Convener: We shall do that. If any other witness wants to answer, they can simply indicate that—speakers are self-selecting. However, nobody else wants to tackle that question, so we will put it to the next panel.

Dr Simpson: The Royal College of Psychiatrists has tried to develop training on supporting people who are deaf or deaf-blind for junior doctors who are training in psychiatry, but are the witnesses aware of whether any such training is being offered to general practitioners, primary care teams and community psychiatric nurses?

Willie Macfadyen (British Society for Mental Health and Deafness): There is little training in Scotland. This year, NHS Greater Glasgow and Clyde mental health partnership allocated money to train mental health staff in deaf awareness. That was for just a basic one-day course and not for an extended course. As far as I know, that is the only training that is available in Scotland. It is unfortunate that, because resources are limited, that training is aimed only at community care teams and mental health teams and does not cover hospital staff.

In England, the University of Salford's nurse training has for several years included a very successful course to allow deaf sign-language users to train as mental health nurses. Without exception, all the graduates of that course are employed in England. The University of Birmingham is establishing a distance-learning course on mental health and deafness, which will go up to certificate level. That is about it at the moment.

Dr Simpson: I saw from the written evidence that we are not training people who are deaf in psychiatric nursing in Scotland, which is not good.

Fife has had a healthy living centre for the past five years to raise awareness of the problems and barriers that relate to people who are deaf or deaf-blind. That centre has been highly successful. It was due to close on 31 March, but I am glad to say that the cabinet secretary gave additional money to it. Do people find healthy living centres of that sort helpful? The healthy living centre in Fife worked with more than 2,000 people over five years. Is that sort of general awareness raising helpful?

10:15

Willie Macfadyen: Any awareness raising is helpful, but it is limited. When it comes to the actual process of diagnosis and treatment, basic awareness training unfortunately does not really allow for the development of specific communication skills that would let medical staff improve the services that they offer. However, awareness training does alert staff to gaps in service and gaps in their own knowledge. If specialist services were available, general awareness training would allow staff throughout the country to become aware of people's needs and to refer them to specialist services.

Lilian Lawson: *(simultaneous interpretation from British Sign Language)* Queen's University Belfast has been training BSL users. The course there has been quite successful, and I would like that model to be copied here in Scotland. If we could start with medical students at an early stage in their career, that would be good progress.

Ian McKee (Lothians) (SNP): Is the main problem a lack of staff who can communicate with deaf people, or is it more the lack of specialist psychiatric knowledge about dealing with deaf people, even if the communication can take place?

Lilian Lawson: *(simultaneous interpretation from British Sign Language)* It is probably both. Staff might be able to communicate with deaf people, but only on a basic level: for example, if they want food or if they need more medication. They need specific knowledge about deaf people's behaviour, language and culture.

Willie Macfadyen: Lilian Lawson has already mentioned the difficulty with the low number of sign language interpreters in Scotland. It can often be a long time between a crisis and an interpreter becoming available. It can sometimes be days, or even weeks. There are legal implications in that.

Having worked with deaf people for nearly 30 years now, I am aware that the provision of sign language interpreters in the mental health setting is, in effect, a third-best option. Ideally, deaf people would prefer to get services, treatment and diagnosis from deaf professionals, who would be totally aware of their needs. The second-best option is to have hearing professionals with good deaf awareness and very good communication skills, so that the deaf patient can work one to one with the professional, for example a psychiatrist or a community psychiatric nurse—a CPN. Deaf professionals working through interpreters is the third-best option, as I said, and it is often difficult to arrange. In the majority of situations, deaf and deaf-blind people are either left with family members to help them communicate or left without any real communication support.

The Convener: Would you concur, Ms Reid? I am trying to break the ice for you—I know that it can be difficult just to come in on the discussion.

Mandy Reid (Scottish Council on Deafness): I agree with what Willie Macfadyen is saying. I wrote our research paper, and I hope that you all received a copy of it in the post.

At the end of the day, we are not asking for a lot, but we are asking for a specialist unit for a reason—to provide a therapeutic community for deaf or deaf-blind people.

On a personal note, as a hearing person I have had experience of mental health services. I had to wait for counselling and treatment. Deaf people in Scotland should not have to go through that, given all the legislation. The Mental Health (Care and Treatment) (Scotland) Act 2003 is new legislation that was a long time coming. All the right things are there for the right reasons, but deaf, deaf-blind and deafened people in Scotland are not getting their rights. We need a unit with professionals who can communicate on a one-to-one basis with deaf, deaf-blind and deafened people. We need professionals who themselves are deaf, because they have the cultural background and the knowledge to allow them to work with deaf, deaf-blind and deafened people and give them the services and the care and treatment they deserve.

The Convener: Linda Sharkey is nodding.

Linda Sharkey (LINK Scotland): I am in agreement. Deaf BSL users are not the client group that I work with and that is not usually our organisation's remit, but I whole-heartedly support what has been said.

Rhoda Grant (Highlands and Islands) (Lab): That supplementary question leads to my questions. In the Highlands, trade unions carried out sign here courses for people who provide services—not just Government services, but any service that involved dealing with the public daily. I was lucky enough to take part in a course but, from watching Lilian Lawson sign this morning, I realise that it is absolutely no good to me. The course was two years ago and I have not practised my signing. We are talking about a specialist service, but how would we train people to get clients into the service, if it were available? There must be communication. How do we get the skills into the public services and keep up the level of usage to ensure that people have a basic level of communication?

