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Official Report

EQUAL OPPORTUNITIES COMMITTEE

Tuesday 23 March 2010

Session 3

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EQUAL OPPORTUNITIES COMMITTEE
6th Meeting 2010, Session 3

CONVENER

*Margaret Mitchell (Central Scotland) (Con)

DEPUTY CONVENER

*Marlyn Glen (North East Scotland) (Lab)

COMMITTEE MEMBERS

*Malcolm Chisholm (Edinburgh North and Leith) (Lab)
*Willie Coffey (Kilmarnock and Loudoun) (SNP)
*Bill Kidd (Glasgow) (SNP)
*Christina McKelvie (Central Scotland) (SNP)
*Hugh O'Donnell (Central Scotland) (LD)
*Elaine Smith (Coatbridge and Chryston) (Lab)

COMMITTEE SUBSTITUTES

Rhoda Grant (Highlands and Islands) (Lab)
Mary Scanlon (Highlands and Islands) (Con)
Margaret Smith (Edinburgh West) (LD)
Shirley-Anne Somerville (Lothians) (SNP)

*attended

THE FOLLOWING GAVE EVIDENCE:

Dr Sandra Grant (Mental Health Foundation)
Martin Hayward (Equality and Human Rights Commission)
Ann Henderson (Scottish Trades Union Congress)
Graeme Henderson (Penumbra)
Geoff Huggins (Scottish Government Primary and Community Care Directorate)
Lorna Meahan (Audit Scotland)
Dr Joseph Morrow (Mental Health Tribunal for Scotland)
Angela O'Hagan (Scottish Women's Budget Group)
Shona Robison (Minister for Public Health and Sport)
Claire Sweeney (Audit Scotland)

CLERK TO THE COMMITTEE

Jim Johnston

LOCATION

Committee Room 6

Scottish Parliament

Equal Opportunities Committee

Tuesday 23 March 2010

[The Convener *opened the meeting at 10:02*]

Mental Health (Care and Treatment) (Scotland) Act 2003 (Post-legislative Scrutiny)

The Convener (Margaret Mitchell): Good morning everyone, and welcome to the sixth meeting in 2010 of the Equal Opportunities Committee. I remind all those present, including members, that mobile phones and BlackBerrys should be switched off completely as they interfere with the sound system even when they are switched to silent.

Agenda item 1 is our second evidence session on the Mental Health (Care and Treatment) (Scotland) Act 2003, which will be followed by an evidence session with the Minister for Public Health and Sport.

I am pleased to welcome Claire Sweeney, portfolio manager for Audit Scotland; Dr Sandra Grant, associate consultant with the Mental Health Foundation; Dr Joseph Morrow, president of the Mental Health Tribunal for Scotland; and Graeme Henderson, director of services and development with Penumbra.

We will kick off with questions, and I will start with a general question. Could you give the committee some examples of why equality duties are needed?

Claire Sweeney (Audit Scotland): By way of context, I note that, in May last year, Audit Scotland published an overview of mental health services in Scotland. Although the report was broad and covered the whole of mental health services, it focused particularly on how resources such as money and staffing were used across Scotland. We picked up on some issues that the committee will be interested in to do with access to services for particular groups within the community. There are certainly concerns about access to services for children and about the transition between services, such as for people moving from prison out into the community. There are some relevant issues in that report.

The Convener: That is helpful.

Dr Sandra Grant (Mental Health Foundation): Obviously, the issue of equality is important for everyone, but one of the extra concerns is double or multiple discrimination, in that having a mental health problem certainly puts someone at a disadvantage and means that they are often less able to assert themselves and have their needs met. If that person is also in a more marginalised or disadvantaged group, they face quite a lot of problems, especially—but not completely—with legal issues.

Dr Joseph Morrow (Mental Health Tribunal for Scotland): The Mental Health Tribunal for Scotland deals with people at the acute end of the mental illness and mental disorder scale and, when they come before us, the inequalities that they face become very clear to the tribunal members. Part of the process is to open up those issues in terms of their care and treatment and detention by providing a just, transparent and independent procedure that allows the best information to be used to address the inequality that is simply just there. As we also deal with the suspension of liberty, which is a very serious issue in terms of an individual’s rights, it is important that the tribunal has not only a general duty to create an environment in which inequalities are addressed but, under sections 1 and 3 of the 2003 act, specific duties to address those issues. The tribunal’s decisions must always have regard to equality issues, and that is enshrined in the legislation.

The Convener: That is a helpful overview. Would Graeme Henderson like to add anything?

Graeme Henderson (Penumbra): I suppose that I wear two hats. As well as working for Penumbra, I am a general member of the Mental Health Tribunal for Scotland.

On the principle of participation, one of the key things that our service users tell us is that they have limited access to information, particularly about the role of a named person and about advance statements. To ensure full participation, it is important that people have the right information and support.

The Convener: That is a helpful overview to set the scene. The equality duty applies to ministers, the Mental Welfare Commission, local authorities, health boards, hospital managers, mental health officers, medical officers, medical practitioners and nurses. How well have those bodies and individuals responded to the legislation? Have they made a difference? What areas could be improved? From our previous evidence session, we are aware that improvements could be made in some areas.

Graeme Henderson: I will make a general point about advance statements that comes from my experience of working with Penumbra and of being a tribunal member. Advance statements often do not appear before the tribunal, so the patient’s wishes for what should happen in the event that they become unwell are often found in other areas. Penumbra has toolkits that can be used to do planning work with individuals. People are quite happy to do that and do not seem to be put off by it; the instruments that we use do not seem to be off-putting. Something should be done to make advance statements easier to use and more accessible to the tribunal process. An advance statement describes someone's wishes about what should happen if they become unwell, and they can make such a statement with support. From my experience, I know that people work on advance statements with patients, but not enough of them are appearing before tribunals.

The Convener: Is that always done?

Graeme Henderson: I know that it is considered. Nursing and social work staff will promote the use of advance statements, but people do not seem to be able to do them, although they are quite happy to use other types of planning tool with nurses and social workers. Something is not quite right with advance statements.

The Convener: It is not the case that statements are taken and not passed on. Rather than a communication problem, the problem is that they are not set down in the first place.

Graeme Henderson: I think that it is more about the administration that is involved in producing an advance statement. When a statement is taken, it comes before the tribunal.

The Convener: Would it be helpful to make guidelines on advance statements available to people so that they can see the kind of things that would help the tribunal?

Graeme Henderson: Guidelines are available—the Government has produced them, as has the Scottish Association for Mental Health. However, something seems to be stopping patients from completing an advance statement.

Dr Morrow: The care plan is an essential part of the tribunal process and is enshrined in the legislation. We must see it, as well as any advances on the care plan, if we are reviewing someone's detention. In general, the professionals tackle equality issues very well within the care plans and address the issues that are significant to the person's mental disorder and subsequent detention. It is sometimes difficult to find those elements in the care plan but, when we sit as a tribunal, we can see the issues being dealt with, particularly cultural issues, sexual orientation issues and issues to do with age, which is relevant when we are dealing with old-age psychiatry. The care plans are always influential in relation to how the tribunal makes its decision and any recorded matter that it might make—a recorded matter is a technique that the tribunal uses in order to consider something specific to the patient that is not provided but should be provided because of the reciprocal principle in the act. As you will be aware, if you are going to detain someone, you must put in place appropriate services for them.

We have just undertaken an extensive training of all our members on recorded matters to try to make them more effective in this area, in the interests of the individual patient. The 2003 act provided for recorded matters but did not say how the process was to be managed. That has taken a wee bit of practice.

In support of Mr Henderson's position, I should say that we do not see many advance statements. However, we always ask whether there is one and, if there is one, we see it and must have regard to it when we make our decision.

I do not know why there are not many statements. My suspicion is that the reason is similar to the reason why many people do not have wills: we do not want to think about what will happen when we are unwell any more than we want to think about what will happen when we die. However, that does not mean that work cannot be done to encourage that process.

The tribunal is keen to ensure that the patient has a say. Even if they are unwell or are unable to come to the tribunal, we make every effort, through a variety of avenues—including going to see them—to try to get them to submit information to the tribunal about their position.

Last week—if I read the *Official Report* of last week's meeting correctly—you heard a lot about advocacy services, which play a key role in expressing to the tribunal what the wishes of the patient are, particularly with regard to equality issues.

The process can sometimes be difficult to follow through.

Dr Grant: I am not involved in the tribunal system, so my comments will be broader.

There is a long list of people who have responsibility for carrying out the equality duty, and that is part of the problem, because that can make it hard to find out who is accountable. When you try to find out information, you do not know from whom you can demand action. It seems strange that we cannot tell the ethnic background of people who have been sectioned, especially because that is a major issue in England and we need to be able to find out whether a disproportionate number of people from certain ethnic backgrounds are being detained.

The issues of communication and information sharing are important, and much of that is down to the individuals who are involved. I do not know how we can deal with things, given what has been said about advance statements. I do not know whether the staff are committed to the issue or know how to follow the procedure. People really need to internalise the importance of the issue. It is a front-line matter, but I am not sure whether it is passed on down the management chain.

The Convener: Would the Mental Health Commission have a role in that regard, given that it is the principal body with regard to monitoring and implementation? Perhaps it should be drilling down a bit to find out why the statements are not available as often as they should be. If it did so, it could determine whether more work needs to be done on training, awareness or whatever. That might be a starting point.

10:15

Claire Sweeney: We considered equalities issues in mental health quite generally; we did not examine the 2003 act in particular, given all the other work that is happening. We made some clear recommendations, particularly on the information gaps. That report is with the Public Audit Committee. One year after its publication—very soon—we will follow up the impact of the report and determine what action to close those information gaps has been taken by national health service boards and councils on the back of the report.

The Convener: Audit Scotland's written submission was helpful for our work in preparation for today's evidence-taking session.

Elaine Smith (Coatbridge and Chryston) (Lab): Earlier, Dr Morrow said that equalities were enshrined in the 2003 act. I would like to pursue that a bit further.

The act enshrined a set of 10 principles that were proposed by the Millan commission, including the principles of non-discrimination, equality and respect for diversity. Under the principle of non-discrimination, people with mental disorders should, wherever possible, retain the same rights and entitlements as those with other health needs; under the principle of equality, all powers under the act should be exercised without any direct or indirect discrimination on a range of stated grounds; and, under the principle of respect for diversity, service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds, and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background. Have those principles generally been reflected in the implementation of the act?

Dr Morrow: That is an important issue, and I want to address it in the context of what I see the act doing. The act is concerned with the care and treatment of the patient, and it requires that the totality of the patient be addressed within the process. Many of the Millan principles—or section 1(3) principles, as we now call them—enshrine that completeness of approach. The tribunal's thrust is always to consider the outcome for the patient as well as the judicial process.

I have captured the essence of the approach in the Americanised term "therapeutic jurisprudence"—it is a legal process that has a therapeutic programme behind it. We always think about what is best for the patient in terms of the application of the principles, including the non-discrimination principle that you mention.

I am conscious that, until the day of the tribunal, we can have patchy information about some of the issues that you raise. However, the tribunal has a semi-inquisitorial role. We do not just sit there passively receiving what is put in front of us; we can probe and ask questions and request that further reports be produced or issues be addressed. I am supportive of that process, although it can mean that the patient must have another hearing, which in itself can become an issue that must be considered.

If we feel that any of the issues that you mention have not been addressed in the care planning or the information that was given to us by the professionals who are before the tribunal, the tribunal will take over the direct information gathering on those issues.

Elaine Smith: Just to be clear, are you saying that, if you do not receive the appropriate background information, you might have to convene another tribunal meeting?

Dr Morrow: It might mean that we have to do that, and I would make no apology for doing so, as we need the full information before us in order to be able to deal with the case, especially with regard to equalities issues.

Since I became president, I have introduced a case management system into the process. We try to identify the cases prior to a hearing, and do work on them in advance. The case goes to me or to another legal convener and we review what the issues might be. The issue could be capacity—a person might be unable to instruct a solicitor. We consider what could be done at an earlier stage. The tribunal decides to suspend somebody's liberty only when it is satisfied that regard has been had to the principles that you mentioned. The information in medical and social work reports often addresses such issues, so it will be clear at that stage whether there is an issue, such as someone's ethnic background. Such reports require to be read before a hearing. We do an awful lot to ensure that a case that comes to a hearing is at its best-prepared level and we can deal with it at a single hearing.

The first principle that I established in the tribunal was that a case should come before the full tribunal only once, when that is appropriate. However, because of the principles, we require sometimes to reconvene to have the appropriate information to make a decision.

Elaine Smith: That is fair enough, but it might be better to have the appropriate information in the first place. We are trying to tease that out.

Dr Morrow: I do not want to comment too much on that. We would be delighted to have the appropriate information before us at a hearing, but we do have a semi-inquisitorial role.

I say with respect that, 30 years ago, I was involved in similar discussions about how to co-ordinate all the bodies that are involved to provide the information. We are a judicial body and we can work only with the information that is given to us, although we have a semi-inquisitorial role that allows us to go beyond that.

When I started in mental health law almost 30 years ago, I had similar discussions about how to co-ordinate the provision of information. I welcome such discussions today because, if the focus is kept on the issue and the accelerator continues to be pressed, we will have much better information with which to improve our service and our tribunal's decision making.

Elaine Smith: Does any other witness feel that the equality principles that are enshrined in the act have generally been reflected in the act's implementation?

Graeme Henderson: The information that arrives before the tribunal is often put together hastily in the few days before the deadlines apply. I think that most paperwork arrives just a few days before the tribunal is due to hear a case—perhaps Dr Morrow can confirm that.

Dr Morrow *indicated agreement.*

Graeme Henderson: There is a rush. There might be lots of information about patients around, but it does not all arrive in as much time as we would like.

Dr Morrow: Convener, do you want me to explain that process or are you happy for me to leave it there?

