The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

MEETING OF THE PARLIAMENT

Wednesday 28 September 2011

Session 4

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Scottish Parliament

Wednesday 28 September 2011

[The Deputy Presiding Officer *opened the meeting at 14:30*]

Time for Reflection

The Deputy Presiding Officer (John Scott): Good afternoon. The first item of business this afternoon is time for reflection. Our time for reflection leader is the Rev Allan Loudon from the Methodist Church in Wishaw.

The Rev Allan Loudon (Methodist Church, Wishaw): Presiding Officer,

"O wad some Power the gift tae gie us, tae see oursels as ithers see us!"

My name is Allan Loudon. I am a Scot by birth, a Methodist by upbringing and a Christian by the grace of God. It feels a bit like a confession at the start of an Alcoholics Anonymous meeting, but my reflection today is about being true to ourselves—knowing who we are.

I was born in the North Lanarkshire town of Airdrie, from working-class roots, and I was brought up in a good Methodist Church tradition. My earliest memory is of singing as part of the church choir, and music has always been one of the distinctive features of Methodism, along with a belief in an inclusive God who loves all people and who rescues us by grace.

The Methodist Church is a mystery to many, a small denomination scattered in communities across Scotland but which worldwide has a membership of 70 million. We sit in the Protestant reformed church tradition but with catholic tendencies, which means we can straddle the ecumenical divide and be a bridge between competing ecclesiology.

My Methodist heritage has a radical nature, envisioned in the 18th century by one of our founders, John Wesley, as a movement for change that today still holds scripture and service at its core, giving birth from within to the Salvation Army and the trade union movement.

One of Mr Wesley's preachers, Kenyon Wright, was at the heart of the Scottish Constitutional Convention, which gave birth to this place, so I am proud to hold this Parliament in a long line of Methodist-inspired bodies and to stand before you and encourage each of you, in our unity, to know who you are and to be true to yourself.

In sharing this short time, I was told I could not sing. However, I have one last word that is rooted in the scriptures from which I gain my inspiration: my Methodist reworking from one of the psalms of David.

"O God the creator, you search me and know me,
whether I rise or whether sit down.
You know all my thoughts, my deeds and my rest,
Acquainted you are with my being and ways.

You know all the words of my heart and my tongue
Before I can think, or speak them aloud.
You enfold me on all sides and lay your hand on me,
Such wonderful knowledge, I cannot attain.

On the wings of the morning if I journey forever
Or dwell in the depths of empty despair,
Even there I shall know that your hand, it will lead me,
Your right hand to hold me and guide me safe through.

O God you created and formed me from nothing,
Within and around me, I cannot be scared.
I praise you my fearful and wonderful maker,
Grateful that I am the work of your hand."

I thank you for the invitation offered to this Scottish Methodist to reflect with you, and I wish you every blessing in being true to yourselves as people who God has created and loves and through whom God's purpose is revealed.

Scottish Parliamentary Corporate Body Question Time

14:35

The Deputy Presiding Officer (John Scott): The next item of business is Scottish Parliamentary Corporate Body question time.

Scottish Parliament Building (Police Incidents)

1. John Wilson (Central Scotland) (SNP): To ask the Scottish Parliamentary Corporate Body how many incidents requiring action by the police have occurred in the Parliament since 2003. (S4O-00234)

David Stewart (Highlands and Islands) (Lab): The number of recorded crimes at the Parliament building since 2003 to date is 158. The numbers were substantially higher during the period when the site was under construction in 2003 and part of 2004. Not all incidents requiring action by the police are recorded as crimes. Information about the number of incidents is recorded separately. A new recording system was introduced in November 2007 and to date 298 incidents specific to the Parliament postcode have been recorded. Lothian and Borders Police has advised that it is time and cost prohibitive to produce data that is prior to 2007.

In April 2009, the Parliament police unit started to maintain records of items surrendered to the police at the public entrance. To date, 368 various items have been surrendered by visitors to the building. Surrendered items that have not been returned to owners from April this year include 126 items that are mainly illegal knives and blades. Surrendered items are not recorded as incidents or crimes.

John Wilson: I am interested in the number of incidents that involved the carrying of knives. Various newspaper reports have stated that stab vests have been issued to staff members. I appreciate the duty of care that the SPCB has towards staff, but how many stab vests have been procured, who will use them and where will they be used?