Lilian Lawson: *(simultaneous interpretation from British Sign Language)* To give an example, Deaf Connections in Glasgow has been running a pilot project to train one GP practice in Glasgow in BSL. That has been successful because many deaf people attend that health centre, which means that staff have been able to practise their signing skills with patients and keep up with their training. In a specialist unit, staff would have more contact with deaf people, so they could keep their skills on-going and keep practising their sign language, whereas in a mainstream service a deaf person might come in only once in a blue moon, so the staff will lose their sign language skills. A service might have to bring in interpreters, who might need training on the mental health setting.

Willie Macfadyen: Ten or 15 years ago, there was a spate of attempts to introduce basic sign language training for social work and medical staff. The training was always offered at a basic level—it was the equivalent of a hearing person going to night school for 10 or 20 weeks to learn Spanish, which would allow them to go on holiday to Spain and order a meal or a few beers or say hello, but it would not allow for in-depth communication. As Rhoda Grant said, if you don't use it, you lose it. The organisation that I work for in Glasgow—Hayfield Support Services with Deaf People—provides residential and day care services for deaf people with additional disabilities or difficulties. We face the on-going problem that there is no pool of people with sign language skills, so we take on staff who have other skills and provide them with communication skills training. The fact that they are working day in, day out means that they are developing all the time. That is another reason why we feel that it is important to have a recognised specialist service for deaf people. It is not enough to send one psychiatrist from every health board for basic sign language training; we need a core of professional staff who are working day in, day out with deaf people in order for them to develop and retain the necessary communication skills.

Rhoda Grant: I agree. That takes me back to my original question. How do you funnel people towards that specialist service if people in the front-line services do not have the necessary communication skills? Given the fact that people who suffer from mental health issues are sometimes in denial of them, you need to reach out. How do you get to them? How do you engage them and persuade them to go in the right direction without that level of communication?

Mandy Reid: NHS Greater Glasgow and Clyde is considering establishing a virtual community team. The Glasgow deaf interest group is a group of professionals who work in the mental health field who get together every six to eight weeks to consider issues around deafness. It has been suggested by the Glasgow deaf interest group that a community mental health team in Glasgow could pull together people who have an interest and the required communication skills, who could move throughout the NHS Greater Glasgow and Clyde area providing some sort of community service.

I know that that does not answer your question about how we can get people who are not accessing the service into the service. However, general awareness of the service can be raised through organisations in the voluntary sector, such as Deaf Connections, the National Deaf Children's Society and the deaf clubs in Glasgow, getting the information out there that the team meets, for example, on a Wednesday at 3 o'clock at a particular place. In that way, the information will get out there to deaf sign-language users and deaf people in general. We should use all the community supports, not just the health services, the mental health officers and the people on the ground. We should use the wider community to help people to access the services.

Lilian Lawson: *(simultaneous interpretation from British Sign Language)* We recently launched our paper, "Making the Case: Specialist Mental Health Services for Deaf People in Scotland", with a representative from the British Association of Social Workers. The association approached us, asking for help with training for mental health officers in Midlothian. So we worked with the mental health officers in Midlothian on identifying deaf people within the community and on identifying the appropriate services to which they could signpost them. I feel strongly that GPs should have the same training, so that they would know how to support their patients, what services are out there, and which ones to signpost patients to. We need to share that information and ensure that it is out there.

The Convener: The report to which Mrs Lawson referred has been circulated to committee members.

Mandy Reid: "Making the Case" talks about the need to ensure access to information for deaf, deaf-blind and deafened people, and especially for deaf sign-language users and deaf-blind people. At the moment, those people do not have access to the information that other people do about the range of mental health issues and how to get support. If that information is there, people are more likely to seek help by approaching their GP, a support group or somebody else in the community who has that experience and can tell people what happened to them.

10:30

The Convener: In a way, success breeds further success.

Mandy Reid: Yes. One of the first recommendations that I made in the research paper was that accessible information has to be provided, so that people can seek help.

Mary Scanlon (Highlands and Islands) (Con): Some of the questions that I was going to ask have just been covered. I want to focus on the first part of the petition, which urges

> "the Scottish Executive to develop and establish a specialist inpatient mental health unit for deaf and deafblind people".

I note from the papers that six individuals from Scotland are receiving in-patient care at the John Denmark unit, which also provides a one-day monthly out-patient service. We need a critical mass of people to justify establishing a specialist in-patient unit. My concern is that Mrs Lawson said that there are no referrals by GPs to psychiatric services. Which NHS boards are refusing to pay for interpreters and has that been challenged? Unless people are referred to the John Denmark unit or the out-patient, one-day monthly clinic, we will not know the level of unmet need.

It is not my decision, because I am a member of an opposition party, but it would be difficult to justify setting up a specialist centre here in Scotland if we did not know how many people would utilise it. I am concerned about there being no referrals. We should name and shame the NHS boards that refuse to pay for interpreters.

Lilian Lawson: *(simultaneous interpretation from British Sign Language)* Mary Scanlon's question about the number of people using the service is interesting. You are right that the number seems small. The previous situation in Northern Ireland, which we talked about earlier, is similar to the situation here. For years in Northern Ireland, some kind of service was provided, but people were also being sent to the John Denmark unit. When Northern Ireland set up its own centre for deaf and deaf-blind people, or people who could use sign language, the number of people being diagnosed increased greatly. People did not need to go to the John Denmark unit any longer, because they had their own unit.

It is about having people who can assess patients correctly. At the moment, we send people down to the John Denmark unit because we do not have anything here. We do not have any statistics, because people are not being referred. However, we have evidence from people who had it recommended to them that they go to the John Denmark unit, but who have refused to go because they do not want to be away from their families and friends and prefer to stay at home in their own environment.

The Convener: I presume that you cannot answer the second part of the question, which was about the various NHS boards that are refusing to pay for interpreters.

Lilian Lawson: *(simultaneous interpretation from British Sign Language)* I cannot answer that. For a long time, we have been trying to get evidence and statistics, but NHS boards, social work departments and local authorities do not keep figures. Mandy Reid tried to get that kind of information when she was doing her research, so perhaps she can help you.