The Convener: We will move on, because we have many questions, but it would be interesting to know whether there are any usual suspects—for example, is one department always late in providing information or do you always have to go back to one area for missing information? You have the opportunity to highlight that in the hope that the recommendations that stem from the review will take that on board.

Dr Morrow: I have no usual suspects for you.

The Convener: What a shame.

Willie Coffey (Kilmarnock and Loudoun) (SNP): I will continue the theme of the difficulties with monitoring and information quality. Monitoring the implementation of the equality duty must be difficult if you do not have the breadth of information that you require and particularly the information on the equality strands. Dr Grant mentioned difficulties in gathering information on ethnicity, to which Dr Morrow referred. What should we do to improve the situation? Should gathering equality strand information be a legal requirement in the act?

Dr Grant: There is a legal requirement to collect ethnicity data but no requirement to do so for the other diversity strands. However, even though people are required to collect ethnicity data, they are not doing so. An awful lot of awareness raising is needed. The mental health and race equality partnership and its networks are well aware of that. However, they tend to be preaching to the converted—the people who go to meetings really want to know a bit more about what they know about. Involving the invisible people is the challenge.

Willie Coffey: If the collection of data is a requirement, what should we do to improve that?

Dr Grant: The Mental Welfare Commission is working on that. Ethnicity data are recorded in about 70 per cent of cases, whereas that was done in only about 15 per cent at the beginning. The commission also has a research project to link those data with community health index numbers. Encouraging work is being done, although it is not there yet.

Willie Coffey: Claire Sweeney mentioned a common theme for Public Audit Committee members in many Audit Scotland reports, which is the quality of information gathering. When we hear from Audit Scotland at that committee's meetings, it brings a consistent message about that to the table. All the service areas in government desire to improve data collection and not to prepare reports at the last minute—Mr Henderson mentioned that. We hope ultimately that improvements will be made, which will enable us to plan services better for the future.

Bill Kidd (Glasgow) (SNP): I do not know the time for which people are in general detained by the tribunal, but are internal audits run in that period, when someone is consistently available for the collection of information? The information on patients might not be available when decisions are being made at the beginning, but is it built up over a period or is it never collected?

Claire Sweeney: Audit Scotland's work was more general than just the acts—it covered the whole of mental health services. We found in our fieldwork a lack of understanding about and attention to the issues. Collecting some information is a requirement on bodies, but the messages that have emerged this morning are echoed in our work.

Hugh O'Donnell (Central Scotland) (LD): In his enthusiasm, my colleague Mr Coffey has pinched a couple of my questions, but I can live with that—I am never short of questions. I will return to monitoring. Will you clarify what monitoring—if any—takes place outside the commission's role? Do other bodies monitor the strands? If so, do you receive that information?

Dr Grant: Ethnicity data are supposed to be recorded, but other strands might not be monitored, recorded and passed up. Such information is largely in case records, but it is not routinely collected or added up, as far as I know.

Hugh O'Donnell: No organisation other than the commission has a statutory obligation to provide such information to anyone.

Dr Grant: That is the case, except for ethnicity information.

Hugh O'Donnell: So none of the other strands is covered.

Dr Grant: Information that relates to age is monitored, but the impact of age or whatever is not specifically monitored. Age is an interesting aspect. The focus always seems to be on young people, but a bit of concern is felt about older people. Despite the larger numbers of older people who are involved, they tend to be more invisible. Why they are admitted and who looks after them are subject to some debate. Another issue is the use of the 2003 act versus the Adults with Incapacity (Scotland) Act 2000—de facto detention and so on. Complicated issues are not being addressed but should be.

Hugh O'Donnell: Is it fair to say that, because of the circumstances that you have described, we cannot be sure that the equality duties are being met?

Dr Grant: We cannot be sure.

The Convener: In recent years, the number of older people who are detained has risen. The commission has a little bit of concern that older people—especially those with dementia—have been de facto detained in hospital, without the rights and protections that the 2003 act confers. As you mention older people, are you also concerned about that?

10:30

Dr Grant: Very much so. Again, though, that issue has been around for a long time. I had an interesting discussion with the commission in that regard. The pattern is changing a bit, because it used to be that doors were locked in dementia wards to stop people wandering out. Concern arose about that, so locked doors were replaced by doors that were hard to open—do you see the distinction? They were replaced by doors that are opened using a key pad or that have different kinds of locks that nobody can really open—or doctors cannot. [*Laughter*.] That was a compromise to maintain a person's human right not to be locked up if they could manage to get out. I think that that might be happening more often as we get more sophisticated ways of opening and closing doors. Obviously, somebody with dementia might not have the cognitive or practical skills to use such ways.

I do not think that this is official, but the commission's idea is that somebody can be kept in such a ward under the 2003 act if it is just to stop them wandering and they are not definitely trying to get out. However, if a person wants to get out and go some place but is prevented from doing so, that becomes less legal—if something can be less legal. That is therefore one of the things that maybe should be considered.

The stigma for older people of being legally detained is so horrendous that I think people bend over backwards to help them not to go through that procedure. The Adults with Incapacity (Scotland) Act 2000 is not seen quite as negatively as the Mental Health (Care and Treatment) (Scotland) Act 2003 in that regard.

Marlyn Glen (North East Scotland) (Lab): The Mental Welfare Commission highlights specific examples of disparities in service use across the different equality groups. For example, men are more likely to be admitted under long-term civil orders and criminal procedure orders; women are more likely to be detained under emergency orders; and young girls are more likely to be admitted to specialist adolescent mental health care than boys are. I want to look at that in a bit more detail. To what extent do such disparities in service use indicate an underlying level of direct or indirect discrimination, or do they reflect different needs?

Claire Sweeney: I am not particularly focusing on the 2003 act, but one of the general issues that we highlighted in the work that we did last year was the variation around Scotland in a range of different measures in relation to access, services and staffing levels in particular councils and NHS board areas. I do not think that there was a real sense of planning that was based on different local needs. There were certainly some issues around capacity, and we had questions about how services were planned around local need. Our report also touches on the single outcome agreement arrangement and the issue of services being designed to fit with local need. Certainly, that needs to be tracked through. It was a very early stage for us to look at the issue but we will continue to take an interest in how that evolves.

Dr Morrow: Mrs Glen's analysis of the categories that come before the tribunal and the ways in which they are dealt with accords with my experience. The care plans that come before the tribunal are usually linked to the individual—they are particular to them. They are not generic care plans to provide X, Y and Z; they say that A, B and C will be provided because the person requires that care. I sit on the tribunal approximately twice a week in different parts of Scotland—I have not managed to get to the islands yet, but I intend to go to see the services there—and there is huge diversity in provision. However, provision is very much tailored to the individual within what is available in the area. For example, as far as possible, appropriate services will be built around a young person who is detained on a ward. That does not mean that the system is perfect, but a lot of good work that is focused on the individual is going on in the caring sector in our communities. When the individual comes before us at the tribunal, we are interested in them and whether the services are appropriate to them, given the possible suspension of their liberty.

Hugh O'Donnell: You enunciated very clearly the person-centred planning principle that has been standard procedure for a good number of years—and thank goodness for that. However, you specifically referred to person-centred planning that is based on what is available "in the area". If you can offer only what is available in the area, that seems to be contrary to person-centred planning. Is that the case, or have I picked you up wrongly?

Dr Morrow: I do not think that you have picked me up wrongly. I am not critical of the care provision that is available on the ground. However, the very complex demographics of Scotland sometimes mean that it may not be possible even to bring people together for group work in an extremely rural area, because of where people live and their individual choices. A care plan sometimes involves the person coming together with others in socialising group work. However, if they live in a remote part of Scotland, that can be difficult to achieve. That does not mean that such work is not recognised as something that should be done. If you have followed the debate around mental health, you will know that people in certain areas have undoubtedly had difficulties in obtaining clinical psychology services. That is beginning to be addressed—we see that at the tribunal regularly, with more clinical psychology provision. I am exploring such areas when I say that provision depends on what there is in the locality. However, there is a high level of service provision for those who come before the tribunal; they are the acute end of the mentally disordered, so a lot of provision is made.

What excites me about the work is the imagination that local providers can put into it. They try very hard to get something that will allow a patient to move forward, step by step. That imagination is obviously put to work in the context of what is available to them in the area. A long time ago, I was mental welfare commissioner for the Highlands, and it was a job then to get consultant psychiatrists to go to the Highlands to work. There was sometimes just a lack of bodies on the ground. That is not a criticism, and it does not mean that it was an attack on any equality issues. Sometimes, that is just the reality of the situation—that is what I am talking about, rather than any deficit.

We have a mechanism to tackle the deficits—we record such matters. If we think that there is something missing from the patient's care in terms of their detention, we can record that. That comes back to the tribunal to be dealt with after a period during which we see whether something can be put in place. We have a mechanism for health improvement in the tribunal. I am trying to get that mechanism used in the next stage of the tribunal's activity—hence, there is training on recording such matters.

Marlyn Glen: I will tease out the two different aspects that I am trying to look at. I was going to go on to geographical discrepancies, which you brought up. SAMH's written submission states:

> "use of compulsory powers in Tayside is 23% higher than the average, while their use in the Borders is 34% below it."

Is that because of what is available in the area, or is there another reason?

My previous question was about disparities in service use across the different equality groups. I am reassured by what you said about treating people as individuals. However, statistically speaking, are men's needs just totally different from women's needs? I am not asking for equal treatment if people are different, but is there discrimination with regard to the different ways in which men and women, and boys and girls, are treated?

Dr Grant: That is a good question that is hard to answer, because there are two sides to it. The presentation of illness is different in the different groups, but I think that society's views and expectations of those groups are also different. For instance, people tend to be more afraid of men, perhaps for reasons that are accurate in terms of violence. Therefore, it makes a sort of sense that men are more likely to be under compulsory treatment orders. I do not really know whether that is the reason, however. Your question is a good one—you might know more about the issue than me. The number of women in prison is quite different from the number of men in prison, and they are treated quite differently. I suspect that the issue is as much to do with society's views of the different genders as it is with something that is the responsibility of clinical staff or their impact.

Claire Sweeney: I will just touch on the rurality issue and the discrepancies throughout the country—again, I will make a general point. When it considered our report, the Public Audit Committee was interested in resource transfer—the overall sense that there has been a real shift from acute services into the community and that mental health services have made progress on that. The committee focused on the differences in the pace of change across boards and councils in Scotland. That is something to be aware of, although there are lots of other issues at play. Certainly, this is about which services are available in the local area and the historical funding arrangements. I know that we are not here today to talk about the money, but it is a definite factor and something in which the Public Audit Committee is interested.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): I thank everyone for their useful evidence, particularly Dr Grant's comments about older people. However, we also have to focus on young people. An issue that comes up repeatedly is the admission of young people to adult psychiatric wards. Commitments have been made by various Administrations to reduce such admissions, and there was much discussion of the subject when the Mental Health (Care and Treatment) (Scotland) Bill went through Parliament. The problem remains, so I am interested in people's comments. Why are things going in the wrong direction? Are there sometimes occasions when admitting a young person to an adult psychiatric ward is the right thing to do? I presume that it is not the right thing to do in general.

Dr Grant: If a young person had to move 100-odd miles away to be admitted because there was not an adolescent bed locally, he would be removed from family, which would be an important factor given that treatment services are often family based at that age. The decision would be an individual one that was based on the person's need. It would also depend not just on the fact that there was a bed on the ward but on the available facilities—for example, whether teaching was available. That kind of thing is important. Private rooms and facilities make staying in an adult ward less difficult for young people. I do not disagree that, on balance, young people should be admitted to specialist adolescent units, but when decisions are based on individual need, there might be reasons for accepting that good service can be provided outside such a unit.

Graeme Henderson: Penumbra runs numerous youth services throughout the country. We would like to see more focus on prevention of mental ill health among youngsters. An example is our work around exam time with Eastbank academy in Shettleston in Glasgow, where we run workshops for secondary 5 and 6 pupils. As everybody knows, exams are stressful—particularly for parents, I must say; my daughter is doing her highers at the moment. If there was somewhere that people could go to talk—not just with guidance teachers and academic staff—about their mental health issues, we might prevent more serious mental ill health later on.

Dr Morrow: We deal with young people who are at the more acute end—thankfully, very few who come before the tribunal fall into the young persons category. A provision in the 2003 act says that as part of the tribunal's decision making we must ensure that there are appropriate services for the young person. I refer to Dr Grant's comments about the broader issues that we take into account, such as family circumstances and the supports that are available where the young person is, as well as simply whether there is an adolescent unit. However, the numbers seem to me to be bigger than you would think: in 2006, the tribunal dealt with 254 young people; in 2007, it dealt with 230; and in 2008, it dealt with 244. Although everybody tells me that those are small numbers, to me, they seem large numbers of young people and children. There are issues to be addressed in that regard.

If my memory serves me right, section 23 of the 2003 act puts an obligation on the tribunal and the health boards to provide appropriate services. I want to focus attention on that, rather than just on new units. We have experience of people being transferred away from their area. Once we have made a decision, that is it done, but if the order means that they are transferred away from the area, they might be taken away from local and family support.

10:45

We have recruited and trained specialist tribunal members to deal with young people and children. If someone is clearly identified as a young person, a convener, a psychiatrist and a general member who have been given additional training with regard to young people will be involved. We attempt to raise some of the equality and inequality issues around young people in detention through those specialist teams.

Malcolm Chisholm: Has Audit Scotland looked at the matter?

Claire Sweeney: Yes. There were concerns about waiting times for access to children's services and gaps in specialist services for children. We also highlighted concerns about how the transition from children's and adolescent services into adult mental health services was handled. We made particular mention of staff shortages as a barrier to the provision of comprehensive services to children and adolescents. Some data in the report give more detail about that.

Malcolm Chisholm: Thank you very much.