David Stewart: I thank the member for his interest in security in the building. As the member will know, the nature of the terrorist threat facing the Parliament has changed in recent years and there is increased concern about the threat from fixated individuals. On the numbers of vests, following a procurement exercise one vest has been supplied for each member of the security staff. The total cost to date is £35,500. Security vests are worn at the public entrance and the car park. I stress that all training has been carried out and that the staff trade unions fully support the move, because the SPCB has a duty of care for all its members of staff.

Living Wage

2. Kezia Dugdale (Lothian) (Lab): To ask the Scottish Parliamentary Corporate Body how many of its staff, including those employed through agencies, are paid less than the living wage of £7.20 an hour. (S4O-00235)

David Stewart (Highlands and Islands) (Lab): I know that the member has a great interest in this particular area. All directly employed corporate body employees and agency-recruited staff employed on a temporary basis are paid above the living wage. In the case of contractors, such as Sodexo, it is their responsibility to set the terms and conditions of their own staff, with the caveat that in both cleaning and catering contracts we have specified that wages must be at least at the minimum wage level.

Kezia Dugdale: I appreciate that there is an issue to do with contractors, especially Sodexo. Is it possible for the Parliament to consider becoming a living wage employer, so that in future even Sodexo staff get the living wage?

David Stewart: The Scottish Parliamentary Corporate Body is not signed up with the living wage foundation as an accredited living wage employer. The member makes a convincing case for why we should be signed up. I undertake to raise the matter at the corporate body's next meeting.

I will request that, in future, the corporate body costs a living wage option prior to the award of new contracts. As far as current contracts are concerned, there is a yearly review of the costs of wages for each contract that we have.

John Wilson (Central Scotland) (SNP): I seek clarification on the member's comment that there is an expectation that Sodexo pays the minimum wage. Does Sodexo pay the minimum wage or not?

David Stewart: In the terms of the contract we make it clear that the minimum wage must be paid. Because of commercial confidentiality we do not know the wages of individual members of the contract. However, I stress that the contract terms for cleaning and catering specify that the minimum wage must be paid.

Procurement (Contract Staff Terms and Conditions)

3. Drew Smith (Glasgow) (Lab): To ask the Scottish Parliamentary Corporate Body how its procurement processes safeguard the terms and conditions of its contract staff. (S4O-00236)

Liam McArthur (Orkney Islands) (LD): The terms and conditions of contract staff are determined by the contract of employment between the relevant contractor and its staff. However, the SPCB requires all our contractors to meet the obligations that are set out in our contract conditions. The contract conditions include equalities, health and safety and all statutory and other legal obligations. There is also a requirement that contract staff follow our guidance and procedures when they are working at the Parliament. In addition, we ensure that all our service contracts contain an appropriate and robust Transfer of Undertakings (Protection of Employment) Regulations—TUPE—clause.

Drew Smith: I am grateful to the corporate body for its answer and for its response to Kezia Dugdale on the living wage. I have heard that there are contract staff in the Parliament who are not paid sick pay. That is extremely concerning to me and I am sure that it concerns the corporate body. Does the corporate body know how widespread such problems are among contract staff? Are there plans to review how contracts are drawn up in future?

Liam McArthur: I am not aware of problems to do with sick pay, but I think that I speak on behalf of the corporate body when I say that if such instances were to arise we would certainly look to investigate them as a matter of urgency. As David Stewart said, the corporate body is minded to consider living wage provisions at its next meeting. I understand that currently 75 per cent of employees contracted to the Parliament are covered by the living wage and those that are not are within 5 per cent of it. Nevertheless, it is important that we take the issue on and reflect on what members have said. If Drew Smith wants to contact me about specific cases in relation to his point about sick pay, I will undertake to get them reviewed as a matter of urgency.

Patrick Harvie (Glasgow) (Green): Can I persuade the member that there is a case for a much wider-ranging review of the Parliament's procurement processes, in relation to a wide range of ethical criteria? Sick pay and the provision of the living wage are good examples; another criterion would be tax compliance. Is the member aware that we procure printers from Hewlett-Packard and catering from Sodexo, which are corporations that indulge in scandalous tax avoidance practices? Should not such issues feature in our procurement policies?