Mandy Reid: That is one of the questions about interpreters that I did not ask when I made my freedom of information request. Only later did I think that I should have asked the individual health boards how much they pay for interpreters, guide communicators and note takers.

However, the information that I received in response to my freedom of information request, which is in "Making the Case: Specialist Mental Health Services for Deaf People in Scotland", demonstrated that health boards do not record how many people need communication support and how many people are deaf, deaf-blind or deafened. Such information might be available in individual patient files, but in the main boards do not keep the figures. I asked only about detention under the Mental Health (Care and Treatment) (Scotland) Act 2003, because I had to request specific information.

One health board—I cannot remember offhand which one—said that it does not keep such information in medical or personal records. When people are referred to a service or admitted to hospital they are not asked whether they are deaf, deaf-blind or deafened and are not asked what their communication support needs are.

Action must be taken at national level to tell health boards and local authorities to record people's basic communication needs. I do not know whether boards record how many interpreters they book and what the cost is, but the requirement to keep records must be fed down the way from national level.

The Convener: The emergency detention statistics on page 44 of "Making the Case" might assist. We can pursue the matter with our next panel of witnesses and with the minister, whose team is no doubt listening carefully to the evidence.

Mandy Reid: The health board that I mentioned was Lothian NHS Board. On page 49 of the report we note that NHS Lothian does

> "not record information in medical/nursing records".

Willie Macfadyen: I take the point about the need for critical mass of identified need to justify allocation of resources: we have always accepted that. As members might be gathering, the problem has been the lack of information and evidence. As Lilian Lawson said, the campaign in which we are still involved started in 2000. A task group involving officials from the then Scottish Executive was set up, which considered the specific matter that we are discussing as well as wider issues. It was recommended that any proposal must be based on evidence of need, and ways of gathering the evidence were suggested.

The Scottish Council on Deafness went as far as to engage a team of university researchers to draw up a proposal for work to identify the level of need. The research outline went back and forward between the university and the Scottish Executive but, when an agreement was reached, we were told that the issue no longer fitted into health service priorities. Therefore, no research was undertaken.

The figures for the number of people who are admitted or treated as out-patients by the John Denmark unit are the tip of the iceberg, because they represent people who are fortunate enough to live near the unit or to be in contact with people who know about it. We have a lot of anecdotal evidence about people who are not referred and treated. For example, we heard about a deaf person in South Lanarkshire who had a history of mental health problems that went back 20 years. It was only last year that the person's GP found out about the John Denmark unit by chance and referred the patient to the out-patient clinic. For 20 years, the person had been treated—or not treated—in mainstream services.

Linda Sharkey: People in the deafened community acquire hearing losses in their adulthood, so they are not aware of deaf services. In the process of diagnosis, such people quite often get as far as audiology and ear, nose and throat services. I am sure that none of those services would make a direct referral to a mental health service. I have had discussions with ENT consultants who said that although they had general mental health training as part of their junior doctor training, they did not feel equipped to send people directly to mental health services. Therefore, we think that people are not accessing services.

On the second part of the question, we had quite a difficult situation in which someone who was a recovering alcoholic lost all their hearing over a very short time. They found it difficult to manage the lapse back into alcoholism, as they could not get support from health and social workers to access Alcoholics Anonymous meetings or similar meetings as a result of the political wrangle that took place about such services not being services that were provided within core health care hours. We know that people cannot manage their health because they require communication support that they cannot fund.

The Convener: I hope that the minister will be able to speak about the data that people do not have—the information about deaf and deaf-blind patients in the NHS that is collated and retained. Obviously, we will ask the minister about that in the first instance. I hope that NHS boards will respond with more alacrity and urgency to the cabinet secretary or the Minister for Public Health than they have done to the witnesses or, indeed, to any of us.

Mary Scanlon: According to the figures, when Northern Ireland got its own centre, the number of deaf and deaf-blind people with mental health problems who were treated multiplied by three. On the basis of the current statistics, 18 such people would receive specialist mental health services if a unit opened in Scotland. Are we talking about a two-stage process? Should we consider the need for more and more accessible information, better communication, better training, better awareness and better referrals to the John Denmark unit and the one-day monthly out-patient service? If we got that right, would that justify a unique centre for Scotland in the future? Should not we address all the problems that have been raised first, before we look for a centre?

Mandy Reid: We want a unit with four to six beds, in the first instance. We are not talking about a big building with lots of departments; rather, we want to take in-patient treatment out of the John Denmark unit and put it into a Scottish environment. SCOD is aware that people who can hear who live on islands such as Orkney and Shetland or on the Western Isles must come to the mainland for treatment and that mothers with new babies who need treatment must go to the central belt. We are aware that children or young people with hearing must go to the major cities, because that is where the beds are. However, all those beds are in Scotland. We are asking for four to six in-patient beds in Scotland. We are not asking for a ward, two wards or a whole hospital, but for a small unit. There is a need to gather evidence, but anecdotal evidence exists, as Willie Macfadyen and Linda Sharkey have said. Deaf Connections, Deaf Action, Hayfield Support Services with Deaf People and all the other deaf organisations know about deaf people who are being treated by mainstream services and are not getting appropriate treatment. Evidence exists.

The John Denmark unit provides a much-needed service, and SCOD is grateful that it provides a service in Glasgow, but there are people who do not want to be moved. People do not want to go to it from Aberdeen or even from Edinburgh. One of the case studies in our submission involves a woman who has a physical disability as well as a mental health issue, and who finds it traumatic even to travel from the east coast to Glasgow to be treated. She wants to see people and to be treated in her own area. She wants what her hearing friends in her area have.