The Convener: I want to take up Mr Henderson's point about early intervention and the services that are sometimes not available in schools, such as dyslexia services. There is a growing body of evidence that says that, if dyslexia is not detected, that can lead to mental health problems, and sometimes criminal prosecutions can stem from its not being identified. Have you come across that?

Graeme Henderson: Yes. As I said, there is pressure on young people around exam time and often they do not have a mental health resource to go to. Where local voluntary organisations and charities would have worked with local schools as part of a community planning process, the pressure on public services throughout Scotland means that sometimes that service is no longer available. Resources are so tight that we are not able to go in and support youngsters.

Let me give a further example of our work, this time with Adam Smith College in Kirkcaldy. We have some money from the European social fund to provide counselling for further education students around their mental health and wellbeing because that counselling is not adequately resourced through the guidance teaching or counselling services that are available in colleges. There is a need to focus on mental health in that group.

The Convener: That is helpful.

Malcolm Chisholm: As you know, section 259 of the 2003 act says that every person with a mental disorder should have a right of access to independent advocacy. The McManus review looked at that and highlighted gaps for specific groups—people with a mental disorder in prison were one group, but there were others. I have a general question first. Just how bad do you think the gaps are? I also ask Dr Morrow to comment on a specific point, given that he probably saw in the *Official Report* of last week's meeting the suggestion that people were not being offered advocacy early enough before they came to the tribunal. That is a specific question, but the general question is about what people think about the gaps, how bad they are and who they are bad for.

Dr Morrow: I now have to explain to the committee the timescales involved, which I was directed not to do. Someone who is on short-term detention gets 28 days' detention, which they have a right to appeal. The bulk of applications for compulsory treatment orders—the bulk of the civil work that we do—come in on days 25, 26 and 27. We must hold a hearing within five days of the end of the 28-day period. You can see that sometimes we have only about six days in which to hold the hearing. You will also see that the McManus review suggests that the five-day rule—the five days between the end of the short-term detention period to the hearing on the compulsory treatment order—be extended to 10 days. Although the Government has not said what it will do in that area, it seems that the extension might assist with some of the equality issues, if nothing else, by allowing more time. It is not my place to say what Government policy will be, but I have already put that point to the review.

The speed that is required means that it can sometimes be quite difficult to engage an advocacy service in the process. If an application for a compulsory treatment order comes in on a Friday and is to be heard by the following Friday, it will be Monday before the advocacy service is contacted. The advocacy service will have to arrange to see the patient from its own resources. The timescale is quite short in that respect.

However, my experience is that advocacy services are usually engaged from a very early stage in the hospital review process that takes place every two years. As the review comes up, a much longer period of notice is given, which allows advocacy services to engage in the process. That means that when someone comes for a review, it is almost certain that there will be some advocacy input, and they will have a prepared statement. The timescales are one reason why it is difficult to get advocacy services engaged at an early stage.

Advocacy provision at the acute end is high quality. A lot is done to ensure that the patient is kept at the centre of the tribunal process. Advocacy services do a great deal to explain the process to the patient prior to the tribunal and to prepare statements that the patient or the advocate can read out at the tribunal. Significantly, they also explain what has happened. After we have given an explanation to a patient, we sometimes move on to the next case and the patient leaves. Advocacy addresses that inequality issue throughout.

The timescales are an issue. We are crushed by the amount of time that we have to deal with the transition from short-term detention to CTOs, but a high quality of advocacy service is provided to those patients who come before the tribunal with an advocate. It is most useful for the tribunal to have the views of the patient expressed in a way that helps it.

Malcolm Chisholm: Does anyone else want to comment on the gaps in advocacy provision?

Claire Sweeney: I have alluded to gaps in staffing, and a particular concern that we raised in our report was about mental health officers, the numbers of which vary across Scotland. There might not be enough mental health officers to deal with the work. In addition, their role has changed in that they now take on more general social work tasks as part of their job. The gaps around mental health officers that we identified are worth mentioning.

Christina McKelvie (Central Scotland) (SNP): Good morning. Dr Morrow mentioned the McManus review, to which the Government has not yet responded. He identified a measure that he would like to be taken. What other actions to address equalities issues would you like the Government's response to the McManus review to contain?

Dr Morrow: Are you asking me in particular?

Christina McKelvie: No—everyone.

Dr Morrow: I have made one suggestion; I will come back in after others have made theirs.

Claire Sweeney: The Audit Scotland report made a series of recommendations to the Scottish Government, NHS boards, councils and their partners. I flag up the gaps in the information that is available in this area, which is an issue that has emerged during this morning's evidence.

Graeme Henderson: The need for training and support for named persons is mentioned in the report, which contains quite a lot of recommendations on named persons. The report also identifies quite a number of other issues. In my experience, named persons turn up at hearings who are not best prepared and who are quite stressed by the whole event. A hearing can be quite stressful for the named person as well as for the patient. I would like more emphasis to be put on the provision of training and support for named persons.

Dr Morrow: I repeat that the core of our work is our judicial role. Our purpose is to ensure that the system for dealing with people's detention is just, fair and timely. The more information that we can be given on the equalities issues that Christina McKelvie has raised, the better the decision we will be able to make and the more we will be able to focus on the patient. Anything that the review does with regard to the provision of such information must fit in with my theory about our offering therapeutic jurisprudence as we go forward. I hope that the review will consider the co-ordination of the provision of such information to us.

Aside from the review, I know that the committee will have a massive amount of legislation to look at on equalities issues, but I would welcome it keeping its foot on the accelerator on the 2003 act, particularly on the co-ordination of information, because that focus on information will enable my tribunal to provide a better service for people who are mentally disordered when their detention is at stake. Keeping a focus on equalities issues as they relate to the mentally disordered is not just an issue for the act.

The Convener: You will probably be aware that our post-legislative scrutiny of the 2003 act was triggered, in part, by our inquiry into women in the criminal justice system and the concern about the number of prisoners in Cornton Vale who have mental health problems. I notice that the tribunal deals with cases of restricted patients—in other words, patients who have entered the mental health system through the criminal justice system. Would you like to comment on that? There seems to be something missing in that regard.

Dr Morrow: As you know, the courts make the hospital orders. Once a hospital order is made, a compulsion and restriction order is placed on the patient. They cease to be part of the criminal justice system and come under the jurisdiction of the tribunal. Before they can be stepped down from one level of security to another, they have to come before the tribunal and if they are to be discharged, the tribunal must do that—in other words, they do not go back to court for that to happen.

The vast majority of people with whom we deal—the percentage is well into the high 90s—are men. Very few women are held on compulsion and restriction orders. I do not have the figures for that, but I could have them sent to the committee, if you require them. We adhere to the Millan principles on non-discrimination in how we deal with people who are subject to compulsion and restriction orders.

The Convener: It would be helpful to know whether anyone is ever referred to you from Cornton Vale, because it is clear from their behaviour that the problem is overwhelmingly a mental health problem as opposed to a violence problem or a protection of the public problem.

Dr Morrow: I am not conscious of such referrals, but it is the case that women who have been in prison come before the tribunal. I do not know of any case in the past year of a woman from Cornton Vale having been referred to the tribunal, but that could happen if someone was under the appropriate order.

The Convener: If it was thought that Cornton Vale was not the appropriate place for a person to be, would approaching the tribunal be the obvious next step, or could some other action be taken?

Dr Morrow: By the time that someone gets to the tribunal, they are normally in a hospital setting. We deal with people who are in a hospital setting. They might have been in prison, but following the issuing of a hospital order, they have been put into a secure unit, which is when they come before the tribunal.

The main powers that we have relate to excessive security. If someone is held in excessive security in the state hospital, for example, we can make an order that identifies that they are being held in excessive security and they can eventually be moved into a medium-secure unit. Almost all our patients are held in hospital settings. There are a few overlaps—someone who is subject to a hospital order might also be under the court's jurisdiction for an offence for which they would be held in a prison—but most of the people with whom we deal are in a hospital rather than a prison setting.

The Convener: I understand that the only secure hospital in Scotland, Carstairs, no longer takes women prisoners. Is that a problem?

Dr Morrow: I understand that the last woman who was in Carstairs as a patient has been moved back to her health board area, because she was thought not to require the level of security that Carstairs provided.

The Convener: There is a subtle difference between saying that the last woman patient has been moved from Carstairs and saying that Carstairs no longer admits women prisoners. My understanding is that the latter is the case. Is there a potential gap there, too?

Dr Morrow: I do not mean to be picky, but Carstairs never admits prisoners; it admits patients. That is important, because the language is about therapeutic jurisprudence.

The Convener: Well, patients, then.

Dr Morrow: I did not want to argue with you about it. My understanding is that provision is being made for women in localities, rather than in Carstairs, where the patients have been predominantly men. I was part of the oversight of the last woman to be removed from Carstairs back to her local hospital.

Each case in the tribunal has to be dealt with on its merits. Dr Grant indicated to the committee that the perception in these situations is sometimes that men are more violent than women, and that men are more of a risk than women. The development of the medium-secure unit in Scotland has gone apace. There is now one in Edinburgh and one in Glasgow, and a new one is being built at the Murray royal hospital. Those facilities will be available across the forensic network with regard to those who are mentally disordered.

The Convener: Any additional information that you can give us on that aspect would be very much welcome.

We have gone past 11 o'clock, when I intended to end the session, but does Dr Grant want to add any brief comments, given that she highlighted that issue in her written submission?

Dr Grant: One of the issues at Cornton Vale is that some of the people are not seen as suitable for mainstream hospitals because of the mammoth amount of self-harm and personality problems. Psychiatrists get into issues about what is mental illness and what is not. It is quite complicated.

The only other issue that we have not touched on is that of interpreters and translators. I was glad to hear Dr Morrow say that there are a lot of skilled people in the tribunal. However, elsewhere in the service that issue raises a major problem in terms of communication and information sharing.

The Convener: Thank you. We will pick up that issue with the minister. I thank the witnesses for attending. It has been a worthwhile session.

11:02

Meeting suspended.

11:06

On resuming—

The Convener: The second item on the agenda is evidence from the Minister for Public Health and Sport on the Mental Health (Care and Treatment) (Scotland) Act 2003. I am pleased to welcome the minister Shona Robison, and Geoff Huggins, head of the mental health division at the Scottish Government.

The Minister for Public Health and Sport (Shona Robison): I want to use this opportunity briefly to outline to the committee some of the activity that has got us to where we are now with the review of the 2003 act. The main provisions of the act came into force in October 2005. The act has generally been well received, and its approach and principles are popular. As a reminder, the act was based on 10 principles, including equality, non-discrimination, respect for diversity, participation and child welfare.

However, some concerns have been raised about the operation of the act in respect of named persons, advance statements, multiple hearings and the patient experience of the process. We took note of people's concerns, and in January 2008 I appointed a review group, chaired by Professor Jim McManus, to undertake a limited review of the act to consider efficiency and patient experience of the act.

The review group reported to me in March 2009. We published a consultation on the review in August 2009. We had 82 responses to the consultation, and the analysis, along with the research findings, were published on the Scottish Government website earlier this month. I intend to use the responses to the consultation to consider future policy development. Any changes to the act will require primary legislation. My colleagues and I will consider that as part of a future legislative programme. I will also consider changes that are possible through, for example, practice guidance and secondary legislation.

I hope that that short summary is helpful in setting the context for the review. I am happy to take questions.

The Convener: Thank you for that statement. You will be aware that in the written submissions, and in oral evidence that the committee has heard, a number of key concerns have been expressed, one of which is on the equality monitoring data that is available. Given the gaps in monitoring, how can the Government be sure that the equality duty and principles in the act are being met, or that there has been progress towards them?

Shona Robison: I recognise the issue. Information services division statistics show that progress is being made, but there is still further progress to be made. In the latest ISD statistics, the overall headline is:

> "For Scotland as a whole there have been substantial improvements in the recording of ethnic group. Completeness of recording approximately doubled between mid 2008 and mid 2009 for both hospital discharges and new outpatient appointments."

That is one example of boards' awareness of the need for better monitoring in order to produce statistics so that we know whether we are going in the right direction. There are still challenges, but the position is improving. Obviously, there is still more to be done.

The Convener: Given that there is still more to be done, does the Government have any plans to improve the equality monitoring data?

Shona Robison: We continue to work with health boards. Our performance management arrangements are pretty robust. Geoff Huggins and his team meet boards twice yearly to discuss a range of matters, including the focus of policy development and boards' implementation of, for example, child and adolescent mental health services, which is a key issue on which Geoff and his team will be pressing health boards. The team has also been working with health boards on data quality for quite some time.

Geoff Huggins (Scottish Government Primary and Community Care Directorate): So far, the committee has largely been looking at the information produced by the Mental Welfare Commission for Scotland or the Mental Health Tribunal for Scotland on their monitoring of their activity and their monitoring duty under the 2003 act. That shows that the information that we have on age and gender is good, but that which we have on ethnic origin is weak across the system.

We collect statistics that go beyond the data or activities under the act. We record two key areas of activity. One is discharge episode records, which are for people who leave services having been admitted. We also collect outpatient appointment data. When we looked at that in 2006-07, we identified that the quality and range of information was very low. We met ISD, and it has been meeting boards to improve monitoring across the system so that people understand the general duties under the legislation and also improve the system and understand the value of the information to service development and design.

As the minister said, from summer 2008 to 2009, we have seen significant improvements in the quality and completeness of the data. However, those improvements relate largely to six or seven boards, not to all of them. They tend to relate to the larger boards such as Lanarkshire NHS Board and Greater Glasgow and Clyde NHS Board. However, that shows that, with attention and application, we can significantly improve the data that we collect in those areas, and we intend to take lessons from those success stories and apply them to the other boards.

