PUBLIC AUDIT COMMITTEE

Wednesday 20 May 2009

Session 3

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PUBLIC AUDIT COMMITTEE
10th Meeting 2009, Session 3

CONVENER

*Hugh Henry (Paisley South) (Lab)

DEPUTY CONVENER

Murdo Fraser (Mid Scotland and Fife) (Con)

COMMITTEE MEMBERS

*Willie Coffey (Kilmarnock and Loudoun) (SNP)
*Cathie Craigie (Cumbernauld and Kilsyth) (Lab)
*George Foulkes (Lothians) (Lab)
*Anne McLaughlin (Glasgow) (SNP)
*Nicol Stephen (Aberdeen South) (LD)
*Andrew Welsh (Angus) (SNP)

COMMITTEE SUBSTITUTES

Derek Brownlee (South of Scotland) (Con)
Linda Fabiani (Central Scotland) (SNP)
James Kelly (Glasgow Rutherglen) (Lab)
John Farquhar Munro (Ross, Skye and Inverness West) (LD)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)
Barbara Hurst (Audit Scotland)
Jillian Matthew (Audit Scotland)
Claire Sweeney (Audit Scotland)

CLERK TO THE COMMITTEE

David McGill

SENIOR ASSISTANT CLERK

Joanna Hardy

ASSISTANT CLERK

Jason Nairn

LOCATION

Committee Room 4

Scottish Parliament

Public Audit Committee

Wednesday 20 May 2009

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

Decision on Taking Business in Private

The Convener (Hugh Henry): Welcome to the 10th meeting in 2009 of the Public Audit Committee. I remind everyone to switch off electronic devices. I welcome staff from Audit Scotland. We have received no apologies.

Under item 1, do members agree to take items 4 and 5 in private?

Members *indicated agreement*.

Section 23 Report

"Overview of mental health services"

10:03

The Convener: Item 2 is a section 23 report. We have a briefing from the Auditor General for Scotland on the report, "Overview of mental health services."

Mr Robert Black (Auditor General for Scotland): Convener, with your agreement, I ask Barbara Hurst to introduce the report.

Barbara Hurst (Audit Scotland): This overview report on mental health services was published last week. It is the first in a series of planned reports by Audit Scotland and it was intended that it would pull together in one place what we know about mental health services for people of all ages, and help us to identify areas for further work.

Mental health has been a priority in Scotland since at least the mid-1990s. There have been significant developments that have shifted resources and services into the community and away from large long-stay institutions. The levels of most mental health problems in Scotland are comparable to those in England and Wales, but suicide rates in Scotland are significantly higher. [*Interruption.*] I am sorry; I got slightly distracted there.

George Foulkes (Lothians) (Lab): I am sorry that I am late. I have been in the building for two hours, but someone caught me.

Barbara Hurst: There is a lot of support among mental health professionals for recent mental health policy and improvement initiatives, the most recent of which was the launch of a mental health improvement plan earlier this month.

The report is pretty wide ranging and I do not want to go into great detail on every point. Instead, I want to highlight three issues: spending, the need for a whole-systems approach in mental health services and accessibility of services.

The wider costs of mental health problems are well over £8 billion a year. Mental health problems have a significant impact on the economy and more than £337 million is paid in incapacity benefits each year. It is also estimated that unpaid carers save society around £376 million each year. We know that the health service in Scotland spent at least £928 million on mental health services in 2007-08, which represents about 9 per cent of its total expenditure. Exhibit 11 in the main report shows the breakdown of expenditure and shows that more than half is spent on hospital services.

It is much harder to get a true picture of what councils are spending, largely because their spend is spread across a number of different budget heads, such as children and families services and services for older people. However, we know that around £142 million was identified separately as being spent on services for adults with mental health needs, and that a significant proportion of what was previously ring-fenced money would have been spent partially or wholly on mental health services. I am thinking of funds such as the mental health specific grant or the supporting people fund.

In 2007-08, the health service transferred more than £90 million to councils to support the development of a range of community services. Exhibit 14 on page 31 of the report shows that broken down by NHS board. We used resource transfer and the spend on different health services—exhibit 13 on page 31—as proxy indicators for joint working and for the progress in moving from a hospital-based service to well-developed community services. Both exhibits show significant variation, but the findings are closely linked, with boards such as NHS Greater Glasgow and Clyde demonstrating a significant shift from hospital to community services.