10:45

The John Denmark unit gives a service, but it is available for only one day a month. What happens on the other days? What happens if somebody has a crisis, or if they cannot make it on that one day? A hearing person has somewhere to go in a crisis because there are other services out there that will pick them up, but a deaf person does not have that option. We should encourage health boards to put in the community services and voluntary services to support people, but we also need a small unit of four to six beds in Scotland so that people can be treated here.

The Convener: I think we are clear about what you are saying. It is not an either/or.

Ian McKee has a question, but I will let Helen Eadie and Ross Finnie in first because they have not asked questions yet.

Helen Eadie (Dunfermline East) (Lab): The papers for today's meeting state:

> "Research has shown a high incidence of deaf people committing suicide and trying to take a life or self harm in Scotland."

Do you have figures on that, and would you like to say anything about it?

Lilian Lawson: *(simultaneous interpretation from British Sign Language)* Deaf Connections in Glasgow did some research that showed that deaf people had been thinking about self-harming or committing suicide. I think that about 28 people in the Glasgow area alone said that they had been thinking about that, so what would the national figures be? We do not have exact figures, but the figure from that small piece of research might give you a rough idea.

Deaf people—as is the case among those who are not deaf—do not want to tell a lot of people that they want to commit suicide or self-harm, so it is difficult to try to get that information out of them. What help is available to people? Deaf Connections set up some training in mental health first aid to train deaf people to go out and identify other people in the community who might have issues and signpost them to the services that they need.

Helen Eadie: May I ask one more question, convener?

The Convener: I dare not say no.

Helen Eadie: Thank you. We know from experience as members of the Scottish Parliament that ministers can issue guidance but that health boards can determine, according to their priorities, how they enact that guidance. Can you give us any examples of best practice in health boards in Scotland? That would help us to be better informed about the matter. Also, Mary Scanlon mentioned the naming and shaming of those who are the worst at following guidance. Will you comment on that?

Willie Macfadyen: An example of good practice is easy to find; there is only one. I refer to Lothian NHS Board, which last year began to work in conjunction with Deaf Action, which used to be the Edinburgh and East of Scotland Deaf Society. Again, it comes down to individuals. An individual who is interested in an area of work and who has commitment and drive can get things done. In Lothian, we are fortunate to have such an individual. The health board pursued the matter and appointed two members of staff—a senior community psychiatric nurse and a senior occupational therapist—who take up their posts later this month. Both are coming to Lothian from down south. Unfortunately, that is the only place where the health board could find staff with experience of working with deaf people.

The staff will be employed and professionally managed by NHS Lothian, but they will be based at Deaf Action and will work specifically with deaf people in Lothian. The plan is for them to work closely with the John Denmark unit out-patient clinic, thereby giving deaf patients access to psychiatric help from consultants who can then advise staff on the ground about on-going treatment and so on. The staff will also make contact with mainstream services throughout the Lothians to provide information and training.

That is just a start. Our overall proposals include the provision of an in-bed unit. Ideally, we want to move towards that. As Mrs Scanlon said, we are talking about a step-by-step process. Perhaps the best way forward is to consider establishing a network of community-based services through which help would be made available in Lothian. The next step would be to establish a bedded unit; people should not have to go down south.

The Convener: We have a submission from NHS Lothian in which it gives its response. I refer members to paper HS/S3/08/16/4.

Ross Finnie (West of Scotland) (LD): My question is on the last point on how to establish a centre. The original petition, PE808, talked about an in-bed unit. However, in most of the submissions and much of the evidence that we have heard this morning, people have told us that unless professionals in psychiatry and other fields deal regularly with deaf patients, the level of treatment will never be what deaf people require. Professionals' signing skills—whether inherent or developed—are a factor in all of that.

Is what is required not a linked network, but a core of professionals who can be made available to the whole community? If the latter is the preferred option, perhaps we should not get too tied down to the petition's use of the word "unit". The issue is how to create a core of expertise that can be made available to deaf people throughout Scotland. I think that you are asking the committee to look at a different way of providing services. As you say, an in-patient unit could be added in the future.

Willie Macfadyen: We have looked at a number of options including individual health boards developing core specialist services or regional provision, perhaps on a north, east and west basis. The latter option would see a specialist core of staff in each area who could make local links and provide specialist advice, support and training to mainstream professionals in the area. At the moment, the blueprint is not set in stone. As I said, we are still looking at the different options. I have been saying for a number of years now that we need identified specialists who carry out this work every day. After all, if you do not use your skills, you lose them.

Ross Finnie: That is very helpful. I think that, if one is seeking to take forward a proposal, one should be prepared to discuss a range of options. However, if we are looking at something more concrete, things have to be honed down to ensure that we are all clear about what is meant. Your written and oral evidence suggests that one of the major factors is getting a core of people with this ability to communicate.

Willie Macfadyen: Our organisations focus on working with or for deaf people. None of us has professional experience—we are not psychiatrists, community psychiatric nurses or whatever—and if we can make links with professionals who know how the system works we will be able to feed in information about, for example, individual deaf people's needs or the whole deaf community. We need professional input about structures and so on.

The Convener: It might be better to put these questions on the proposal to the professionals in our next panel and to the Minister for Public Health.

I see that Ian McKee still wishes to ask his question. Ian, is your question necessary? I suppose that everyone thinks that their question is necessary.

Ross Finnie: What a test!

Ian McKee: My question is vital, convener.

The Convener: I asked for that. Please ask your short, but vital question.