The Convener: There has been a heavy reliance on health boards, but the duty is wider than that and includes medical practitioners, nurses and, to an extent, local authorities. Is there any intention to go back to those people who have a duty to find out more about gaps in the data and how they can be plugged?

Geoff Huggins: We track data at different parts of the patient journey, and we use the data in different ways. The data that we produce from the Scottish morbidity rate returns largely give us an understanding of what is happening across the system, such as the range of different ethnic groups that are seen within a particular geographic area.

At the local level, we expect the day-to-day offering, reach and nature of the services that are available to be built into the development of local plans. However, that is not subject to the same reporting and monitoring, if it is being given attention.

Over the past two years, we have funded through NHS Health Scotland a piece of work on primary care settings that has two objectives. First, the fact is that people from certain ethnic communities are less likely to seek help, particularly with mental illness, because of stigma or uncertainty about the response that they will get. Through this work, which is being piloted in north Edinburgh and south Glasgow, we have been trying to improve the reach of services and understanding about how to work with different communities.

11:15

Secondly, we are looking at the nature of our response to those who come forward and how it might have to differ from our response to the general population. For example, how might approaches such as cognitive behavioural therapy vary according to cultural differences? Also, we might have to take into account different cultural approaches to medication when designing systems. We have developed those as learning approaches to give us a better understanding of what we should be doing and to allow us to generalise that work.

We have also supported collaborative work that NHS Health Scotland has undertaken in Alaska with Cook Inlet tribes and in Toronto, where similar questions of dealing with different ethnic and cultural groups have arisen, to see whether any issues or approaches might be translatable.

Hugh O'Donnell: You have focused on ethnicity, but how are you addressing other equality strands, such as physical and learning disability, religion and gender? The danger with focusing on only one strand is that one might inadvertently discriminate against others.

Shona Robison: Are you talking about data collection?

Hugh O'Donnell: Yes.

Shona Robison: Geoff Huggins made it clear that particular problems had arisen with ethnicity and highlighted the various reasons for that. That is not to say that no challenges have emerged in other areas, but ethnicity was regarded as the weakness in the data collection and the steps that we have taken and the work that Mr Huggins has outlined are a response to that. We have collected pretty good data for many of the other areas, particularly age, although Geoff Huggins might have something to say about physical disability.

Geoff Huggins: There are some data on that, but I think that the stronger and bigger connection is with the learning disability group, on which we have been doing a lot of work on the crossover between mental illness and learning disability and on co-morbidity, and trying to identify different service models. This particular population is going to grow for a range of reasons, not least because of the increased longevity of people in both groups—people who previously would have died in their 40s and 50s are now living into their 60s, 70s and 80s. Although that progress is to be welcomed, it poses greater challenges, which is why we have also focused strongly on learning disability.

We have probably focused less on physical health. That said, we track connections between general physical health problems and mental wellbeing because of the strong connection between the ability to address mental health and mental illness issues and the long-term outcomes that people get with regard to their other challenges.

Hugh O'Donnell: Do we track, for example, people who are affected by developmental issues such as autistic spectrum disorders, who are not classed as having learning disabilities but often have mental health issues? Are those people included in the learning disability sector, inappropriate though that might be?

Shona Robison: I think that the gathering of data on that will have been done under learning disabilities. "The same as you? A review of services for people with learning disabilities" covered learning disabilities and people with autistic spectrum disorders. I imagine that the same would apply to the statistics and data collection.

Geoff Huggins: The data will be recorded there, but there are particular issues about crossover, because people often have different diagnoses over a period of time. I am thinking particularly about people who are subject to compulsion orders under either the civil or the justice provisions. A range of patients have had a learning disability diagnosis at one time but at another time, following either activity, work or reconsideration, they have been identified as having a mental health problem. There is therefore a degree of crossover between some of the populations. In service delivery and design, that makes it important to understand the connections.

Shona Robison: One thought on this important issue is about adults with undiagnosed autism. We think that there is a high number of such adults in the prison population. The continuing discussions about transferring responsibility for prison health services to the national health service presents an opportunity to do something about those people who have gone through life without a diagnosis, which might be related to their offending behaviour. That is for the future, but it is worth while to flag up the opportunity.

The Convener: We have spent some time on the matter because it is fundamental to monitoring and implementation.

I draw the minister's attention to paragraph 4 of the written submission from the Mental Welfare Commission for Scotland, which states:

> "We have no quantitative data on other disability ... religion or sexual orientation".

I think that learning disability is looked at in part. The minister might want to look further into that.

Shona Robison: I am sure that we can pick that up.

Malcolm Chisholm: We have quite a few questions on advocacy. I will start off and then Hugh O'Donnell will take over.

The background is section 259 of the 2003 act, on the right to access to advocacy, and the McManus review, which focused on the issue. Certain gaps have been highlighted by that review and by witnesses. You might have seen the *Official Report* of our meeting last week. What is the Government's view of those gaps and what action can be taken to deal with them? Does the Government regard the matter as one for central Government or is it something for local provision?

Shona Robison: Obviously, we will not ignore the findings on advocacy. We will have to discuss how we go about addressing some of the concerns. I remind members that, as part of the implementation of the 2003 act, significant resources have been given to local government and health boards, and advocacy is an important part of that. In 2004, £13 million was given to local government as part of grant-aided expenditure to implement the 2003 act. That has, of course, continued. From 2005 onwards, £5 million was given to boards for implementation and, again, advocacy was an element of that. Since 2004, there has therefore been £18 million in the system to implement the act, of which advocacy is an important part.

Of course, there is a statutory duty, so advocacy is not something that may or may not be provided. The question is clearly therefore about how it is provided. I know that there have been issues about advocacy services that are appropriate, for example, for people who also have other disadvantages or for young people—in other words, people who require a particular type of advocacy service. Are our advocacy services appropriate to meet the needs of those sections of the population? Obviously, in more rural areas, the capacity of advocacy services to provide specialist services is limited. Beyond that, advocacy organisations also have concerns about the three-year funding cycles.

On the positive side, I can tell the committee that a piece of work has been carried out and a report has been published called "'Advocacy makes you feel brave': Advocacy support for children and young people in Scotland". I am not sure whether the committee has had a chance to look at that report, but it was published in January, and we will use it as a starting point to prepare a national plan of action to improve the quality, consistency and availability of advocacy support for children and young people. That is not exclusively for mental health services, but it will cover them.

I suppose that my short answer is that there is resource in the system but I appreciate that there are issues with the type of advocacy support beyond the generic and there are challenges in specialist support. We are taking action on the support for children and young people, but as ever there are challenges and we are aware of them.

Malcolm Chisholm: Thank you for that, in particular the information about the report on children and young people, which I am sure we will look at.

At last week's meeting, there was an interesting disagreement—I think that that is the correct word—about the definition of "independent advocacy", which you may have seen in the *Official Report*. The majority view was probably that it is clear, but some service providers for young people took a different view. Does the Government have a view on that controversy? I am sure that you are aware of it.

Shona Robison: I am not sure that I have a view, other than to say that we need to provide the widest choice for people who require advocacy services, but we can do that only within what is a difficult public finance context—we cannot get away from that.

The onus is on us all to do what we can to address some of the major concerns. As I have already said, we have a really good report on the needs of children and young people that we can use to take forward some work on that group. Children and young people have particular needs, and it is fair to say that we cannot assume that the skills of some organisations in providing a service to adults will be transferable to meeting the needs of children and young people.

Malcolm Chisholm: I have one other question. The witnesses last week, from Advocacy Matters for example, highlighted particular problems in people from black and minority ethnic groups accessing translation and interpreting services when they use advocacy services. What is the Government's view on the level of provision, and what can be done at either national or local level to address any issues?

Shona Robison: Geoff Huggins may be able to help on that.

Geoff Huggins: First, may I pick up on the previous question about advocacy for young people? In mental health services for young people, we often see a reluctance, which is probably a shared reluctance, to diagnose and formally to identify somebody as having a mental illness. That produces a degree of ambiguity about access to advocacy. There may be good reasons for that. There may be many things going on in a young person's life that manifest as chaotic or difficult behaviour, which may show the substance of an illness but may be caused by other things.

The more general approach to young people's and children's advocacy may be stronger in reflecting and respecting that uncertainty and reluctance. The answer could be that we end up with a different approach for that group from the approach that we take with adults. That is one of the issues that we want to explore as we look further at the material on the review of the 2003 act and take forward the broader work on children's advocacy. The model in the 2003 act may not be the right one.

11:30

Shona Robison: I come back to translation and interpreting services. You might be aware that NHS Health Scotland has undertaken a piece of work on the issue and has been discussing a more co-ordinated, NHS-wide procurement of quality translation and interpreting services. It has agreed a strategy in which all health boards will work together to secure improvement in the four areas of translation and interpreting provision: written translation, face-to-face interpreting, telephone interpreting and British Sign Language. We recognise that service is patchy—it is good in some areas but not so good in other areas—which is why we are ensuring that no matter where someone lives in Scotland, and whether they are from a BME community or whether they have a sensory impairment, they should be able to access an interpreting service.

On sensory impairment, I highlight the fact that a pilot programme is under way to test a BSL online interpreting system in several NHS boards. We are keen to use technology where we can to overcome the practical barriers that people face. However, in the arena of mental health, where people who require the service have a need for discretion, a face-to-face service may be more appropriate—it depends on the circumstances and the person's needs. I am aware of, for example, the inappropriate use of family members when no other interpreter has been available. That can be distressing and means that there is a complete lack of confidentiality, even though the person may be discussing family issues.

We are aware of the issue and work is under way to ensure that we have a much more consistent service. I hope that we will be able to keep the committee apprised of developments.

Hugh O'Donnell: Minister, you referred to the three-year funding rounds. Have you been made aware of any instances of advocacy translation services operating on a one-year funding round? If so, have you had any opportunity to make encouraging noises with regard to that? Also, I make a plea for Makaton to be included in the provision.

Shona Robison: I am not aware of one-year contracts, but I take it from your question that there may be some out there. The Government continues to make the point to those who commission and contract services locally that three-year funding deals and contracts are preferable because they ensure continuity. That is especially important for discreet services such as advocacy services. At the end of the day, however, those decisions are for local organisations such as local authorities and health boards to make. It would not be appropriate for me to comment on Makaton, but I am sure that your point was well made.

Hugh O'Donnell: Thank you, and I am sorry for sandbagging you. Makaton is a hobby-horse of mine.

The committee heard last week from various witnesses about the need to provide advocacy for particular groups. Forthright evidence was given on the need for carers' advocates. Should the right to independent advocacy, which is in the 2003 act, be extended to carers?

We heard challenging evidence about the extent to which advocacy services are firefighting. In other words, they get involved at the acute end of the process. That means that we do not have a preventive approach, through earlier intervention. Is that to do with funding, or does something else underlie the issue?

Shona Robison: I picked up from the evidence the issue to do with advocacy services, and I knew that advocacy services inevitably give priority to people who are subject to an order, given the time limits that operate, which means that other people might have to wait longer for advocacy. We must do what we can to address that, but I am not sure that we can completely remove the issue from the system, given that emergencies arise and someone who is subject to an order will require support and assistance then and there. Perhaps that is just part of the system.

I noted the evidence on carers' requirements. Carers have particular needs for advice and support, which are different from the needs of service users. Perhaps we could consider the issue in the context of the review of the 2003 act. The carers strategy might also provide opportunities to consider the issue.

Geoff Huggins: We have pressed the issue quite hard in the context of service development and design, in that under the general practitioner contract people who are caring for someone who has a long-term condition, including a long-term mental health condition, have a right to an assessment, which should take account of their physical and psychological support needs.

That connects strongly with the dementia diagnostic target that we are working with, which was framed with the intention of ensuring that not just more people with dementia but more carers of people with dementia would be identified, so that carers could get the support that they needed, in terms of their health and welfare.

As the minister said, the point at which there is most likely to be an advocate in the system is when someone goes before the Mental Health Tribunal for Scotland. At that point, the person's lawyer, named person, carer and perhaps guardian will be there, and the person will appear before three people who have their welfare in mind. It does not seem entirely right that that should be the point at which there is most likely to be an advocate in the system, because two months later, when the question is whether the person is getting all the elements of their care plan, those other people will no longer be there. We asked the McManus committee to consider how we might rebalance the process, given the amount of support and attention that is built into the tribunal process. That seems to be a challenging objective.

Hugh O'Donnell: Your observation about building into the legislative framework a right for carers to have an assessment was helpful. It is regrettable that although there is an entitlement to an assessment there is not necessarily a statutory entitlement to the services to meet the needs that are identified in the assessment. That causes major challenges, although I understand many of the reasons for the situation.

The Convener: The committee has taken a huge interest in that, as the minister will know. We eagerly await the strategy. It makes sense to identify carers' needs early—it would save the Government a significant amount of money.

Elaine Smith: In your response to Hugh O'Donnell's question about autism you mentioned the prison system. You will know that in our report "Female offenders in the criminal justice system" the committee called for the Government to shorten its timescale for transferring the responsibility for prison health services to the NHS. We thought that that recommendation was important. In its response to the committee, the Government confirmed that the transfer is expected to be completed by the end of 2011. You have mentioned that that is a matter for the future. Why is the transfer taking so long? Can responsibility for prison health care not be transferred to the NHS before the end of 2011?

Shona Robison: I will outline the process. The transfer represents a big undertaking and a big change. My short answer is that we need to get things right and ensure that they are done properly. John Ross, who is chair of the national programme board for prisoners' health care, is considering a number of issues, such as the models of care, finance, human resources, throughcare, which is important, and governance. All the health boards have nominated leads for prison health care, supported by their chief executives, and health boards, prison governors, community justice authorities and other local agencies have established local implementation groups to start the discussions on the transfer of responsibility.