Liam McArthur: Patrick Harvie raises legitimate issues. I would have no objection to broadening the scope of the review to which David Stewart referred, to include other issues, although I make no comment on allegations about corporations that are contracted at the moment. If we are to undertake a review, it makes sense to encompass a wider range of issues, if that is appropriate, rather than address matters in a piecemeal fashion.

MSP Staff (Bicycle Loans)

4. Helen Eadie (Cowdenbeath) (Lab): To ask the Scottish Parliamentary Corporate Body whether, in order to promote cycling, it facilitates loans for MSP staff wishing to purchase bicycles, which are deducted from their salaries. (S4O-00237)

Linda Fabiani (East Kilbride) (SNP): The Scottish Parliamentary Corporate Body does not directly offer loans to MSP staff who wish to purchase bicycles, but it will assist members to provide interest-free salary advances to their staff for such a purchase. A member can authorise a salary advance to a member of their staff, which is paid from the expenses scheme in one month and reclaimed from the salary over the next 11 months.

Helen Eadie: I thank the SPCB for that very helpful answer. I have asked the same question before, but that was a much more positive answer than I have received previously. My information tells me that such a scheme can save the employee and the employer sums of money with regard to national insurance and taxation.

Linda Fabiani: Helen Eadie alludes to the very useful United Kingdom Government cycle-to-work salary sacrifice scheme. The SPCB does not currently operate that scheme, but it offers interest-free salary advances for its own staff and will assist MSPs to do the same for their staff.

The SPCB is exploring whether it should consider implementing the salary sacrifice scheme. I do not know whether MSPs would be able to avail themselves of that as employers, but I will ask the SPCB staff who are considering the issue to ask that question.

The Deputy Presiding Officer: That concludes questions to the Scottish Parliamentary Corporate Body.

14:46

Meeting suspended.

14:50

On resuming—

Mental Health

The Deputy Presiding Officer (John Scott): The next item of business is a debate on motion S4M-00949, in the name of Michael Matheson, on mental health. I call Michael Matheson to speak to and move the motion.

14:50

The Minister for Public Health (Michael Matheson): I am pleased to open the debate on behalf of the Government. As the motion says,

"significant progress ... has been made in mental health services, mental health improvement and mental health law in Scotland".

That progress reflects the priority that the Scottish Government and the Parliament have given to mental health since devolution. However, as the motion also says,

"there is still work to be done".

We have recently published our consultation document on a new mental health strategy for Scotland, which is intended to build on previous and continuing work and to establish the priorities and actions for the next four years. There will be many opportunities for service users, carers, providers and professionals to engage with that consultation and to shape the agenda for the next few years. I will also be interested to hear members' views in the chamber this afternoon.

I will start with a few brief comments about the reports in the press over the past 24 hours relating to antidepressant figures. First, it is clear that there is a general misunderstanding of the relationship between prevalence and defined daily doses. Although the figure for defined daily doses has risen, the evidence from research is that the number of people who are taking antidepressants is not increasing. Secondly, the evidence is that general practitioners are prescribing appropriately and in accordance with clinical guidelines, often in conjunction with psychological therapies but also for longer periods, which is consistent with those guidelines. The Royal College of Psychiatrists and the Royal College of General Practitioners have previously raised that as a matter of concern with Opposition parties and will make further representations on it.

It is not possible, in a brief debate, to capture all the work that has been undertaken over the past four years—and, indeed, in the period before that—but I will touch on some of the main achievements. In the previous session of Parliament, we made the commitment, as part of the national health service health improvement, efficiency, access and treatment—HEAT—targets, that we would improve the speed of access to specialist child and adolescent mental health services. We said that, by March 2013, no child would have to wait more than 26 weeks to begin treatment. That commitment was made against a backdrop of different levels of performance throughout Scotland, both in speed of access and in the number of children being seen by specialist services. Some children and young people are seen very quickly, but we know that others wait far too long to receive the care that they require.

We have been working closely with NHS boards and other partners to develop information systems and referral pathways and to increase workforce capacity. We are confident that we will achieve the target by the set date. We know that earlier action is likely to have better outcomes and offer a benefit to children, their families and the health service overall. We have also supported the target with new investment to increase the specialist child and adolescent workforce. In 2011-12, that new investment equates to £5.5 million of ring-fenced money for specialist services, and that money will continue across the spending review period. It is a long-term investment in our children and young people.