On the need for a whole-systems approach, people with mental health problems might require different services from a wide range of agencies, which includes the health service, councils, possibly the police, prisons and the voluntary sector. Family and friends also provide a considerable amount of unpaid care. That means that there is a real need for a whole-systems approach to ensure that services are joined up from the user's perspective. That relates to both sharing information about a user's needs and joint planning, so that a full range of services are available locally. We found that services that are provided out of hours and at times of crisis are not well developed in all areas.

Strong partnership working is essential in planning and delivering services, as is a real understanding of the spend and the effectiveness of the services. We saw good examples of partnership working and have highlighted two case studies on pages 22 and 23 of the report. Paragraph 76 describes some good joint working that we saw between the statutory and voluntary sectors in Glasgow. In addition, we published examples of good practice on our website.

I draw to the committee's attention the section in part 3 on quality and outcomes, which is on pages 24 to 26. Currently, there are few outcome measures for mental health, although we acknowledge that that is quite a difficult area. Single outcome agreements are now being used to measure improvements at council level, but they do not as yet focus on outcomes for mental health. Quality standards have been developed for mental health services within the health service. Work is under way to align the different performance targets and priorities across the public sector. Single outcome agreements are a way of doing that.

There are four mental health targets for the health service: reducing readmissions to hospital; reducing antidepressant use; reducing suicides; and achieving earlier diagnosis and management of people with dementia. However, those cannot be delivered by the health service alone, which is why it is so important that there is a concerted effort by all relevant agencies. It is not yet clear whether the targets will be met.

Part 2 of the report highlights the high vacancy rates for certain professional groups, problems with recruitment of staff in some areas, and the wide variation in staffing in Scotland. Those factors can affect availability of services and contribute to long waiting times. We looked into waiting times in some detail because we believe that it is an important area, but we found it difficult to compare positions in different areas because basic information is not available. However, where we did our fieldwork, we found evidence that children and adolescents wait a long time to access services. We believe that that is likely to reflect the picture throughout Scotland. Parliament's Health and Sport Committee found similar issues in its inquiry into child and adolescent mental health services, and the Scottish Government has announced that it will introduce waiting times targets for such services.

People who might find it more difficult to access mental health services include minority ethnic groups, people with sensory impairments, homeless people, prisoners and people with drug and alcohol problems. We found little evidence of local equality and diversity monitoring in mental health services. Agencies should do more monitoring to ensure that services are appropriately targeted and sensitively delivered.

As usual, we are happy to answer any questions.

The Convener: Thank you. I am struck by the differences between different parts of Scotland. We know that not dealing with mental health problems and the associated difficulties that arise has a significant cost to the public purse. It is evident that there is a need for closer co-operation, not just between the health service agencies and local authorities, but with agencies that help people back into work and support people in employment. Employment is often a critical factor in improving people's circumstances. I cannot understand why there is such disparity.

Exhibit 14 shows that there is four times as much resource transfer per head of population in Greater Glasgow as there is in Lanarkshire, but the two areas do not have hugely different socioeconomic circumstances. That inconsistency is worrying. This is not the first time we have seen such inconsistency in health services.

We say that there should be local decision making and accountability, which inevitably means that there will be differences between services in some areas, but in a country that is as small as Scotland we should reasonably expect that people who need access to services will have the same rights irrespective of where they stay. Is there any evidence of a move towards better and more consistent services, or can we anticipate that the disparity will continue?

Mr Black: That is an important question. You mentioned the figures on resource transfer in exhibit 14, but the report shows elsewhere that resource transfer means something in reality. Exhibit 3 shows that NHS Greater Glasgow and Clyde has the second-highest number of staff in mental health psychology services per 100,000 population.

Exhibit 5, on page 15 shows the number of staff working in child and adolescent mental health services. The report alerts us to some issues around waiting times in relation to those services in parts of Scotland; exhibit 5 shows that NHS Greater Glasgow and Clyde has the highest number of staff working in child and adolescent mental health services in the NHS as a percentage of the population.

10:15

Exhibit 12, on page 30, shows that the highest national health service spend on mental health services per head of population is in Greater Glasgow and Clyde. The resource transfer issue seems to be related to the fact that there has been a lot of change and development in the "system", to use Barbara Hurst's word.

It will be interesting to know a bit more about how effective that is, and whether there are any reasons—because there may be justifiable reasons—why boards such as NHS Lanarkshire, or NHS Lothian, which sit in marked contrast to NHS Greater Glasgow and Clyde in terms of resource transfer, do things so differently.

The Convener: That is an important point. I am disappointed that more boards are not following the lead that has been established in Greater Glasgow and Clyde and, to a lesser extent, by Forth Valley NHS Board.