In the meantime, we should recognise that health boards already provide specialist services to prisoners, and that will continue to be the case. We are talking about a fundamental change to primary legislation to give effect to the transfer. Having taken all of that into account, and given all the work that must take place in the run-up to ensure that the transfer happens smoothly and properly, we believe that a 2011 timeframe for the transfer is reasonable.

I highlighted an area in which there are opportunities, but the biggest opportunity by far lies in getting throughcare right. The health service will have intimate knowledge of the health needs of each and every prisoner. Unfortunately, at the moment, there are opportunities for people to fall through the gap between when they leave prison and access health care in whichever board area they go back to. In the new system, there will be huge throughcare opportunities, but we need to ensure that all the systems are established.

In short, the timeframe is reasonable to ensure that we get things right. We are talking about a big change in the provision of prison health care.

Elaine Smith: I suppose that the situation is the other way round for people who are going into prison. Their health needs must also be addressed.

Shona Robison: Absolutely.

Elaine Smith: The committee is concerned to ensure that the issue is prioritised. You mentioned a change in primary legislation being required. Does that still have to be addressed? It will have to be done while all the planning is going on. When will the change occur?

Shona Robison: Given where we are in the parliamentary session, I think we are looking at the matter being an early priority for primary legislation in 2011-12 to allow the transfer to take place at the end of 2011. Such a big piece of legislation would have to go through in 2011-12—trying to rush it through this year would be extremely challenging, given all the other legislative challenges that are in the system. This is a big undertaking and we want to get it right. I therefore see it being an early priority for 2011-12, with transfer taking place at the end of 2011.

11:45

Elaine Smith: I do not know whether I have missed something, but it seems to me that all this work is going on with an end date in sight but the primary legislation is not in place. What if the Parliament votes in such a way that the legislation does not go through?

Shona Robison: You do not just wait for legislation to take effect; you must do all the groundwork to establish what changes are required to ensure that the legislation underpins the new system. The on-going work, the workstreams and the work that John Ross is doing will inform the primary legislation that is required to ensure that the transfer can and does go ahead. Legislation does not just appear; it is a result of informed discussion and work. The workstreams on, for example, governance, finance and the models of care will feed into the legislative process.

Elaine Smith: And then, when the bill appears, it is necessary properly to go through the consultation process, stage 1, stage 2 and the remainder of the parliamentary process, so 2011 is beginning to look very ambitious. That worries me.

Shona Robison: A lot of the work that will inform the consultation and the legislation will have been done by that stage. The consultation may throw up other issues, but all the people with a stake in this are already round the table and inputting into the workstreams. It is right and proper that that work takes place now. That will be the bedrock of the legislative proposals that emerge and a consultation process will have to be undertaken on the back of it. I can make Elaine Smith and the committee aware of some more detail about the workstreams and how that work will feed into the rest of the process.

The Convener: That would be helpful because we are given to understand that responsibility for prison health care will be transferred but we are having difficulty understanding the 2011 date and where the legislation that achieves that aim fits in. Any further information that you can give on that would be welcome. Elaine Smith’s point about the evidence that we have taken indicating that throughcare is not the only issue was well made; we have taken pretty horrific evidence of prisoners turning up not knowing where or who they are and medication not being available when they are taken into custody. We are hopeful that the NHS taking on responsibility for prison health care will help to solve that problem. That may be another issue to investigate.

Bill Kidd: The SAMH submission cited figures that show that the number of admissions of young people to adult psychiatric wards has increased. A commitment was made in 2006—under the previous Administration, but obviously it was to be carried through—to halve the number of such admissions. Why is the trend in inappropriate admissions of young people to adult psychiatric wards going in the wrong direction? What will the Government do about it? When can we hope to halve the number of such admissions?

Shona Robison: This is an important issue. As you point out, in 2008 there was an increase in the number of admissions to adult wards, from 142 to 149, but it is fair to say that until then the number was going in the right direction.

We think that there are several reasons. The highest number of such admissions is of young males aged 15 and over. They are usually for short periods at times of crisis and when there is concern about the safety of the young person or the safety of others. It is absolutely right and proper that we reduce the number of such admissions, but I was interested in the comments of the Mental Welfare Commission for Scotland last week: it said that, on occasion, an adult ward might be the best place for a young person—probably a young man—if his safety or the safety of others might be compromised in a children’s environment. So, although absolutely the right direction of travel is to minimise the number of times young people are admitted to adult wards, there may be instances when such an admission is in the young person’s best interests. It might also be better for a young person in the Highlands who has to be in for a short period if the alternative is to take them to the unit at Dundee—they might need only a very short stay in an adult ward in the Highlands. Sometimes, judgments will have to be made about what is in the interests of the young person. Nevertheless, the direction of travel is absolutely as you state, and a lot of work is going on to take that work forward.

Around the time when the figures were gathered, some major changes were happening with the format of services, where the services were located and where they were provided. The closure of the in-patient facility at Stobhill may have had an impact as, between that facility closing and the new facility in Skye house opening, admissions were redirected to adult facilities. There was a period between the closure of the Stobhill unit and the opening of Skye house when people were transferred to adult facilities. I hope that, in 2010, the figures will settle down, now that Skye house is open.

A lot of effort has gone into the service and more beds are now available in young people's units. I hope that, with the investment in CAMHS, we can also prevent children and young people from ending up in a hospital bed. When they do end up in a hospital bed, it should primarily be a young person's bed; nevertheless, on occasion—I stress that it would be only on occasion—a very short stay in an adult ward may be in the best interests of the person or of the safety of others. That will happen only occasionally and should not be the norm or happen routinely.

Bill Kidd: Thank you for that reply. There is obviously concern about the vulnerability of young people in an adult environment, especially one in which there are adults who have considerable difficulties with socialisation. The worry is not only about their safety being maintained there, but about their receiving the appropriate treatments. Are the appropriate treatments available at all times in the units that receive adolescents?

Shona Robison: Geoff Huggins will give some detail of the services that are available. Are you talking about the services that are available while the young person is in an adult bed?

Bill Kidd: Yes. Is their safety maintained and do they receive whatever services they should receive that are appropriate for their age?

Geoff Huggins: That is certainly an issue. Along with our clinical advisers, we in the mental health division go out to visit our colleagues in each health board twice a year, who are generally joined by their local government partners and members of staff from the voluntary sector. Over the past three years, admissions to adult beds has been a key area of discussion that we have used as a focus for CAMHS development.

Where the figure for such admissions has not changed, it generally reflects not a one-off failing but a failing in how the overall system is functioning. For example, as a consequence of an absence of intensive community services, people often become more unwell and might become particularly unwell during an out-of-hours period. Many of the admissions take place in the evening—quite often on a Friday evening—at a point when the concern is that the individual might pose a risk to themselves. The young person might be admitted as a protective measure, even though the likelihood is that the only place available will be in an adult facility.

We have focused on the structural changes that are needed to reduce such admissions and on what happens when such an admission takes place. In most cases, the admission will be for only two or three days, so questions about the on-going provision of age-appropriate care and support are not as significant as they might be for those who are admitted for long periods. However, we are concerned when there is no provision of CAMHS components that the Mental Welfare Commission has identified as being services that it would expect to see for young people. Therefore, in addition to tracking the overall figure, we have tracked the degree to which specialist CAMHS inputs are available for services that are provided to young people. We are seeing an improvement in that line as well as an improvement in the overall figure.

Safety can be quite a difficult issue in both environments. When deciding whether to admit a person to a younger people's unit, consideration needs to be given to the safety of the other young people—as a caricature, we might imagine between a third and a half of the unit's patients being young women with eating disorders—before we admit, for example, a quite large 16 or 17-year-old young man who might be psychotic. That is probably what Donny Lyons was referring to when he talked about the need to be able to make the choice to admit elsewhere in appropriate cases. Both within CAMHS units and when we take the step into adult units, we need to be conscious of such issues in ensuring that appropriate protections are built in to how the service functions.

Elaine Smith: Perhaps Mr Huggins can confirm this point for me. I was a bit surprised to learn that there is no young persons provision in the NHS Highland area. Having lived and worked in the Highlands for a number of years, I cannot understand why such provision should be available in Dundee, Glasgow and Edinburgh but not in Inverness. Is it correct that there is no young persons provision in NHS Highland?

Geoff Huggins: As NHS Highland now stretches quite far south, part of its provision will be picked up within the Skye house unit in Glasgow and the other part will be picked up within the Dundee unit that is provided by NHS Tayside. Both those units will take admissions from that area.

The average admission period to a child and adolescent mental health unit is still in excess of 100 days; the period for which people are admitted is quite considerable. I do not know exactly how many of those in the Tayside unit might come from the NHS Highland area, but the unit is quite small so we might anticipate that the figure at any one time might be one, two or three people.

The question is whether, if we were to create capability within Highland, people would receive the best and most appropriate service. In mental health services generally, the trend has been to provide appropriate community services rather than to create new beds. I think that that trend applies equally to specialisms such as CAMHS as it does to services that deal with eating disorders.

Elaine Smith: Do you look at how many young people are admitted to adult facilities in Inverness? Would you flag up any concerns that you had about that? I can very well understand, as the minister said earlier, that it might not be in the best interests of a young person from Dingwall to go to Glasgow or Dundee. Are you monitoring that?

12:00

Shona Robison: It depends on what is appropriate for the young person. For a longer-term stay, it would be preferable for them to be in a specialist unit designed for that purpose; for one or two days—that is the scenario that I was painting—other options might be more appropriate, particularly if they are an older young person. The difficulty here, as with any specialist provision, is that the units have to be located somewhere that will serve the population of Scotland and they should have enough beds but, wherever they are, someone will have to travel to access them. When provision was considered, Dundee was seen as serving the north of Scotland. People in the southern Highlands would probably go to Skye house as their first option. It is important that the CAMHS investment comes in: we want to prevent as many children and young people as possible from having to access specialist units—the CAMHS in the Highlands will be very important in that respect. In addition, young people who are coming out of a specialist unit require support in the community. CAMHS investment is important from both ends: preventing admissions and what happens post discharge.

Marlyn Glen: The committee has heard evidence that there are geographical differences in the use of compulsory treatment. Donald Lyons from the Mental Welfare Commission for Scotland hypothesised that it may reflect inadequacies in community care provision. The issue was repeated by this morning's witnesses. Is the minister concerned about geographical differences in the use of compulsory treatment? Why do differences exist?

Shona Robison: I will hand over to Geoff Huggins in a moment. We monitor performance in each health board area carefully. The member is right to highlight that there can be variations in the decisions that are made and in the number of people accessing different services, but I can assure the committee that they are picked up and monitored with the health boards. It is fair to say that some health boards have strengths in certain areas and concerns in others. Geoff, do you want to—

Marlyn Glen: Before you bring in Geoff Huggins, I repeat the statistics:

> "Use of compulsory powers in Tayside is 23% higher than the average, while their use in the Borders is 34% below it."

There is a huge discrepancy.

Shona Robison: Geoff Huggins has been doing a lot of work with the Tayside folk.

Geoff Huggins: We have been looking at more general trends in admissions and readmissions and how people move through the system in both of those areas. The data about the use of compulsions sit within the broader use of in-patient resources. What we have seen in both of those areas is a continuing higher rate of readmissions compared with other areas in Scotland. The readmissions target, which is well on track to being achieved, is a 10 per cent reduction. At the moment, the figures that we have for Tayside suggest that it is probably the least well-performing board in respect of that target, but the next one after Tayside is probably Borders, which has a low use of compulsion. We have been trying to understand that and put it into a broader context. Donny Lyons's comments were interesting because he was quite careful not to make a judgment about the reasons. I have been reviewing what he said. He identified that it could be something to do with the balance between in-patient and community services, but he also said that it could reflect different styles and approaches by different groups of clinicians in their use of voluntary admissions. Another factor to which he referred is the exact degree of encouragement that clinicians apply to people to be voluntary patients.

The bigger picture is that, throughout the country, the overall figures for the tribunal show a decreasing use of compulsion since the introduction of the 2003 act. Although there is variation in practice and although 23 per cent might be seen to be a big figure, there is a question about the degree of variation that we should expect among 14 boards. We continue to consider the issue and to work with Tayside on the interaction between in-patient and community services, but at this stage it is difficult to produce a definitive reason for the figure.

Shona Robison: There is a theory, not just on mental health services but on health services generally, that the closer someone is to an in-patient bed the more likely they are to be admitted to one, and that services find alternatives for people who are not close to in-patient beds. That might be a rather crude theory but there is something in it. Despite that, I am going to contradict myself slightly because, in relation to the work that Geoff Huggins is doing with NHS Tayside and the questions about readmissions, Tayside is still at the high end on readmissions when compared with similar boards that serve similar populations.

We need to continue the work with Tayside and get the board to address the rate of readmissions. The board should ensure that alternatives to readmission to hospital are in place and that those alternatives are considered. Complex clinical judgments are being made, but we must ensure that people do not have different outcomes just because they happen to live in different health board areas. I can assure Marlyn Glen that clinical judgments that seem to be made more in one area than in another is a top priority; Geoff Huggins and his team are spending a lot of time working with boards, particularly Tayside, on the figures.

Marlyn Glen: Can you reassure me that you are working with NHS Borders, too?

Shona Robison: Absolutely. With any outlier, as we describe it, no matter what element stands out, it gets a lot of scrutiny and attention from the performance management structures.

Geoff Huggins: In both those areas, the mental health collaborative provides support to the boards in analysing and understanding their data and it works with them to support change. One particular issue in Tayside is probably the extent to which discharge planning is being done effectively. An issue with that might have the consequence that people do not receive adequate support and so then return more quickly than they should. Because we have been able to work with better data and closer knowledge, we think that we will be able to address issues more quickly. One big transformation in the system in the past three or four years has been to do with the availability of knowledge and information about what is going on. Marlyn Glen probably could not have asked her question four or five years ago in exactly the same way.

Marlyn Glen: We have discovered that about a lot of our questions. The monitoring is not good, so we cannot ask direct questions because we do not have the correct data.