Ian McKee: Mandy Reid said that the aim was for deaf and deaf-blind people to get the mental health services that hearing people get and we have been talking all morning about psychiatric services. I know, as a former GP, that there is no psychiatric contact in 90 per cent of all such services that are provided in general practice. Even having a centre in Glasgow would still be very inconvenient for someone in Inverness who has what might be a minor health problem. It would be like using a sledgehammer to crack a nut. How should these services be provided? Could the Midlothian service model be extended to ensure that GPs, who might see a person with such a problem once in every 10 years, can secure access to services near a patient's home instead of sending them to a specialist centre miles away?

Was that question not short enough, convener?

The Convener: At the risk of getting my knuckles rapped, I believe that Ross Finnie asked whether services might be delivered in some way other than through a fixed unit. We will want to explore that with the professionals.

I am trying to end this session by 11 so that we can move on to the next panel.

Mandy Reid: At the moment, the only unit is the Manchester-based John Denmark unit, whose staff come up to Glasgow and Edinburgh. If we are talking about establishing a Glasgow-based service in which a psychiatrist can make diagnoses, prescribe treatment and examine care pathways for patients, I should point out that it is easier to travel from Glasgow to Inverness than it is to travel from the John Denmark unit to Inverness.

The Convener: I will conclude this evidence-taking session, because we have to hear from witnesses from the NHS. I thank the witnesses for their extremely interesting evidence.

I also thank the BSL interpreters, who will stay for the rest of the meeting. I hope only that we were not too testing—and I see from that nice smile that we were not.

10:59

Meeting suspended.

11:08

On resuming—

The Convener: I welcome our second panel: Dick Fitzpatrick, project manager with the mental health strategic programme at NHS Lothian; Delia Henry, the director in Scotland of the Royal National Institute for Deaf People; Dr Deborah Innes from the Royal College of Psychiatrists; and Andy McDermott, assistant director at the National Centre for Mental Health and Deafness, John Denmark unit. We have heard a great deal about the unit.

Ian McKee: I ask Dick Fitzpatrick to tell us a little more about the developments in NHS Lothian's mental health service. I see from the briefing that the community mental health nurse and occupational therapist who will be employed to work with deaf people will have a focus on people with severe mental health problems. In view of the relatively small number of deaf people in the community, do you expect to be able to extend that service to deaf people with any mental health problems, so that such problems can be tackled in their early stages?

Dick Fitzpatrick (NHS Lothian): Although it is correct to say that their main focus will be on severe mental illness, that will not be to the exclusion of the mild and moderate end of the spectrum. We expect that they will work closely with primary care colleagues, as well as with other community and mental health teams and services and other organisations that provide support to the deaf community.

Ian McKee: Thank you.

The Convener: You said that gleefully. There is something behind that smile—we will find out what it is.

Mary Scanlon: My question is directed at Andy McDermott. I put the same question to the first panel, whose evidence you heard. Are you aware of huge unmet need in Scotland? Are there people who try but are unable to get treatment at the John Denmark unit? Are you overwhelmed by patients on the one day a month that you come to Glasgow? Should more be done in Scotland on referral pathways, awareness, information and so on? Is this a two-stage process, or is there evidence of huge unmet need in Scotland at present that would justify our establishing a unit? I hope that I have asked you the right questions.

Andy McDermott (National Centre for Mental Health and Deafness): The problem that you face is similar to the problem that we face in England—what you do not know, you do not know. In England, we run what we call hub-and-spoke systems. We have a CPN who works in the north-east of England and is linked to the John Denmark unit. When such posts are established, numbers tend to increase—the same point has been made about Northern Ireland. To return to Ian McKee's question, many of the primary care issues that the CPN in the north-east of England picks up are not severe and enduring mental health problems. I am sure that the same will be true for the person who has been appointed in Scotland, who comes from the John Denmark unit. If you had a hub-and-spoke model across Scotland, you would start to identify unmet need and that might reinforce the argument for establishing an in-patient unit in the future, if there are already questions about doing so.

Mary Scanlon: Would a hub-and-spoke model be a catalyst for overcoming the problems with referral, awareness, information and communication that the first panel highlighted?

Andy McDermott: It would. The model has two elements. The first is a clinical element—CPNs work directly with individuals. The second aspect of the job is to develop pathways and links with local primary and secondary care services, and to undertake a training and educational role. That element would address the issue of pathways that you have raised.

The Convener: Any panel member who wishes to answer a question should indicate that they would like to contribute.

Helen Eadie: Many people this morning have alluded to the fact that the evidence base for establishing a unit is not strong. If you had the ability to design how evidence on the issue was gathered, what changes would you make to ensure that such evidence began to come through?

Delia Henry (Royal National Institute for Deaf People): Earlier, Richard Simpson asked about the research that futurebuilders Scotland is funding. Futurebuilders Scotland has given the Royal National Institute for Deaf People in Scotland £40,000 to look at the issue. In our submission, we indicate that three years ago we proposed to establish a specialist unit in Scotland—not an NHS unit, because we are a charitable organisation rather than an NHS body. The RNID provides mental health services for adult deaf and deaf-blind people in other parts of the United Kingdom but not in Scotland. One issue that we faced was the one that we have heard about this morning, which was that although we thought we knew what was needed, all the evidence supporting it was anecdotal. We were in a chicken-and-egg situation, and we needed to gather the evidence that would allow us to proceed.

To the credit of futurebuilders Scotland—Communities Scotland, as it was then—it agreed to give us money to consider the issue, and we have commissioned Glasgow Caledonian University health school to do so. We want to look at the prevalence of people who are trying to access specialist mental health crisis services. As you have already heard, one of the difficulties will be the fact that recording of such data is not required in the NHS, so we will gather the data by talking to front-line NHS professionals rather than getting the data from recorded information. I heard yesterday that we have ethical approval to do the piece of work, and we will be looking at three different health boards to try to get a picture of urban and rural situations across Scotland. That picture might not be definitive, but it will be the first step in a process.