Some of the exhibits that have been mentioned show that Fife NHS Board has a very low level of resource transfer as a percentage of total mental health expenditure and per head of the population. However, the exhibits also show that Fife does very well in relation to certain areas of mental health: for example, the number of staff working in psychology services and in child and adolescent mental health, and the number of mental health officers per 1,000 of the population. Something else is happening in places such as Fife that seems to compensate for low resource transfer.

Barbara Hurst: Fife is an interesting NHS board, and—as I said—the report is an overview, so we have not gone into great detail. We think that the reason for the low resource transfer is probably that Fife still has too many beds: exhibit 8 shows that its bed occupancy rates are relatively low in comparison with some of the other boards.

Resource transfer is linked to closure of beds and the transfer of some of the resources into the community. It is obvious that Fife has built up an infrastructure for its services, but it is still maintaining what seems to be quite a lot of beds.

Murdo Fraser (Mid Scotland and Fife) (Con): I will follow up on the convener's point about the disparity in spend with regard to exhibit 12. The difference between Lanarkshire and Greater Glasgow and Clyde is quite dramatic. The two areas are similar in terms of their social situation, but it seems from the figure in exhibit 12 that NHS Greater Glasgow and Clyde is spending roughly double the amount that NHS Lanarkshire is spending.

There did not seem to be much in the report about outcomes. I appreciate that it is, as you said, difficult to measure outcomes, but we do not get a feel for how the disparity in spend translates into outcomes. Is that fair?

Barbara Hurst: It is absolutely fair. We did not go down that road because it was so hard to get any information around outcomes. The difference between Lanarkshire and Greater Glasgow and Clyde is very interesting. The Greater Glasgow area alone would probably have looked even better before it incorporated Clyde, where mental health services were less well developed than they were elsewhere in the country. NHS Greater Glasgow and Clyde is now doing a lot of work to bring that area into line with the city of Glasgow.

NHS Lanarkshire recognises that its mental health services need to be developed, but that development depends very much on making significant shifts in how the whole health service is configured in Lanarkshire. The board had plans to develop community services, but those were linked with issues around closure of the accident and emergency department at Monklands hospital releasing funding. The board has had to go back almost to the drawing board to find out how to do

that. There are obviously lessons to be learned from places such as Glasgow, which looks as if it is managing the issue better than the other areas.

The reason why we mention the single outcome agreements in the report is because we see them as a way of starting to get at some of the outcomes, but there needs to be joint ownership of them.

Andrew Welsh (Angus) (SNP): You point out that people with mental health problems often receive services from more than one agency and that strong partnership working is essential to plan and deliver effective services. However, different information systems are being used by NHS boards and councils. How difficult is it to amalgamate those information systems? Is one system better than the others? Does the situation require a completely new system, or could you extend one of the existing systems? Without the information background, there is a failure to gather together the resources to meet the needs of patients.

Barbara Hurst: That is a difficult area. The medical element of the information that is held on individual patients is confidential. However, we know that there are systems that allow access to particular bits of information. The main frustration among the users to whom we spoke appeared to be that they kept on having to tell different people the same things, which they should not have to do. It is an important area that is complicated because it crosses agencies. When a person is in extreme distress, a mental health officer would need access to some of the information. A system would have to allow access to necessary information without breaching confidentiality. Because that is felt to be almost too difficult, we keep going round in a loop on that issue. I have said previously to the committee that I am not an information technology specialist, but I imagine that there are ways of doing this in order that the person who is dealing with a person's needs is able to access that information out of hours, in a crisis.

Anne McLaughlin (Glasgow) (SNP): I have for some time been particularly concerned about mental health services for children and adolescents. You have quite rightly focused on that in the report. Children and young people have less experience to draw on than adults, and adults who suffer from mental health problems are in a better position to rationalise it. From that point of view, I would have thought that children's waiting times should be a priority.

The Mental Welfare Commission for Scotland has said that where possible, children should be treated in children's wards and not in adult wards. A couple of years ago, I was working in a role in which I came into contact with children who had pretty severe mental health problems, and who were lucky to get a bed in an adult ward, never mind a children's ward. You say in the report that

"The Scottish Government is developing an NHS target on delivering faster access to mental health services for children and adolescents during 2009/10."

Do you have any details on what those targets might be and how it is expected they will be implemented?

Claire Sweeney (Audit Scotland): The easy answer is no—we do not yet have those details. The targets were set as developmental targets, so in essence the Government is still working on the detail of how they will be framed.