We are growing the specialist workforce. I can report a 33 per cent increase in the specialist workforce between the end of 2008 and March 2011, and we will ensure that the increased workforce capacity is maintained over time. That increase in workforce means that more children and young people are being seen and that they are being seen more quickly.

Progress has been made on reducing the number of young people who are admitted to adult wards. Such an admission is an appropriate decision in some circumstances, but that is not always the case. When the 2010 Mental Welfare Commission for Scotland figures are published shortly, they will show an improvement of 18 per cent on the 2009 figure, but performance is not acceptable. I have asked for further work to be done to ensure that children and young people are always admitted to an appropriate location.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I understand why the minister quotes percentages all the time, but the hard figures would be a little more meaningful and would be helpful.

Michael Matheson: I appreciate that, but the figures are unpublished. In general, they will show an 18 per cent drop nationally in the number of young people who are admitted to adult wards.

We have taken forward the agenda that is set out in "Towards a Mentally Flourishing Scotland:

Policy and Action Plan 2009-2011". That work covers the social inclusion of people with mental illness, the prevention of mental illness and the creation of good mental health. The agenda is challenging but it is one for which Scotland is well regarded. We have delivered our commitment and I will briefly mention three areas of work that have been covered.

Our work to tackle stigma through our continued financial support of the see me campaign has been highlighted by the European Union as good practice and a demonstration of how national Governments can tackle the issue successfully. We will continue to work on that and we are considering how to take greater account of discrimination as well as self-stigma. Service users and their families will continue to be key to that work.

Since 2008, the suicide rate has reduced. The figure for 2009 was the lowest for 20 years, and the 2010 figure was also one of the lowest for that period. Between 2000 to 2002 and 2008 to 2010, the suicide rate in Scotland reduced by 14 per cent. That is progress, but there is more work to do, and we will continue to develop evidence-based approaches to the issue.

Progress on reducing suicide is a testament to the choose life programme and to the excellent local clinical work to tackle depression and alcohol abuse and to support the management of people with long-term mental illness. We met our target that 50 per cent of all front-line staff would receive appropriate suicide awareness training.

People with mental illness tend to die younger and generally from physical health conditions such as heart disease and diabetes. The work that we have done to improve the physical health of people with mental illness has resulted in patients receiving regular physical health checks and being supported in developing healthy lifestyles and in tackling issues such as smoking and diet. That will continue to be part of our work to deliver excellent clinical outcomes and to support patient safety through effective medication management.

As the first Government to establish dementia as a national priority, we published "Scotland's National Dementia Strategy" in June 2010, which set out two key priority areas, as well as commitments to action. Work to deliver the strategy is being progressed with health boards, local government and organisations such as Alzheimer Scotland.

We have exceeded our target to increase the number of people with dementia who are properly recorded on GP registers. Diagnosis leads to better information and support, physical health checks, medication when that would offer a benefit, and support for carers. We are considering how we can improve and enhance post-diagnostic support, with learning from the pilots that have just concluded, and how we can offer that service in a way that meets the needs of people with dementia and their carers.

Mary Scanlon (Highlands and Islands) (Con): I very much welcome the dementia strategy, but I do not see alongside it the commitment to training and to ensuring staff awareness and understanding of dementia.

Michael Matheson: We continue to take forward the dementia strategy. An annual report was published in September this year, and a further annual report will be published next year on the progress that we have made, so the Parliament will be able to check what progress has been made.

We will continue to focus on two change areas: the provision of excellent support and information to people with dementia and their carers after diagnosis, and improvement of the care of people with dementia in general hospital settings. In particular, I am grateful for the support from the Mental Welfare Commission for Scotland, NHS Education for Scotland, the dementia service development centre at the University of Stirling and Alzheimer Scotland, which have assisted in taking the work forward.

In the consultation document, we identify four broad areas of activity in which we believe we can have a significant impact on outcomes. In each case, the focus is on a particular target or objective, but we believe that the work will have broader benefits in integrating services and producing change. I have already mentioned work in two of the areas of activity—suicide reduction and dementia—but I also want to say something about our work on access to therapies and service structure.