The Convener: We take your point on that specific issue.

Willie Coffey: Minister, you will be aware that sections 25 to 31 of the 2003 act place a duty on Scotland’s local authorities with respect to care, support and the promotion of wellbeing for people with mental health problems. Given the tight economic climate in which we are living, are you satisfied that our local authorities are observing and delivering on those duties? If not, is there anything that we should be doing to ensure that monitoring and reporting take place to allow you to reassess the situation?

Shona Robison: Sections 25 to 31 of the 2003 act are clear about the need for access to general services. The Scottish recovery indicator asks service providers to assess themselves and measure how well they embed, promote and understand recovery. That is intended to drive system and behavioural change in services in order to improve them.

The local authority will use the system—as is the case with any self-improvement model, by its very nature—to drive its performance management and improvements. The monitoring of that lies, in effect, predominantly with the local authority. The Social Work Inspection Agency undertakes external monitoring to some extent, given its role in highlighting where local government services are performing well and where there are challenges, and it is obvious that local government takes the reports from SWIA very seriously.

We are referring to duties that are set out in legislation; they are not maybes. If the Mental Welfare Commission, for example, investigated a particular case and said to us that it did not believe that a local authority was discharging its duties under sections 25 to 31, we would raise that concern through dialogue with the authority and we would expect something to be done to improve the situation.

We are focusing on one set of duties in one piece of legislation, but many duties in most legislation that applies to local authorities fall under the category of self-monitoring and self-improvement; that is the system that we have. The system with regard to health is a bit different in terms of performance management arrangements, but if any concern were to be raised with us regarding a local authority not discharging its duties, we would discuss it with the authority in question.

Willie Coffey: Under any self-assessment framework, there is perhaps an inclination to report on the positive side. However, I would expect local authorities to be open and honest, and to speak up if they are not able to address certain issues rather than waiting for that to be discovered by an external body that is examining performance. I hope that authorities take up that challenge.

Shona Robison: Absolutely. The premise of the legislation was that the recovery indicator would set out explicitly the signs of a good service. Local authorities were enthusiastic about the inclusion of the indicator in the legislation to enable them to develop and drive up improvement in their own services.

Geoff Huggins: We encourage local services, including councils, to use the indicator under sections 25 to 31 and to follow the general principles of the 2003 act not only in relation to themselves but through involving service users, carers and others so that they get a collective picture. We do not require them to report to us on the indicator because we want them to use it for improvement. We want them to have a local dialogue about their understanding of what is going on so that they can take action on the situation. We think that embedding service user and carer perspectives in the indicator probably adds a different dimension and makes it different from what it would be if it were something on which they reported to us.

12:15

Malcolm Chisholm: This question is relevant to the debate that will probably take place on Thursday, because someone else has lodged the amendment to the Public Services Reform (Scotland) Bill that I lodged in committee and which I was persuaded not to lodge at stage 3. It is relevant because, strictly speaking, the Mental Welfare Commission for Scotland, which currently has a responsibility to monitor the operation of the act, ought to be monitoring the operation of sections 25 to 31. I cannot remember exactly what Donny Lyons said last week, but I think that he said that, in practice, it was not really possible for the MWC to do that, or to monitor the operation of lots of other aspects of the act.

If we accept that a change is to be made to the relevant wording that results in a move towards monitoring the principles of the act, perhaps it would be helpful if we were reassured that someone else would monitor those bits of the act that the MWC was not monitoring. Should the role of monitoring that part of the act—I presume that it would be exercised by social care and social work improvement Scotland—be made more explicit?

Shona Robison: You raise an extremely important issue. The truth of the matter is that the MWC has never had the necessary scope to do what was expected as regards monitoring. If it were doing all that work, it would not be able to spend the necessary time and attention on its core business—protecting the welfare interests of individuals. That said, if in going about its business the MWC discovers concerns about any service provider in relation to the operation of the act, of course it can flag that up to us. Importantly, under the Public Services Reform (Scotland) Bill, it will have a duty to flag up such situations to healthcare improvement Scotland or SCSWIS, which will be able to investigate further.

I think that I can give you the reassurance that you seek. In some ways, if the MWC is more explicit about that, SCSWIS and HIS will be more explicit in their focus on mental health services. I can certainly assure you that mental health will feature strongly in the work that we will do on the programmes that HIS and SCSWIS develop.

Geoff Huggins: The other issue is that, in effect, sections 25 to 31 parallel changes that were made to the equalities legislation on a United Kingdom-wide basis on indirect discrimination, in that the provisions might be read as requiring local government to take account of the needs of those who have, or who have had, mental disorder in the way in which they develop and deliver their general services. That is the territory of the equalities bodies, which are probably the group that is best able and best equipped to consider the extent to which mental illness is properly being considered in other contexts. I know that the human rights commissioner who was appointed by the Parliament is taking an interest in that issue, so it is probably already picked up in another area, where it should be dealt with effectively.

The Convener: That is helpful because, as the minister will be aware, the submission from SAMH expressed concern that the extent to which the local authorities meet those duties is very patchy. It said that they tend to concentrate on intensive support to the detriment of early intervention. That clearly has a cost implication, in that the later one leaves it, the more firefighting one has to do and the more expensive that is. In the current climate, I would have thought that it would be particularly important to address the issue and to ensure that early intervention is not neglected.

Shona Robison: Absolutely. I certainly hope that early intervention is highly visible and is focused on in the discussions that take place locally between health boards and local government on their joint plans. The convener is right—the evidence shows clearly that when early intervention services are good, that can help to avoid unnecessary admission to hospital, regardless of the context.

Christina McKelvie: I want to ask a few wee things about some of the amendments to the Public Services Reform (Scotland) Bill. Before that, however, I pick up something that Willie

Coffey said about referrals and specific groups. There has been sharp focus, over the past few weeks, on people seeking sanctuary in Scotland and their access to mental health services. I have anecdotal evidence that the UK Border Agency has only ever referred one individual in all the years that it has been involved with cases in Glasgow. What work is being done with local authorities and health boards to ensure that people are referred earlier, so that we do not have horrific consequences such as those in the case that came into sharp focus a few weeks ago?

Shona Robison: I will say a word about the sanctuary project, which was developed through NHS Health Scotland and contains three strands of work. The first of those strands is mental health awareness raising with asylum seekers and refugees through peer educators who are all refugees who have gone on to deliver group sessions with a wide variety of communities. Their job is to raise people's basic awareness of mental health and wellbeing, to challenge stigma and to signpost people to where they can go for support. The second strand is the training for mental health staff, which ensures that they are aware of the particular mental health needs of asylum seekers and refugees. So far, six sessions have been delivered with up to 10 staff in each session, and a resource pack is available. The third strand is a training DVD that captures the inside stories from asylum seekers and refugees themselves, showing the impact on them of poor mental health. Again, it is about raising awareness.

Geoff Huggins will say a little bit about the additional work that is going on.

Geoff Huggins: We have been looking more generally at the issues around trauma, which is one of the key issues that that particular population faces. Last week, we had a discussion with clinicians working throughout the NHS and people who are involved with asylum seekers and the sanctuary project about the extent to which we can improve the general offering around trauma, viewing asylum seekers as a particular focus within that. We are also considering issues around service structure and service redesign, as well as the interventions that we offer. There are two components to that. Quite often, people who have been subjected to difficult regimes or challenges in their lives will, when they experience health services in general and mental health services in particular, experience circumstances that feel similar or resonate. We need a better understanding of that before we get to the point of offering interventions, which is part of what the sanctuary project is doing.

When we met the Mental Welfare Commission a couple of weeks ago, we picked up the issue of the quality of services for asylum seekers. Generally, the experience is that those services are good and equivalent to the services for the general population. Nevertheless, we continue to dig into that and we are acutely conscious of the enormous challenges that we face in the area.

The Convener: That completes our questioning. Thank you very much, minister, for the evidence that you have presented to the committee. We have found it very helpful; I hope that our questioning has helped you equally. We look forward to receiving the additional information that has been promised.

I suspend the meeting briefly to allow the next set of witnesses to be seated.

12:24

Meeting suspended.

12:29

On resuming—

Budget Strategy 2011-12

The Convener: This is the first evidence session in the committee's brief inquiry, in which we will consider how we ensure that the provision of public services that are aimed at equality groups is adequately maintained during a period of tightening public expenditure.

I welcome Lorna Meahan, who is assistant director of audit services, central Government, for Audit Scotland; Martin Hayward, who is policy manager at the Equality and Human Rights Commission; Ann Henderson, who is an assistant secretary at the Scottish Trades Union Congress; and Angela O'Hagan, who convenes the Scottish women's budget group—Angela is no stranger to the committee.

The witnesses are aware that there is uncertainty about the future profile of the UK budget and how that will translate into the Scottish block. Do you agree with the projection that net public spending will need to be reduced by about 12 per cent during the next four years? If not, what is your assessment of the outlook?

Lorna Meahan (Audit Scotland): We have published a number of reports that are directly or indirectly concerned with how public bodies are responding to projections about public finances and potential reductions in spending. I refer in particular to "Scotland's public finances: preparing for the future", "Overview of the NHS in Scotland's performance 2008/09", "An overview of local government in Scotland 2009" and, most recent, "Improving public sector efficiency".

In "Improving public sector efficiency", we commented on the emerging gap between public spending and forecast budgets during the next few years. We analysed current spending and budget projections and concluded that if public spending continues at the 2009-10 rate, a significant gap will emerge during the period to 2013-14, which could be between £1.2 billion and £2.9 billion. In the current economic climate, the plan to deliver 2 per cent efficiency savings will not generate enough savings to bridge the gap.

Ann Henderson (Scottish Trades Union Congress): The STUC questions the prevailing presumption that public expenditure cuts on the scale that is suggested are the only way to deal with the current economic situation. The presumption that such cuts would be a simple cost-saving exercise is wrong and raises a number of questions. For example, if jobs in the public sector are reduced, the tax base is also reduced, so less money goes back into the economy—especially the local economy, given the local economy's dependence on jobs in the public sector, particularly women's jobs. Significant cuts in public spending would have many consequential costs.

The Convener: I understand that there are different ways of reducing public spending, but as an opening gambit, I wanted to establish whether the witnesses agree that public spending must be reduced by 12 per cent, however that is achieved.

Ann Henderson: We do not agree that saving that amount of money across the public sector is the right approach.

The Convener: You appreciate that there will be a squeeze. There will be less money. Opinions might differ on how we deal with the situation, but do you contest the baseline figure that people are talking about?

Ann Henderson: We do not agree with the figure. There are other ways of bridging the gap.

The Convener: Would you argue for the status quo?

Ann Henderson: We think that there are other ways of raising the necessary revenue, such as altering the taxation system or collecting the large amounts of unpaid tax.

The Convener: You do not think that cuts are inevitable.

Ann Henderson: Reduction of public spending on such a scale is not inevitable. We do not agree with the prevailing presumption in that regard.

Angela O'Hagan (Scottish Women's Budget Group): We support that position. A 12 per cent cut across the public sector is not necessarily the only way to address some of the wider economic difficulties. What would a 12 per cent reduction mean for social policy costs, and what impact would it have on services and employment across the public sector?

The Convener: It was helpful to establish that at the beginning. At the strategic level, what approaches should be taken to ensure that the needs of equality groups are properly considered? Are there any risks with those approaches?

Angela O'Hagan: A central focus of the Scottish women's budget group is on the processes by which decisions to cut services and jobs are being made. It has been suggested—in practice and in corridors—that the public sector's equality duties can be dispensed with or overlooked and that the integrity of the equality impact assessment need not be applied to the process. Anecdotally, we are hearing about local authority funding cuts and about the relationships between the local authority and voluntary sector providers being contracted very quickly. We are concerned about the speed with which decisions are being made and the lack of evidence of robust equality impact assessments supporting or informing the decisions about where spending cuts will be made.

We have made the point to this committee before that, rather than apply equality impact assessment to budget cutting it should be applied to budget setting. That would identify a different starting point in terms of the users that public funding is seeking to reach and the services that are to be provided for them. Our concern is that the first cuts fall on the margin of spend, which is where equality groups tend to sit, so simply wondering where to start cutting affects marginalised people more directly. Although a focus on the impact on equality groups is welcome, because there will be specific instances of spending cuts severing services, including lifeline services, we also argue that the focus must be on all public authority services and their impact on equality groups, whether direct or indirect. If public services are withdrawn, there might be unintended and unforeseen impacts, and the focus must be on where those impacts fall and how they fall on women, on men, and on older women and men, particularly picking up social care and education responsibilities and other wider social support. That relates to my earlier point about consequences. Whose efficiencies are we talking about? The cuts that are being made in the name of efficiency in one budget may well have displacement and consequential impacts on the lives of individuals and on other budgets such as social work, health or education.

The Convener: You are highlighting that equality impact assessments are key and that they must be applied whenever difficult spending decisions are made.

Angela O'Hagan: There is a read-across between your questions and those of the Finance Committee. The legal requirement to comply with the public sector duty equality impact assessment is not a moveable feast. They are legal obligations and public authorities must meet them, and they are acutely important at a time of cuts.

Ann Henderson: From our experience, and from the information that we are getting from workplaces and our members, we see that the decisions that local authorities have taken so far are not equality assessed. We are seeing a disproportionate impact, with financial difficulty facing projects that would provide child care, support people with disabilities getting back into work or have a particular focus on keeping people in work. There is no evidence that any equality impact assessment was carried out before the decisions were made on them.

When we are talking about equality groups, another point that is important to all the committee's considerations is that women form the greater part of the public sector workforce. The issue is not just the women who work in groups and projects that focus on equality but the disproportionate impact that cuts in the public sector will have on women. That links to the cuts in the different services—if a child care or education project is lost, that will affect the ability to keep people in work. Cuts in hours also have an effect. A number of our members are reporting that what appears to be a small exercise of reducing the hours of somebody who works part time from three to two days a week can completely destroy a family budget. There are disproportionate impacts.