The concern about waiting times, particularly for children, comes out clearly in the report. A year is a long time for anyone to wait to receive care for mental health problems, but there is a particular concern with regard to children in that respect.

We have been unable to go into great detail about the cost of services for children and adolescents because some of the information is not available. We approached the report as an overview, to provide a good sense of mental health services throughout Scotland, so we did not really drill down. However, cost is an area of particular concern for many of the people and groups that we spoke to during the fieldwork.

Nicol Stephen (Aberdeen South) (LD): First—on the same subject—I notice that paragraph 46 on page 13 of the report gives information from some health boards on the length of waiting times for children and adolescent mental health services. Was that information obtained from all health boards, or do we have only a snapshot from the three boards that are mentioned? Further, the report notes that in the Greater Glasgow and Clyde NHS Board area—a board that we have already noted is one of the highest spenders on child and adolescent mental health services—some 16 per cent of patients, or one in six, had been waiting for more than a year. That seems to be a very alarming figure. Do children in other health board areas face similar situations? What was the longest waiting time that was discovered? Were there any outliers, or severe examples, that should cause us real concern?

Barbara Hurst: We carried out detailed field work only in three NHS board areas so, in a sense, it is a bit unfortunate for those boards that we have highlighted their waiting times—

Nicol Stephen: So, we just do not know whether those boards are the best or the worst.

Barbara Hurst: Exactly. We think that they are probably pretty typical. The difficulty with getting comprehensive information across Scotland is that boards do not necessarily collect the information in

the same way. As the information is not collected routinely, we could not just ask each board to tell us its waiting times because boards would need clear definitions about whether, for example, the wait is measured from assessment to delivery of a service. Therefore, we do not actually know whether other boards have longer waiting times, but we are pretty sure that the three boards that are mentioned are not complete outliers. The Health and Sport Committee inquiry is finding that long waits are an issue throughout Scotland and not just in those three boards. Actually, we would be concerned about any of those waits.

Nicol Stephen: Were examples found of particularly long waits? When the report was published, the media talked about a 77-week wait. Did that come from the report, or was that perhaps discovered from a general inquiry of health boards?

Jillian Matthew (Audit Scotland): That figure is quoted in the report as a waiting time for psychology services in the Highland NHS Board area, where there are long waiting times because of rurality.

Nicol Stephen: The figure was not specifically for child and adolescent mental health services.

Jillian Matthew: No. The 77-week wait was for psychological services.

Nicol Stephen: So, there are also long waiting times in other areas of mental health service provision.

Barbara Hurst: Yes, I think so.

Nicol Stephen: Convener, if I may, I will switch to a different subject unless others want to follow up on issues relating to children and adolescent mental health services.

The Convener: Before we move on, I want to ask something. Will the statistics for children who require access to an educational psychologist be accounted for separately?

Barbara Hurst: Yes. The report deals with access to clinical psychological services.

The Convener: I think that if we overlaid the issue of access to educational psychologists—I know that local authority expenditure is dealt with by the Accounts Commission—with the issues that are highlighted in the report, we would start to see real problems with child psychology services. Like other members, I am aware that children with mental health problems or behavioural problems often have difficulty in getting access to adequate child psychology services because of the shortage of specialists. However, we cannot afford to look at those issues separately. We need some joined-up thinking. If a child has a problem, they need early access to services and consistency and continuity in the way that support is developed. If the matter is not dealt with early, those problems develop and escalate as the child grows into adolescence and adulthood. They then not only remain with that individual but become a problem that society must deal with.

Perhaps what we need—I do not know how we could get it, whether through this report or through the work of one of the other committees—is closer co-operation between the different agencies that work with children to begin to address the shortages in some specialist services.

10:30

Barbara Hurst: I have just checked with colleagues whether the Health and Sport Committee has picked that issue up. We are not sure.

If the Health and Sport Committee had not been reviewing child and adolescent mental health services, we would have loved to do some more detailed work in that area. We absolutely agree that the services across the piece need to be reviewed. If the information had been readily available, we would have put it in the report.

Nicol Stephen: You raise a very important point. Responsibility in that area rests not only with the Health and Sport Committee. A lot of the funding for child psychology services comes from local authority education departments.

I have heard anecdotally some horrific stories involving children with the most serious needs. Often, because of their chaotic family backgrounds and drug-using parents, an appointment that is made with a child psychologist or a child psychiatrist is missed. That leads to some children who are most in need dropping off any waiting list—they just disappear because the service is not geared up to cope with that situation and to support the child. The focus is not on the child, but on the system and the waiting times. The child might be expected to attend a visit not at their school but on the other side of the town or city or, if they are in a rural area, a significant number of miles away. If they do not turn up, they are treated as no longer being a problem. In fact, the problem simply gets worse.