Additionally, we are working with the voluntary sector and the John Denmark unit to identify six people who have required to access services and been successful or unsuccessful. Again, that is not a lot of people, but we will do some in-depth case studies on people's experiences, which might inform what a service should look like. The study will take up to a year. The researchers are finding it difficult to identify the right people, so we are doing that through the voluntary sector and the NHS, because the population is hidden, as was the case in Northern Ireland, which has been alluded to. We hope that a picture will start to emerge.

As a personal observation, previously I worked in another field and when I came into my current field, I found the lack of evidence quite stark. The work that we are doing will inevitably lead to a recommendation that additional evidence will have to be gathered for this and other fields. We are looking at the acute end of the business, if you like, because the study is relatively small, but inevitably the situation that it has been suggested today exists for people who have mild or moderate mental health problems in this patient group will indicate that more research is required.

11:15

The Convener: I might have missed it if you said it, but have you any idea when that evidence will be concluded?

Delia Henry: As I said, I have got confirmation of ethical approval to start the prevalence study, so it is happening now. Part of the evidence gathering is starting and researchers are going to the John Denmark unit this week to talk about its experience. It will probably take 10 to 12 months.

The Convener: Yes, you said that the case studies would take a year. I was just trying to work out when there might be more data.

Delia Henry: The prevalence data might be available sooner, but it is very early days.

Dick Fitzpatrick: I support the views just expressed, and offer our input to the evidence that will be collected. We are doing another piece of work with the deaf community in Lothian to provide a counselling service for deaf people through British Sign Language accredited counsellors. We are four months into the pilot and we have a caseload of 12 people.

Anecdotally, we know from our mainstream counselling services that deaf people have rarely been referred in the past, which suggests that there is a cohort of people who would benefit from our approach. At the end of the pilot, we will be in a position to share the figures with interested parties.

The Convener: There is information about the 14-month pilot in your written submission.

Helen Eadie: Thank you for that helpful information, convener. I was also impressed by the paper from the Royal College of Psychiatrists, and in particular by the commitment in it to fund two conferences. Did key information emerge from those conferences that you would like to share with the committee?

Dr Deborah Innes (Royal College of Psychiatrists): The conferences showed that although many people are keen to provide services and champion the cause, we still have difficulty with the basic service infrastructure because people from different health boards and different professionals are involved.

The first conference dealt with what training and competencies would be required and the second conference dealt with how a service would be set up. Rather than dealing with facts and figures, the conferences were concerned with gathering information from and giving information to the many professionals who attended.

The college is also supportive of the provision of training to junior staff. That is being discussed with members of the college in London at the moment.

Ross Finnie: As you heard earlier, the starting point that has been put to us—which is not necessarily the best starting point—is the petition’s call for an in-patient unit for deaf and deaf-blind people. From the evidence that we have heard and the submissions that we have received, several issues arise: people have talked about creating a service like the one provided at the John Denmark unit; great concern has been expressed about the need for specialists in the health service to deal with the deaf and deaf-blind more regularly to improve their ability to elicit the correct information from patients; and people have mentioned the need to slightly restructure the service that health boards, such as Lothian, provide to make the primary care sector more accessible to deaf and deaf-blind people and provide them with greater support.

I think that we are looking at not three separate problems but a single problem. I invite the professionals to bring those issues together, so that we do not set the in-patient unit model against the satellite model, for example, or, given the numbers involved, end up with the view that the improvements must be delivered by individual NHS boards. We know that the service must be delivered in the community, but the organisation of the service need not take place in the community.

That is the mess that we are dealing with. The subject is important, but it is getting a bit flat. Can the panel help us with that?

The Convener: I think that your colleagues have nominated you to answer, Mr McDermott.

Andy McDermott: I agree that the situation is complicated, and I would point out that we in England have not solved the problems. What is needed is a global vision of how you want to solve all the problems; I do not think that you can pick out various bits. Having an in-patient unit in Glasgow will not solve the problem across Scotland—the John Denmark unit does not solve the problem in the north of England. To me, the issue is more about infrastructure and training. I think that having a relatively small number of trained people across Scotland who could link back to either a virtual centre or a real centre, like the John Denmark unit, would be a good solution. You would need that sort of global strategy to solve the problem.

The Convener: Something has just crossed my mind—it is usually a bad idea to ask a question that has just crossed your mind in a miscellaneous fashion, but I will do so anyway.

Has the John Denmark unit had much of a ripple effect on other services in England, such as mental health services?

Andy McDermott: The impact was pretty contained until the past two or three years. There has been an assumption in England that the centres will handle all of the problems of the people in the group of people with whom they work. We used to work with people with primary care needs, social care needs and so on—the spectrum of mental health problems—but that situation has changed, and remodelling is going on throughout England that will create a hub-and-spoke model. More and more areas across England are developing services through local CPNs and members might be interested to know that there is a bid with the Government to set up a similar model for mental health services for children and adolescents who are deaf. Currently there are two bases for such services—one in York and one in London—but the aim is to have another 10 bases, or spokes, to cover the rest of England.

Dr Innes: I agree with Andy McDermott that a central small group of core people who have more experience of and skills in signing and communication with and understanding of deaf culture and the deaf community could provide an outreach service around Scotland. As Mr McDermott said, they could have an actual base or a virtual base.

That is similar to the set-up in Ireland, which started with one consultant who provided services for two days to Northern Ireland, as well as to southern Ireland. There is now a service that is based around that one consultant: she has nurses and psychologists working with her and the service covers the whole country.

Having such a set-up in Scotland would mean that somebody could liaise with primary care services and get involved in trying to spread some training throughout the country to allow better access for deaf and deaf-blind people.