The Convener: Martin Hayward, your written submission raised some concerning issues that the general public has approached you about.

Martin Hayward (Equality and Human Rights Commission): Yes, we are picking up on concerns from members of the public about the situations that previous speakers have referred to, in which decisions are made about cuts to services with little, no or poor consideration of how they will affect different people. Fundamentally, the equality impact assessment tool exists to help people think about how their decisions affect different people.

The Convener: Would you like to add anything, Lorna?

Lorna Meahan: This is not particular to equalities, but a general point. One major theme to come through Audit Scotland's reports is the lack of good information that public bodies hold about the quality of services, cost and other aspects of performance. It is a recurring theme that public bodies do not have good information on which to base their decisions on future service provision.

Malcolm Chisholm: I would like to focus on the independent budget review that the Scottish Government has established to discuss future budgets at Government level. I heard what Ann Henderson and Angela O'Hagan said about the overall decision about budgets, but I suppose that it is a matter of fact that most of the macro decisions will be made by the UK Government. It may therefore be that the Scottish Government budget is cut significantly and, even though that assumption is not accepted, it is reasonable to contemplate the possibility of that happening through factors beyond our control.

Against that background, do you think that the approach taken by the independent budget review is satisfactory? It has said that the key issues for it—the general headings—are identifying the primary programmes, the focus of expenditure, the role of capital expenditure, additional resources and efficiency. I suppose that this is your opportunity to give some advice to the review and to tell it how to ensure that sufficient weight is given to equalities issues.

Angela O'Hagan: In the first instance, the inquiry by this committee and the Finance Committee's recommendation to have a budget strategy phase are welcome and significant developments, as is the independent budget review. From the perspective of the women's budget group, it converts the budget into a primary policy vehicle. It may sound naive to say that, but that is not always how budgets have been perceived.

We hope that the independent budget review will not just take the legal requirements to give political leadership and direction on compliance to public authorities but give some clear direction and leadership to—or, turning that round, not undermine—the achievement of the equality goals that are implicit and occasionally explicit in the Government economic strategy and recovery plan.

12:45

The Scottish women's budget group argues that gender impact analysis and, more broadly, equality impact analysis are important in identifying the primary programmes that will be economic drivers for change. We must ensure that the provisions within those programmes are effectively gendered in addressing skills gaps, occupational segregation, employment creation and unemployment prevention. It is important to have a gendered analysis of skills and economic stimulus programmes.

On the role of capital expenditure on construction and other programmes, we hope that a different mindset will apply in thinking about how employment-related capital expenditure can more effectively address the labour market dynamics that are well known to the committee.

Perspectives on efficiencies vary according to where one is sitting. I return to the question of whose efficiencies we are talking about. What appears to be an expedient economic reduction or a straightforward cut in the money that is allocated to something might not be an efficiency in the context of overall gains in other budgets or meeting the overall aspiration for a more equal Scotland.

The Convener: I wonder whether Lorna Meahan would like to give her perspective, because Audit Scotland has presented a detailed paper on some of the issues that the Government faces. If she covers that, the rest of the panel can comment specifically on the equality duty.

Lorna Meahan: Our efficiency study focuses on the approaches that public bodies should take to improve efficiency in its broadest sense and help to accommodate the significant adjustments that will be made to budgets in the next few years. We suggest that public bodies should continue to pursue existing efficiencies and initiatives but that they should ensure that they take a priority-based approach to budgeting. They should focus their budgets on the key priorities for their organisation, council, public body or health board, and they should consider those priorities in their spending as well.

I have said before that improving information on the cost, productivity, quality and performance of services can inform better decision making. It is also important to extend collaboration and joint working in the delivery of public services and to look at innovation far more than has been done so far.

The Convener: That calls for some radical thinking, or thinking outside the box, which has perhaps not been a priority so far. Are there any other comments on that?

Martin Hayward: If we are serious about objectives such as increasing disabled people's autonomy and the control that they have over their lives, we need to think about the implications of decisions on, for example, transport, which might impact on those objectives.

Ann Henderson: As was mentioned, there is an opportunity for organisations to revisit their priorities and think more imaginatively. We have suggested significant investment to expand publicly provided child care, which we believe would make a positive contribution to the economy, both locally and nationally, in relation to upskilling and the retention of properly qualified staff. It is important to invest in support that keeps people in work. In recognising that there are constraints on spending, we have a chance to revisit our priorities and say, "What do we want our society to look like? What kind of Scotland do we want?"

I will give a specific example, which I am mindful that the committee mentioned in its request for written evidence on the ageing population. We sense that an uncomfortable situation is developing, given the number of redundancy packages that are being offered to people over 50. That means that we are losing a significant skilled workforce, and yet there is a growing ageing population who will have significant needs and demands for care services. There is a contradiction there, which we think could be addressed in a different way. The independent budget review could helpfully consider such issues.

Marlyn Glen: Can you provide a brief definition of equalities budgeting as you see it? Why is it particularly important now? Can you explain—briefly, if possible—some of the tools and techniques involved, and how effective you consider them to be? I realise that those are huge questions to expect you to answer briefly.

Angela O'Hagan: I will take a deep breath. The principles of equalities budgeting involve transparency and a greater and more effectively targeted allocation of resources. That takes us back to colleagues' points about good information. Intrinsic in equalities budgeting is having good information about who is using services, what the differentials are and how resources will be allocated to address the various divergences. There might be positive differences in usage, or there could be a need to address some gaps. To give a brief definition, it is about transparency and the effective allocation of resources to meet diverse needs across the community.

As for tools and techniques, some will be familiar to the committee: good-quality information, disaggregated data, trained staff and an awareness of equality impact—both recognising it and using procedures that allow people making decisions on programmes and services to identify equality impact and to do something about it. It is not good enough for public authorities to say that they have conducted an equality impact assessment and have recognised that there is a problem if they are not actually going to do anything about it.

Identifying the flow of resource allocation in the budget is a key technique or tool. Beneficiary analysis—the breakdown of who is using which services—is a further effective tool for redirecting policy priorities to achieve greater efficiencies, to address need and to provide targeted services, rather than just adopting what was described by the STUC as a masochistic approach to spending cuts. I had misread that as "machoistic" earlier—perhaps it is the same difference. Anyway, efficiencies could involve better targeted and more effectively delivered services, and we would argue that that is what equalities budgeting delivers.

The Convener: I am conscious that these are quite technical questions, and that the call for information was more general. We may well incorporate some more of the general questioning and allow other panel members to participate more fully.

Marlyn Glen: It is really useful knowing that our work is feeding into that of the Finance Committee—we can establish different things here.

We have discussed equality impact assessments. Can I ask Martin Hayward as well, because of the equality measurement framework that you are working on?

Martin Hayward: What is your question, Marlyn?

Marlyn Glen: Just the same thing: I am wanting brief definitions of equalities budgeting—and why it is particularly important.

Martin Hayward: It is important because the needs of all people are taken into account at the beginning of a process, rather than at the end of a process or not at all. The implications of decisions are thought through, and where there are different effects on one group of people, for instance, something is put in place to address or mitigate them. However, unless that approach is built in from the beginning, with money being allocated to an action, it is hard to address the issues later—it is hard to start thinking about the issues once decisions have been made about how the money is to be spent and where and how it will be channelled. That is my understanding of it—although my colleague is much more expert about the particularities of budgeting than I am.

Marlyn Glen: Do you wish to say anything about the equality measurement framework that you are working on?

Martin Hayward: Yes. It is part of our statutory responsibility to produce a triennial report on progress against equality and equality of opportunity. The first such report will be done later this year. To support that, we are building something called an equality measurement framework, as you say, which attempts to expand the evidence base with regard to how different people are affected during their life course by such factors as personal safety, opportunities for access to education and so on. Those are the things that define the progress that people are able to make in their lives.

As colleagues have said, the evidence on that has tended to be partial or poor in quality. The measurement framework is an attempt to build something much more comprehensive that will allow us to report on progress overall. The framework will also allow us and other agencies to consider the different stages in different people's lives, and their different opportunities. It is an attempt to provide a much more holistic picture of how people's life chances are affected by who they are at different stages of their lives.

Marlyn Glen: Are there resource implications to collecting all the information that you say is necessary?

Martin Hayward: Yes, but my understanding is that the first stage of the framework will involve identifying where there are a lot of gaps and how easy it could be to fill some of the gaps in information and data. Some of it might not be terribly resource intensive, but some of it might be. First, we need to find out what we know.

Hugh O'Donnell: Sticking with the equality measurement framework, I am looking at an extract that I believe to be from your organisation. I will quote a paragraph:

> "These domains focus directly on those things in life that people say are important for them to actually **do** and **be**."

The framework addresses, for example,

> "an adequate standard of living, being healthy",

which is subjective,

> "legal security, and being free from crime and the fear of crime. It is particularly concerned with the position of individuals and groups with regard to characteristics such as age, disability, ethnicity, gender, religion".

I will not go on—it is, in effect, the six strands. It strikes me that that covers everybody in the UK. How will it be possible, across all those strands, to develop a tool that in effect encompasses everyone? We all fall into those categories: we all have an age and a social class. How can it be anything other than motherhood and apple pie?

Martin Hayward: If we have information about everybody, we are able to decide what our priorities are and where our action needs to be directed. At the moment, we have information about some people at only some stages of their lives.

Hugh O'Donnell: So we do not have information about everyone at every stage of their lives.

Martin Hayward: Yes.

Hugh O'Donnell: And you think that such information would be helpful.

Martin Hayward: Yes.

Hugh O'Donnell: You do not think that attempts to gather all that information might run aground because of the right to privacy.

Martin Hayward: No, I do not think so. If we find that it does, we will find a way to address that.

Marlyn Glen: I would like other members of the panel to answer my question about the definition and importance of equalities budgeting. Could the witnesses also comment on Scotland's record on the process of equalities budgeting?

The Convener: Those questions are very technical. Did you want Ann Henderson to respond?

Marlyn Glen: Yes.

13:00

Ann Henderson: My response is not so much about the technicalities, but it would be useful for any approach to the budget to take into account the different impacts as outlined. As I said earlier, we are already seeing the consequences, with certain sections of the workforce being affected disproportionately. The fact that higher numbers of people with disabilities and from black and ethnic minority communities are either out of work or in lower paid jobs must be taken into account in budgeting and spending money. After all, we do not want spending decisions to exacerbate the situation faced by certain sections of our community. Coming back to Malcolm Chisholm's point, I believe that we should look at the budget through an equalities lens. Even when resources are limited the money available should be used to address inequalities and level things up rather than down.

Malcolm Chisholm: Local authorities play an important role with regard to equality duties. Of course, the concordat has changed the situation and I suppose that the issue that has attracted most attention in that respect is the way in which certain previously ring-fenced funds have been given to local authorities, which now have a much greater degree of freedom. What has been the result of that move? I know that the EHRC has begun a research project on that very issue so, to keep things general and neutral, I would like to hear your views on whether the concordat's impact on programme delivery, particularly for equality groups, has been positive, negative or indeed both.

Martin Hayward: In a project that we have started only this week, we are directly contacting local authorities to ask about the effect of the concordat and, in particular, the beginning of the removal of progressive ring fencing in some areas, which we think signals a major change in the relationship between local and central Government and the operation of local government in Scotland. We want to examine the first year of this changing relationship and way of working through the lens of the three existing equality duties of gender, disability and race. The project will report this summer and, although I do not want to anticipate its findings, I hope that it will cast some light on this area.

The Convener: It sounds very worth while.

Ann Henderson: The Educational Institute of Scotland, Unison and other unions representing staff who work in education have raised concerns about the consequences of the removal of ring fencing for certain services, with a number of our members reporting loss of services and difficulties in protecting what used to be regarded as essential services or services that had previously been ring fenced.

The removal of ring fencing has had consequences for women-specific projects; indeed, one high-profile example has been the removal of funding from the Women's Support Project in Glasgow. The issue is not just the loss of funding by a project but the removal of a whole management and workforce resource. For example, we might be talking about training budgets for women-specific services such as violence against women services and counselling services, and the public sector in general and management and human resources teams in particular draw on some very skilled and experienced services that it could be argued are being reduced by the removal of ring fencing. Certainly, evidence that has been collected through UK-wide projects that I can make available to the committee shows a definite loss to the wider community because of the removal of ring fencing for women-specific services.

Angela O'Hagan: I would like to comment more broadly on the concordat and the absence of priority that is given in it to achieving equality as a central and shared objective. In last year's draft budget document, the Scottish Government stated that it "stands back from micro-managing" service delivery in local authorities. The view is that doing so frees up local authorities and reduces bureaucracy. I link our concern about that to my earlier comments about compliance with public sector equality duties and providing clear political leadership. From our perspective, that is not micromanaging. The Scottish women's budget group has been concerned with the absence of equality analysis and equality narrative in the single outcome agreements since the inception of the arrangements.

Scottish Women's Aid has so far conducted two surveys on the impact of ring fencing and an analysis of the single outcome agreements. The committee may already know about that work or may be interested in it.

I have a further concern. Anecdotally—although I hope to provide evidence of this to the committee either in writing or at a future date—there seems to be a mismatch in that, with the removal of ring fencing, local authorities are able to access designated funds from central Government that are then used in the general allocation. Funds that are designated for a specific purpose in directorate budgets are added on to the allocation. There is then no read-across in respect of the Government's priorities and how the mechanisms for drawing down and accounting for spend are managed.

The Convener: Does Lorna Meahan want to pick up on anything in particular?

Lorna Meahan: The only point that I want to reiterate is to do with priority-based budgeting and spending. The key to accountability and transparency in decisions is people knowing their priorities and having good information in deciding those priorities, and spend following.