The issue is how the education department, the health service and the local authority, with their different responsibilities, can work together to support children and young people. That is an important area of study. Somehow, as a follow-up to the report, we must ensure that the Parliament continues to work in that area, whichever committee takes the lead responsibility. It is important to ensure that that work is done.

Switching subject, I draw your attention to exhibit 10 on page 25 of the report, which is a quite shocking graph. It came as a big surprise to me that the level of the daily prescribing of antidepressants per 1,000 of the population has risen more than fourfold since 1993-94. I well recall that, in 1993-94, people were concerned about the level of prescribing. They were saying that it should come down and that the seemingly quick and easy solution of prescribing antidepressants should be used less. Nevertheless, since 1993-94, which is only 15 years ago, we have seen a fourfold increase in the prescribing of antidepressants.

Does the Audit Scotland team have any insight into that? For example, does it reflect the fact that a significantly higher number of patients now receive antidepressants? Does it reflect the fact that a higher dosage of antidepressants is being prescribed? Are both those issues a factor? What is being done to reduce the level of the prescribing of antidepressants beyond glib reassurances and the occasional headline saying that the health service is working hard to reduce unnecessary prescribing? There seems to have been an explosion in the prescribing of antidepressants since the early 1990s.

Barbara Hurst: I ask Jillian Matthew to answer that question.

Jillian Matthew: There are a few issues around antidepressant prescribing. Obviously, the target is to reduce the use of antidepressants, but it was set as a proxy for improving care for people with depression and anxiety. If people do not need the medication, other therapies should be available, such as psychological therapies. Behind the target, therefore, should be the development of services. However, as we said in the report, there are long waiting times for psychological therapies. Through the collaborative programme, the Government is considering work across Scotland on the health improvement, efficiency, access and treatment targets to ascertain what approaches are being taken and how alternative services are being developed.

Another issue that we picked up through the fieldwork on antidepressant prescribing is that a certain amount of people need to be prescribed those drugs because they work for them. Guidelines were issued recently on the drug dosage that should be prescribed, because people were not getting a sufficiently high dosage. However, the measurement of the level of prescribing does not deal with the number of patients or the drug dosage that each person gets: the information is just on the overall amount that is prescribed. From that, we cannot say—

Nicol Stephen: It could be both. The increase in prescribing could be because of higher dosages and a higher number of patients.

Jillian Matthew: Yes. We cannot say how many patients are being prescribed the drugs, what dosage they get or how long they have been prescribed them. Some people need both medication and psychological therapies or other support. The situation is therefore not black and white.

Nicol Stephen: And you cannot give that detailed information to us because health boards do not track it. Is that correct?

Jillian Matthew: Yes. The prescribing information that is collected is not yet identifiable in terms of patients and diagnoses.

Nicol Stephen: The Government collects a lot of information, much of which is unnecessary and is never used. However, I would have thought that it was important to know whether the number of patients being prescribed antidepressants was increasing, whether the level of dosage was increasing, or whether both were increasing. The information is important in understanding how we treat mental health problems in Scotland. We might want to raise that issue with the Scottish Government.

While we are on the issue of children and adolescents, I would be interested in seeing a similar graph to that in exhibit 10 for prescriptions that are issued to young people—children under 16 or under 18—for Ritalin and other drugs. I do not know whether there is a chart with that information. I suspect that there has been a similarly significant increase in prescribing such drugs to young people, but I do not have information on that. I wonder whether Jillian Matthew or anyone else knows whether it is available.

Jillian Matthew: There is some such information. Again, it is a bit difficult, because some of the drugs are used for different conditions. The issue is whether the drugs have been prescribed for a mental health problem or for something else. However, some of the drugs are specifically for mental health problems.

Nicol Stephen: Are children with behavioural problems categorised differently from children with mental health problems or depression? Do you know what the different health board categories are in that regard? Again, it is about joined-up thinking and having an overview. The classifications of social, emotional and behavioural difficulties are often used. The emotional aspect is often linked to mental health problems, as, indeed, is the behavioural aspect. However, such links might not be categorised, so it would be difficult to get the information that we seek in that regard.

Jillian Matthew: On page 7, exhibit 1 lays out the different classifications for mental health problems for children.

Nicol Stephen: Yes, that is helpful. Therefore, of social, emotional and behavioural difficulties, the only aspect that is not categorised as a mental health problem is the social. Hyperactivity seems to be an additional classification.