Delia Henry: I endorse that. If we set up a service using the hub-and-spoke model, part of the outreach remit would be to raise awareness of the service. I am sure that Andy McDermott will back me up in saying that the people who access his service and are given support are the fortunate ones—if one can put it like that—because they know about the service. Many people out there do not know, and are left with nothing. It is important that we bear that in mind. At the moment, provision is pretty hit or miss.

Dr Simpson: Is the legislative framework correct, or is there a need for further legislation? We have the Disability Discrimination Act 1995; the Adults with Incapacity (Scotland) Act 2000, the Mental Health (Care and Treatment) (Scotland) Act 2003 and legislation that covers vulnerable adults; and we have incorporated the European convention on human rights, which gives protection. My first question is: am I right in saying that the legislative framework is now in place?

Secondly, I do not know whether other committee members share my difficulty in getting my head around the size of the need. The appendix to Delia Henry’s submission mentions 758,000 people with deaf problems, of whom 40 per cent may have depressive problems: that is 300,000 people. If that is so, we cannot talk about a single unit or even a hub-and-spoke system—we might need three managed care networks, as one of the earlier witnesses suggested. I know that we are getting the results of the research on prevalence at some point, but it seems that we have to try to get the primary care right if we are to manage the problem. Will the panel comment?

Delia Henry: That is a valid point. The indication is that there are 758,000 people in Scotland with a hearing loss, and a significantly high proportion of people who also have mental health difficulties—that is acknowledged. The petition was about people who are acutely ill, and we have moved on in the past couple of years. Everyone who is here to give evidence will support the development of a specialist unit, but the committee is discovering that the problem is much bigger than the problem of a relatively small group of people who are acutely ill. As you rightly point out, some people will need to access primary care.

What we must acknowledge is that people with a hearing loss have a higher incidence of mental health issues, and it is not clear that that is acknowledged at the moment. I realise that the evidence is anecdotal, but we can all give you case studies of the people we come across daily who have withdrawn from society and cannot go to work because their colleagues do not understand their hearing loss. People are experiencing mental health problems—they might not become acute or reach crisis point, but they are part of the spectrum. I am encouraged that NHS Lothian will not just consider people who are acutely ill, but we are still talking about the tip of the iceberg—I am sure that Dick Fitzpatrick can comment on that. We must consider the bigger picture, but we must also start somewhere.

11:30

The Convener: You were named, Mr Fitzpatrick, so I give you an opportunity to comment.

Dick Fitzpatrick: I agree largely with what Delia Henry has said. Discussion about the size of the problem took up much of our time before we got round to doing anything about it, but we concluded that although we did not know the size of the problem, we needed to get on and do something about it. That will be the case in the context of in-patient provision, too. In the first instance, we should focus on building the community infrastructure, whether using a hub-and-spoke model or another model. When the infrastructure is in place and is working, we will have a much better idea of the requirement for in-patient provision. By starting to invest in bricks and mortar, we could end up disfranchising people in the community at all points on the spectrum.

The Convener: That is helpful. I understand you to mean that if properly supported services are put in place, the problem identifies itself, as people become aware of a resource that enables them to be understood.

I thank the witnesses for their evidence, which was extremely interesting. At our meeting next week, the Minister for Public Health will give evidence, after which the committee will take a view on how to proceed. This is an instance in which a petition that the Public Petitions Committee considered proved extremely useful in bringing a matter to the attention of a subject committee. I hope that we will be able to move things forward.

Are members happy to delegate to me responsibility for arranging for the Scottish Parliamentary Corporate Body to pay witness expenses in respect of our consideration of the matters raised in the petition, under rule 12.4.3 of the standing orders of the Scottish Parliament?

Members *indicated agreement*.

Subordinate Legislation

Food Labelling (Declaration of Allergens) (Scotland) Regulations 2008 (SSI 2008/180)

11:32

The Convener: We are considering a Scottish statutory instrument that is subject to the negative procedure. SSI 2008/180 implements European Commission directive 2007/68/EC, which amends the list of allergens, the presence of which must be indicated on the packaging of pre-packaged food. The regulations also implement the directive's changes to the list of instances in which a product is exempt from the labelling requirement because of the level of processing that has been undertaken. I seem to remember some difficulty with labels in the past; I hope that we get it right this time.

The Subordinate Legislation Committee drew the regulations to the attention of the Health and Sport Committee because an explanation of the use of enabling powers had been sought from the Scottish Government. The SLC was satisfied with the explanation that was given. No comments have been received from members and no motion to annul has been lodged. Do we agree that the committee will make no recommendation in relation to the regulations?

Members *indicated agreement*.

European Elected Members Information Liaison and Exchange Network

11:33

The Convener: I refer members to committee paper HS/S3/08/16/9, which encloses an invitation from the Minister for Europe, External Affairs and Culture to nominate a representative to attend meetings of the European elected members information liaison and exchange network—which has the nice acronym, EMILE—when issues of particular relevance to the committee are to be discussed. The next meeting will take place on 12 June, in Edinburgh—on a Thursday night, which I know members will find exciting. A copy of the agenda is attached to the paper. It includes an item on cross-border health services, by which I mean European borders and not the border with England. The committee is invited to decide whether to nominate a representative to attend the meeting and relevant EMILE meetings in future.

Rhoda Grant: I would like to sound out Helen Eadie, who has an interest in the issues. However, she might not be happy to be our representative.

Helen Eadie: Thank you. I would be interested in attending the meetings, if that is acceptable to members.

The Convener: Are there other nominations?

Mary Scanlon: I would have been interested, but I am quite happy to work with Helen Eadie. One representative is enough.

The Convener: I am happy to accept other nominations and for us to have a vote—it would produce a bit of excitement in our lives.