Willie Coffey: A report by Audit Scotland says that, if the current plans come to fruition, we will face a £3 billion shortfall over the next four years. That means that everybody in Scotland will suffer to some degree from cuts. The question for the Equal Opportunities Committee in considering equalities groups is what our specific concerns are about the impact of cuts on them and how we can assist them or enable them to continue their work, bearing in mind that it is inevitable that there will be cuts across the board. What specific issues do equalities groups face? In particular, what protections might we want to maintain?

Lorna Meahan: In a recent report on drug and alcohol services in Scotland, we made an observation about the complexity of the funding arrangements for voluntary groups in particular and the complexity of navigating and managing them. A focus group of voluntary sector representatives for that study reported that the funding arrangements, which involve all the different parts of government and external bodies, are particularly challenging, as projects are often supported by numerous funding streams with different timescales and different reporting mechanisms. Therefore, there is already a challenge in the system for the voluntary sector in particular, which represents a number of equalities groups, in managing funding streams. If their funding is increased or decreased, depending on decisions that are made by public bodies, there could be a significant impact on them.

The Convener: Perhaps as well as answering Willie Coffey's question, the panel might want to consider whether there is a greater role for the third sector in the delivery of services.

Ann Henderson: As I said earlier, I think that there will be an impact—although I am not quite clear how an "equality group" should be defined—on equality groups. Groups that are focused on delivering services in the community, such as locally run or community-managed projects, can provide valuable support in keeping vulnerable families in employment. We need to take into account what consequences reductions in such projects will have on the labour market and what impact that will have on families who are already living in poverty. Evidence coming back from trade union members suggests that apparently small reductions—for example, a reduction in the number of hours of care or the closure of a community centre—can have a huge impact on keeping other people in work. We would be interested in exploring some of those questions.

Another issue that occurs to me is about performance management and the anxiety that can go along with conversations about achieving greater efficiencies. Talk of reducing costs can place particular sections of the workforce under particular pressure. For example, a supported workplace might keep in work sections of the community that need particular support. If the organisation's performance targets are then raised significantly—obviously, we are in favour of things working as effectively as possible, but people can have different levels of output and ways of working and need different levels of additional supports—it is important that those people are not disproportionately affected by unemployment. We are quite concerned about that.

We are receiving worrying stories from our members about such pressures resulting in an increase in mental health issues in the workplace. For example, particular difficulties might arise if flexible working arrangements were previously allowed but have now been withdrawn. We should be sensitive to some of those issues and consider how equality groups in the different local authority areas might help with that. People must not be put under so much pressure that they are in effect driven out of work.

Martin Hayward: In its 2008 report on the race equality duty, Audit Scotland found that—as with budgeting, which I spoke about earlier—thinking about equalities groups was often insufficiently built in early on within the core work of public authorities. In that kind of situation, services that are marginalised—to repeat the word that colleagues have used—can more easily be removed if they are not seen as being central to an authority's core business.

I might add that that is an argument for strong, Scotland-specific duties under the new Equality Bill. The situations that everyone on the panel has described are an argument for strong specific duties to be placed on Scottish public bodies to consider equalities in their work. That should then be followed up by the wider scrutiny sector—Audit Scotland and other scrutiny bodies—which should continue to consider equalities issues in their work.

Angela O'Hagan: In answering Mr Coffey's question, I do not want to start singling out particular groups, as I support what colleagues have said about the need for a broader focus. Linking the issue back to Hugh O'Donnell's point about the equality measurement framework, I think that public authorities need better information—Lorna Meahan also made this point—about people's needs, about the impact of services on those needs and about the extent to which services, and therefore budgets, meet those needs. Hopefully, that is what the equality measurement framework and other tools will deliver. Along with the analysis that the EHRC is conducting, that kind of information will show how to approach service redesign and what the consequential impacts will be that we have talked about.

I know that there are concerns throughout the voluntary sector about the future relationship between voluntary sector organisations and public authorities in terms of service provision, local advocacy and locally provided services. There are issues to do with the appropriateness and level of delivery as funding becomes more precarious and less sustainable.

13:15

I will highlight a couple of examples in which specific equalities groups, dynamics or issues may help to enlighten the argument. If we consider, for example, people with disabilities, the withdrawal of funding to support independent living in the community will have significant knock-on effects on the individual's independence. It may reinforce isolation and limit economic and social participation, which will affect other aspects of local authority and public authority budgets.

From a gender perspective, we would be concerned about the impact of cuts on gender-based violence, rape and sexual assault services, which might be withdrawn or targeted for cuts. As we have all said, although spending that sits on the margins is more easily identifiable as a target for cuts, the impact of those services is perhaps not so widely considered.

Bill Kidd: Thank you for all the answers so far. I have a couple of questions about equalities duties and the public sector. I am sure that none of us is happy about the idea of 12 per cent cuts but, if we work on the basis that is what is likely to happen, could we approach the equalities duties with an awareness of the specific duties that the UK Equality Bill will introduce to Scotland, and the consultation that the Scottish Government launched last September? Socioeconomic disadvantage is included among those duties. Everyone will be affected by that, whether or not they are one of the other equalities strands. On that basis, I want to ask about the cost implications of implementing the equalities duties. It might be said that not implementing the equalities duties has even bigger implications because, in a recession, it is always those at the bottom of the pile who take the biggest kicking. Is it possible to consider how the tools and techniques that Angela O'Hagan mentioned earlier in reply to Marlyn Glen's question can be used more effectively to ensure that we manage to deliver these equalities during this period?

Martin Hayward: In the EHRC's response to the Scottish Government consultation, we said that we are very interested in working with public authorities' existing reporting cycles and ways of thinking about their work in order for them to address equalities. Rather than bringing in duties that impose another requirement for reporting about something else at a different time and in a different sequence and so on, it should be built into the natural reporting cycle of the public authority. In that way it will not add additional cost and will become more central to the way in which the business thinks about its work. That is how I would think about Bill Kidd's question, although he both asked and answered it at the same time to some extent.

A public body should be able to think about what its priorities are, based on its own evidence. We have said enough about evidence already today. Being able to set priorities that are based on that and take actions that are based on those priorities, which can be measured and reported on in a way that fits with the way in which that public body works, is very much the model that we see for the way in which a set of public sector duties should function in the future. In that sense, the new duty should be brought more into the way in which a public body works instead of being an alien thing that has been added on from outside to the work that the public body sees itself doing.

The Convener: It must be intrinsic. I do not think that the rest of the panel would disagree with that approach.

Bill Kidd: Thanks for that answer, which was very useful. I have one more question, on the willingness of the public sector to deliver the policy. Is there a danger that public sector bodies might focus purely on delivering the legislative requirements at the expense of the valuable discretionary services? That was mooted earlier, but it bears mentioning again. Alternatively, might public sector bodies take a minimalist approach to delivering the legislative requirements and duck out on the basis that they do not have the money?

Ann Henderson: The point has been made that some of those things do not cost money. It is about looking at how public services are delivered. If the plan is to deliver a public service that everybody can access, putting in place whatever additional things are needed to ensure that everybody accesses the service should not be seen as an additional cost. Some of the ways in which services are delivered can be adjusted in a way that does not involve spending more money if they are looked at in the way that has been discussed. I reinforce the point that we see the importance of reaching everybody in the community and of workers and their families benefiting from the services. That does not need to be an additional cost; it should be the right way in which to do things. The approach just needs to be changed.

There is a nervousness around the language, with people talking about a big, additional cost coming. Training and capacity are an issue, but it is about everybody doing the job that the service should be doing in the first place. In the past, the experience of some of the equality impact assessment stuff may have been that it was seen as a tick-box exercise. The trade unions would be concerned about that, as that is not how we imagine that the new duty will work. We see it as a matter of considering whether the outcome is being delivered and whether the service is being delivered in the way that we think it should be. There is scope for tighter monitoring and working with the agencies that will do that, but it does not need to be more expensive.

Angela O'Hagan: I echo much of what Ann Henderson has said. One of the strong messages about the new equality duty that are coming from those who are required to implement it is that they welcome and are looking for a more outcome-focused approach, which gives the process a purpose. The purpose, not the process, is the overriding feature of the equality duty, and the purpose is to ensure that public services are delivered more effectively across the community according to people's diverse needs.

Externally, we have concerns about the extent to which the implications of the contraction and constriction of statutory services may not fall evenly. For example, if there are to be cuts to an education budget, what does that mean? What hidden or indirect impacts will the new duty have, in terms of enabling different groups to access services if the services are centralised? There are transport and other access issues.

You ask whether public authorities will want to duck out. Effective equality impact analysis should not allow public authorities to duck their statutory obligations either on the equalities side or in terms of provision. I echo Ann Henderson's point—I do not know who has been reading whose notes: I had written "audit, inspection, scrutiny and accountability processes". Both through the national agencies and in the parliamentary processes, you must come into your own in the future.

The Convener: Elaine Smith has the next question, which is on the important issue of the third sector. I inadvertently covered a bit of the topic earlier.

Elaine Smith: The third sector has been mentioned throughout the evidence. It is particularly important in relation to local government. Overall, the increase in the Scottish budget will not be as big as expected, although the actual percentages and figures are a matter for discussion—we have had some discussion and dispute about that. The Government can consider its services and priorities. Nobody has mentioned the option of using tax-varying powers, which have not come into play at all.

Much of the work of the third sector is focused on local government, either because organisations get grants from councils or because councils engage with the third sector to deliver services. That takes us back to the concordat. There is a contradiction in that, under the concordat, local councils get on with deciding their priorities and nothing is ring fenced any more—we have heard discussions about how that impacts on the third sector—but, on the other hand, councils have been asked to freeze their council tax, so they do not have autonomy to think about how to deliver their priorities and whether to raise tax at the local level to do so.

That is a big problem, so perhaps we could finish the session with a discussion of it. I am interested in the panel's opinion, but my view is that the third sector will suffer because local government will look to the services that it has to deliver and might find it easier to cut funding for third sector projects. That will have an implication for services and will mean that the third sector might suffer disproportionately.

Lorna Meahan: In our report "Improving public sector efficiency", we recommended that public bodies consider using alternative service providers, including those in the third sector, if those providers can improve efficiency, the quality of service and productivity. The issue is about having good information on what the priorities are and good option appraisal of how services can be delivered, including using the third sector.

Elaine Smith: But if local authorities are using the third sector, there has to be funding to the third sector from somewhere and not just from charitable fundraising. Many third sector organisations get grants from local government, but that might be the funding that is hit if local government decides that there is not enough money. Will you comment on that?

Lorna Meahan: We do not have any evidence about that at present, but we have commented that, in delivering and funding services, public bodies should prioritise budgets and spending and consider using the voluntary sector for the delivery of services when doing so can improve quality, cost and productivity. That is our strong recommendation in our recent report on efficiency.

Elaine Smith: Did you examine in detail how the third sector can deliver and improve quality, productivity and so on? Does it do that by having lower wages, for example?

Lorna Meahan: We did not find any evidence of that. The case studies in our report contain good examples in relation to outcomes and outputs, but there is not necessarily information on whether the measures reduced costs or supported efficiency. There are certainly good examples on delivery of services and improvement in quality.

13:30

Ann Henderson: I will pick up on the point about the alternative delivery of services. The STUC has the fairly straightforward view that wages and conditions across the third sector should be comparable with those for comparable local authority jobs. There is a view that it is cheaper to run services by putting them out to tender and having third sector organisations bidding to provide them. We have a concern about that, which is why our policy is to argue for comparable wages and conditions.

Significant issues arise about the capacity of the third sector to maintain and deliver training—for example on the equality issues that we have been discussing this morning—and to do regular skills appraisals and updating. It is harder for small organisations to do that. As has been said, economies of scale need to be addressed. Things that appear cheaper are not always cheaper; the fact that something appears to be cheaper should not be the motivating factor when we consider how we deliver our services. People might ask why their mum, who is a school cleaner, was last year worth £X in her pay packet and this year is worth less. That is a real question and a society in which that happens is not one that is about fairness, justice and respect for the jobs that the people whom we work with do. It looks like a number-crunching exercise, but we are talking about people's lives, people's jobs and the families that they are bringing up in our Scotland. I therefore feel strongly that we should be looking at other issues such as adequate funding and, as I said, levelling up rather than levelling down.

On Elaine Smith's question about council tax—

The Convener: Before you move on to that, it would be a mistake to look at provision by the third sector as being purely about providing value for money. It is about the expertise that organisations in the sector have and the flexibility of their working hours, which perhaps goes beyond the time that a public sector organisation could work—it can even go into the evening. The equation is not so straightforward as being purely about value for money—all these factors have to be taken into account in the round.

Ann Henderson: Absolutely. There are trade union members who work in the third sector. Obviously, there can be innovation, services that develop can complement one another and organisations can work together in a community to provide services. Advocacy projects, welfare rights projects and all sorts of things make people's lives better. It is just that nervousness is beginning to be evidenced—the recent local authority experience in Edinburgh is one example and members will have their own stories from their own constituencies—when a simplistic conclusion is being arrived at that provision by the third sector would be cheaper and that the same service would be provided. That is not the case.

The Convener: I think that we would all have concerns if that was the only reason why services were being provided in that way.

Ann Henderson: Absolutely. The services provided should be complementary. It is about protecting conditions.

The Convener: I ask you to be very brief on the last point.

Ann Henderson: It is the STUC's view that the council tax freeze will make it impossible to deliver the services that we all appear to require locally. At some point, that issue will have to be addressed, as it would be more efficient for taxation to be used locally so that families pay a small amount of money into a bigger pot and services are protected for the greater good.

The Convener: That completes our lines of questioning. What we wanted to get from this evidence session—and we have achieved it—was to establish the positive economic benefits of spending on equality issues. For that, I thank the panel very much.

Meeting closed at 13:33.

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