George Foulkes: The report is helpful and revealing; it gives us some valuable insights. Like Nicol Stephen, I was worried about exhibit 10 and the increase in the prescription of antidepressants, but three other startling and striking issues came out of the report. The first is that the suicide rate in Scotland is nearly double that in England and Wales, which is a remarkable statistic. The second is the explosion in the numbers of elderly people. We know about that, but it will have an effect on the numbers of people with Alzheimer's and dementia.

The third touches on a slightly different issue. As others have said, there is great variation in the expenditure in different local authority areas. It is much more than I would have expected and, as has been pointed out, it is inexplicable in some cases. It has nothing to do with levels of poverty, and something will have to be done about it.

I hardly ever criticise Audit Scotland, but the only thing that slightly disappoints me in the report is the recommendations. They are well meant, but I have heard some of them again and again. Now, I know that we have had a revolution in mental health since the days of the old asylums, but the recommendations include, for example, the idea that the Scottish Government and local partners should

"ensure that they work together"—

which makes it sound as if they will sit down and pray and hope—and that they should "collect information".

However, I was encouraged by the checklist in appendix 3, and by the suggestion that external auditors be appointed to carry out the checklist. Robert Black and Barbara Hurst will know about my obsession with following up reports. Have external auditors been appointed? If so, who are they and when will they start? We need to do something quickly, to ensure that money is being spent wisely and effectively. We are talking about nearly £1 billion, which is an enormous percentage of the health service budget and the Scottish Government budget as a whole. You say that the amount that is spent in local authorities is unknown; it is at least £150 million, but it is probably much more.

So, as I say—I sounded like Kenny MacAskill when I said that—have external auditors been appointed and when will they start? To whom will they report, and how will their work be followed up?

Mr Black: That was an extremely wide-ranging, and appropriately challenging, series of comments. I will step up to the crease first, and then invite the team to come in behind me.

Thank you for your remarks about the report. I feel that the team has succeeded in providing some interesting shafts of light on some of the issues, and I am grateful that committee members have appreciated that. However, this is one of those reports in which the words on the page raise as many questions as they answer. In her introduction, Barbara Hurst said that the report offered a high-level overview of where we are, and that we intend to follow up the themes in different ways. In due course, we will welcome further discussion with the committee on which areas might be considered in more detail.

I will offer a thought on how the system works and the questions that arise. In a report such as this one, we go as far as we can with the information that is available. The Health and Sport Committee has been considering the issues but, because of the diversity of approach that we have seen, it might be appropriate for this committee to ask questions about how systems are really working. That would help us in framing future work that Audit Scotland might want to do—in children's services, for example, or in psychiatric services for children. It would help us if there were a greater understanding of how systems worked. I think that Barbara Hurst talked about looking at the whole system.

I will deal with the specific question about auditors. This report is an early example of the way in which we are producing reports now. The Audit Scotland team will do its very best to put together a checklist at the back that tries to summarise the key questions that we think that partnerships should be asking themselves.

Each local authority and health board has an appointed auditor for a five-year period. The model that we are working on is one whereby, after a couple of years, through our guidance to the auditors, we will invite the auditors to go back to each of the stakeholder bodies and say, "What did you do with that report? Did you use the checklist at the back? If you did, how are you measuring up against some of those issues?" That will allow us, in the fullness of time, to return to you with a progress report on how things are going.

Would you like to add to that, Barbara?

10:45

Barbara Hurst: Yes. On Friday, we will have one of our periodic meetings with the auditors. An item on following up is already on the agenda. We are going to say that we would like better feedback on what has happened with the self-assessment

checklists over the past six months or so. The issue is definitely at the forefront of our minds in terms of what we do. I am glad that you spotted the checklist in connection with the recommendations.

I want to pick up a point that Nicol Stephen raised earlier. I am sorry, but I was being a bit slow witted when you were talking. We have information about the rate of prescribing per 1,000 of the population by health board, which shows some variations for different drugs. That information covers antidepressants, drugs for dementia and drugs for attention deficit hyperactivity disorder. In relation to the latter, it probably captures some of the issues for children that you talked about. We can make that information available to the committee if that would be helpful. It is background information that supports what we say in the report.

Nicol Stephen: That certainly would be helpful. Thank you.

George Foulkes: Barbara Hurst takes us back to the issue of prescribing, but I am not fully satisfied with the previous answer. From what Mr Black said, it sounds as though all that is happening is that the existing auditors in each health board are continuing to do what they are already doing.