Mary Scanlon: No. Given the new directives that are coming, it is extremely important that the committee is fully aware of what is happening. I am quite happy to support Helen Eadie's nomination.

The Convener: That shows the bonhomie that exists among committee members.

Helen Eadie will be our nominated representative. That is grand, as we know that she has an interest in many European issues.

Budget Process 2009-10

11:35

The Convener: Agenda item 4 is consideration of our approach to the budget process 2009-10 at stage 2. I refer members to the recommendations in paper HS/S3/08/16/10, which I will deal with one at a time.

Recommendation a) invites the committee to

> "consider whether, in addition to focussing its scrutiny of the draft budget 2009-10 on finance and governance issues affecting the shift in the balance of health care, it would like to follow up on its recommendations on the budget allocated to people with drug and alcohol problems and their families".

Are members content with that recommendation?

Members *indicated agreement.*

Ross Finnie: I have a question. The Cabinet Secretary for Finance and Sustainable Growth, John Swinney, helpfully said that he would try to resurrect the piece of work that had been done on tracing expenditure on drug misuse. I am strongly in favour of such an exercise. However, if that work has not been done, we will find ourselves in the same cul-de-sac that we found ourselves in the last time we considered the issue. Do we know what the position is?

The Convener: The clerks have just reminded me that the Cabinet Secretary for Finance and Sustainable Growth gave us a commitment that he would come back to us on the issue. We have not had a response yet, so we will write a reminder and refer his team to the *Official Report* of the relevant meeting.

Dr Simpson: We might find that the Audit Scotland review will cover the issue that Ross Finnie has raised. It emerged in last week's statement by the Minister for Community Safety on the Government's new drugs strategy, "The Road to Recovery", that Audit Scotland is to look into the effectiveness of funding and to report back early next year, so the most reasonable response would seem to be to ask Audit Scotland to consider the matter in detail. Perhaps we should write to Audit Scotland and ask it to take account of the committee's particular interest in ensuring that the 2001-02 figures are updated.

The Convener: We should also write to the cabinet secretary, given that he said that he would get back to us.

Does the committee agree in principle to seek to appoint a budget adviser? That is recommendation b).

Members *indicated agreement.*

The Convener: Recommendation c) invites the committee to

> "consider the remit and person specification annexed; agree any changes; agree the remit and person specification for the post so that approval from the Parliamentary Bureau may be sought".

The annex, which is on the next page, spells out the adviser's duties.

Michael Matheson (Falkirk West) (SNP): Is the first bullet point in the annex correct? It says:

> "compare the Scottish Government's previous forecast for the 2009-09 budget and the actual figures published in the 2009-10 draft budget".

The Convener: No. It should say "2009-10 budget" rather than "2009-09 budget".

Ross Finnie: Eagle eyes, Hawkeye Matheson.

Michael Matheson: I will take that as a compliment. [*Laughter.*]

The Convener: That laughter was rather sardonic.

Do members agree to the remit in the annex?

Members *indicated agreement*.

Rhoda Grant: If we are making an application to the Parliamentary Bureau, can we flag up the remuneration issues that we discussed previously, so that we can widen our choice and attract someone who can do the job?

The Convener: I am advised that we do not have a locus in that. However, given that there was general agreement on the issue, I certainly intend to raise it at the Conveners Group.

Ross Finnie: I am sorry, convener, but I read the adviser's duties last night and it seemed to me that although our most recent adviser did quite a bit of analysis and gave quite a bit of assistance with drafting our budget report, he did not help us a great deal with our interrogation of the witnesses. That might just have been his style, but it did not seem to me that we benefited greatly from his assistance in that regard. I do not want to draft alternative wording, but perhaps Tracey White could consider the matter further.

The Convener: Frankly, it depends on which expert one appoints. It is not always the expert's fault if we do not have a suitable selection.

Ross Finnie: I am not blaming anyone; I am just saying that, given the nature of the job, we need assistance with interrogation as well as with analysis and report drafting.

The Convener: In my experience, our previous budget adviser gave us detailed help with analysis of the Government's figures. That is an issue to consider when we come to pick our adviser.

I do not want to prise open the subject.

Dr Simpson: I just want to know also whether, over the years, 15 days has been the standard length of time for which budget advisers have been expected to provide advice. Is that period adequate, given that there is a feeling that we should be undertaking greater scrutiny?

The Convener: The period is 15 working days.

Dr Simpson: Yes. That was just a question; I do not know whether the clerks can help me with it. In view of our comments on the fact that—[*Interruption.*]

The Convener: Fifteen working days is the standard period, but if we felt that we required a longer period of assistance, we could request that. Are you satisfied with that?

Dr Simpson: Yes, thank you.

The Convener: This is on the record, because we are still in public session.

Recommendation d) is to

> "agree to consider in private a list of candidates at a future meeting",

when we can look at CVs. Is that agreed?

Members *indicated agreement*.

The Convener: If anyone wants to suggest a possible adviser to the clerks, they are welcome to do so.

Recommendation e) invites the committee to agree to

> "delegate to the Convener responsibility for arranging for the SPCB to pay, under Rule 12.4.3, any expenses of witnesses in respect of the Committee's consideration of the draft budget".

Is that agreed?

Members *indicated agreement*.

Rhoda Grant: I agree, but can we agree to delegate that responsibility for all time? Each time we take evidence, you ask about expenses, which could be embarrassing for people.

The Convener: Such responsibility can be delegated at the start of an inquiry or a particular piece of business that will continue for a number of weeks, but we cannot agree to delegate it for all time.

Finally, recommendation f) is that we

> "agree to consider in private drafts of the Committee's report to the Finance Committee on the draft budget."

That is usual practice. Do members agree to do that?

Members *indicated agreement*.

The Convener: That concludes the committee's formal business.

Meeting closed at 11:42.

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