Mr Black: I am sorry if I am not explaining myself very clearly. We have moved the system along considerably over the past year. Barbara Hurst will be able to explain this more fully. In essence, there are now a couple of high-level planning meetings at which we get the auditors of all 14 health boards or the auditors of all 32 local authorities together. We work with them to agree on priorities and a risk analysis of the issues that they should be addressing. They cannot address everything in one year, but they can address some things every year. We are able to issue a requirement to all the auditors that, in such-and-such a year, we expect them to ask every health board or council, as the leader in community planning, questions around the checklist. In that way, we can get a picture of what is happening throughout Scotland a couple of years down the line. That is the model that we are going for.

We would like to do more, but we are not resourced to do more than that. Even that requires auditors to stop doing other things. However, we share the thought behind your question—that this is more important than some other things that auditors have done in the past.

George Foulkes: You can tell your meeting that, if the auditors do not follow matters up, that awful man Foulkes will give you a roasting when you next report back to the Public Audit Committee.

Barbara Hurst: We could always offer you an invitation to the sector meetings, so that you could deliver the message yourself.

George Foulkes: Now, there is a thought.

Willie Coffey (Kilmarnock and Loudoun) (SNP): I would like to pick up some of the issues that are raised in the report to do with access to mental health services for socially excluded groups. I am thinking particularly about prisoners. The report says that, as many of us will probably know, 70 per cent of all prisoners in Scottish prisons—males and females—have some kind of mental health problem. Could you tell us a wee bit more about the Tayside case study, which seemed to go down particularly well? Could you explain what that is? Could you also talk a wee bit about why there is no consistency in the referral of prisoners to community mental health services when they come back into the community?

I want to think ahead to the possibility that there will be more community disposals, particularly for people with mental health problems. Are mental health services in the community geared up to handling such referrals, particularly from prisons?

Barbara Hurst: I invite Claire Sweeney to answer those questions.

Claire Sweeney: Willie Coffey is referring to case study 3 on page 23 of the report, which is on work in Tayside. That case study was taken from work that was done by Her Majesty's inspectorate of constabulary for Scotland, and was not therefore directly collected by us as part of our field work. However, themes that that work threw up have certainly come through in the work that we have carried out.

I return to earlier discussions about sharing information. One of the big messages in the report, which came from several agencies, is that people experience difficulties in moving between services. An example is provided by the ease with which people who are about to be released from prison can access the services that they need. We found that there are accessibility issues for prisoners in particular that other groups also experience, such as children who are moving between services and who move to adult services when they grow older. We found that the joins between services and agencies that provide services are definitely a problem. Some of those issues will definitely be thrown up as work progresses on NHS provision of health services for prisoners. We flagged up that risk area. We wanted to include case study 3 in the report to give an example of somewhere that seemed to be starting to work on the issue.

Willie Coffey: Have people in Tayside been assessed and therefore not been imprisoned or held in custody overnight as a result of their

assessment? I am not sure what the case study means.

Claire Sweeney: I am not certain about what the difference has been for individuals. We will need to go back and check that.

Willie Coffey: We will come back to it.

On the wider issue of the development of more community-based mental health services, the report says that there is a lack of information about how well those services are developing. Are you confident that your report sufficiently emphasises the recommendation that clear information about that be gathered? I see such information as crucial if we go down a route whereby more people, whether or not they are prisoners, draw on mental health services in the community.

Barbara Hurst: We feel strongly that a lot of the development of services is happening in the community, but we do not really have a strong feel for that development. Several years ago, we did some work on case load sizes for community mental health nurses. The variations were massive. We would have liked to redo that exercise this time round, but doing it was quite labour intensive for us and for every community psychiatric nurse who was involved. However, we are keen that the self-assessment checklist is used as we go forward. We will return to some issues. Even if we look at older people's services, we will need to do more detailed work in that area. The discussion has been useful to us in informing us of the key issues that we will need to build into our investigations, whatever we go back and look at. What is happening in the community will certainly be key to anything that we consider in the future.

Willie Coffey: That is helpful. Thanks.

Anne McLaughlin: Willie Coffey picked up on a point that I wanted to make. However, I have a slightly different question, on the third key message in the report, which is about the shift away from hospital-based treatment services to community-based services.

It is a fact that there is insufficient information about what is working. I am reminded of the report on drug and alcohol services that we discussed two or three weeks ago and the astonishing fact that the rates of people who die as a result of drug and alcohol abuse are going up in Scotland and down in Europe. We do not assess what works best in Scotland. I know that mental health is not just about suicides and I do not know whether mental health problems and suicide rates are increasing, staying the same or whatever in Scotland, but the fact is that, as George Foulkes said, the suicide rate in Scotland is almost double the rate in England and Wales. I would therefore expect that we would want to assess which treatments are working more effectively. Is there any recognition among service providers of the need to monitor the effectiveness of treatments? Are there any Scottish Government guidelines on making assessments, as I understand will be done in the future in relation to drug and alcohol problems? Is there a desire to do anything to address the problem?

Barbara Hurst: I will kick off and will invite the team to come in if I have missed things.

The services are, on the whole, staffed by very committed people who want to do a good job and make a difference for the people with whom they are working. On one level, there is work to be done on care plans and all the things that are done for the individual to ensure that they are working for that person. The bigger gap will be in bringing all the information together to inform service delivery.

The most recent mental health improvement plan has a strong commitment to look at the effectiveness of different services. Sometimes, we sound like a stuck record, but this is not about collecting information for the sake of it or in order to build up a bureaucracy; we feel strongly that it is about ensuring that the money is spent in the right way for the best benefit. We absolutely agree with your and Mr Coffey's comments about the need for monitoring, and we would like that to be done more systematically through joint planning in local areas. As we said earlier, different areas can learn from one another, so there is no reason for the work to be done in a very narrow way.

The Convener: Thank you for your contributions to that discussion. We will return to the matter later in the agenda.

Public Audit Committee Report: Response

"Police call management"

10:57

The Convener: Item 3 is a response from the Scottish Government to the report on police call management. Members have the relevant paper before them. Are there any thoughts or comments? There are some areas on which we will have to agree to disagree, but we have been over the matter in some detail.

Willie Coffey: On reading the response to paragraph 18 in the appendix to the paper, I did not get a sense that we are going to get performance reporting per police board or police area. There is a suggestion that the Government wants to wait until the national performance indicator is developed. I am not sure that we are going to get the information on a per force basis, which is what I thought that we had asked for. I would like some clarification of that.

If someone in Strathclyde, for example, has reported something to the police, we should know how long it is taking the police there to attend non-emergency incidents without having to wait for a consistent national indicator for the rest of Scotland, which might include Orkney and Shetland. It is important that we are given local information as quickly as possible after it becomes available. We should not have to wait for the national indicator to be developed. Some clarity on that would be appreciated.

Murdo Fraser: My point relates to the response to paragraph 53, on the single non-emergency number. I suspect that we have taken the issue as far as we can and that, as you say, we will have to agree to disagree on it. At least we have received a somewhat more comprehensive response from the Government than we received previously. I still think that it is wrong, but it is difficult to see what more we can do about it.

George Foulkes: I agree with Murdo Fraser. As is suggested in annex A to the paper, we should ask what progress has been made on the alternatives that have been suggested. We should also ask what progress has been made on the work with the Association of Chief Police Officers in Scotland.

11:00

The Convener: I notice that Tayside police is moving to an 0300 number, which is commendable.

Is there anything in the accountable officer's response that we wish to follow up on? Does the committee wish to write back to the accountable officer on the issue that Willie Coffey has identified?

Andrew Welsh: We are talking about a work in progress. We are told that meaningful indicators are being developed, so it is a continuing process. Some timescale would be helpful. One thing that bothers me is that the response says:

> "the considerable expense in terms of funding and organisational change needed to install a single non-emergency number across Scotland would not be justified by the possible benefits at the present time."

Everything will be overshadowed by the 2010-11 budget, when there will not be much money for anything. I just feel that the response is holding everything back and that there is no great desire to get anything done. We should at least ask for a timetable for the development of meaningful indicators.

The Convener: Okay. Members also have a list of potential updates. Do we agree to ask for those?

Members *indicated agreement*.

George Foulkes: There is not likely to be a change in the accountable officer in the near future, is there?

The Convener: I could not comment on that; I have no idea.

George Foulkes: Is he getting on a bit?

The Convener: The truth is that we are all getting on a bit—some of us more than others.

George Foulkes: That might improve the situation.

Murdo Fraser: Is that not a case of the pot calling the kettle black?

George Foulkes: Yes.

The Convener: Do we agree to follow up on the points that have been raised, and to ask for a series of updates?

Members *indicated agreement*.

The Convener: Beyond that, there is probably not much more that we can do with the response. Have we sent it to the Justice Committee for its interest?

Joanna Hardy (Clerk): We will do.

The Convener: We now move into private session, as we agreed earlier.

11:02

Meeting continued in private until 13:04.

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