We are committed to meeting our target to deliver faster access to mental health services by delivering the 18-week referral to treatment for psychological therapies across all age groups from December 2014. On the face of it, that seems to be a clear and simple undertaking that can be agreed on all sides, but reworking how a complex system operates involves significant effort over time. We must also remember that the work on access to psychological therapies is just one part of creating a well-functioning mental health system. In parallel with that, boards and their partners will offer access to information and advice, self-help approaches—some of which will be online or given through NHS 24—bibliotherapy, counselling and other accessible low-intensity treatments, including exercise, to meet the needs of those who are experiencing psychological distress.

We propose work to look further at the structure of services for people with severe and enduring mental health problems. During the last session, we undertook work to reduce readmissions, and we significantly outperformed our target. We also considered crisis and first-contact services. During the next period, we propose a more structured examination of first-contact, crisis, community and in-patient services to develop recommendations for service redesign. We now have better benchmarking information about mental health services than we have ever had before, and we have experience of and expertise in local service redesign. It is time to capitalise on the information that we have and to develop our understanding to improve services more effectively.

The consultation on the draft strategy is open until the end of January 2012. I encourage members to engage in the consultation exercise; I also encourage them to encourage local organisations that work in the mental health field to engage in it to ensure that we have priorities that meet the needs of people with mental health problems in the years ahead.

I move,

That the Parliament recognises the significant progress that has been made in mental health services, mental health improvement and mental health law in Scotland, but notes that there is still work to be done and in that regard welcomes the publication by the Scottish Government of a consultation document on a new mental health strategy for Scotland that builds on previous and continuing work and establishes the priorities and actions for the next four years in support of a healthier and fairer Scotland.

15:03

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I declare that I am a fellow of the Royal College of Psychiatrists and I have an honorary professor appointment in psychology at the University of Stirling.

I agree with the minister that there is not enough time in the debate to cover in detail the full panoply of mental health. My party and I very much welcome the consultation, but I gently point out to the minister that his referral to the suicide rate in his written introduction to the consultation is slightly misleading because, as he sort of hinted, the suicide rate is again rising after a prolonged slow fall.

The consultation document refers to 14 high-level outcomes and has 35 questions, but it focuses on four particular areas. I want to cover some of those areas, although colleagues will go into greater detail.

The Government has set new targets for psychological therapies. That is welcome, but I cannot but reflect that the dropping of the target to reduce antidepressant medicine levels perhaps came just in time to slightly alleviate the Government's embarrassment about the very large rise in overall prescribing that has occurred. No matter what the minister's explanation is about daily doses and so on, antidepressant medicines are still being used extensively for the treatment of moderate to mild depression rather than only for moderate to severe depression. The inability to provide adequate numbers of psychological therapies at present, which I understand is a capacity issue, means that those medicines are still being used more extensively than they should. My colleague Mary Fee will have a bit more to say on that.

Dementia has been quite rightly identified by the cabinet secretary and the Government as a particular area of concern, and I welcome the work to achieve early diagnosis and good information for patients and carers. I applaud the continuing work of the world-class, internationally renowned dementia services development centre at the University of Stirling. The information, support and training that it provides make a major contribution to the management of dementia in Scotland, the United Kingdom and beyond. However, I am concerned that the impact of this centre of excellence could be diluted by spreading the funding to develop expertise to other Scottish universities that, hitherto, have had little expertise in the field. I am not convinced that new players will be able to deliver the training that is vital to achieve the response to dementia in general hospital settings that the minister and I both want.

The suicide reduction target towards which some progress was being made is now in serious danger of failure. I wonder how long it will be before that target is also dropped. I have made freedom of information inquiries to find out whether the removal of ring fencing from the choose life programme has led to a reduction in funding, and indeed it has. The Government has a duty to at least audit that in light of increases in suicide rates. Some local authority expenditure is being replaced by NHS expenditure but, nevertheless, the fact is that that money was given to the local authorities for that purpose. Attempts were made to reduce the funding in the Western Isles which, in view of its small population, has one of the highest suicide rates. That is of concern.

According to evidence from Professor O'Connor at the University of Stirling, self-harm in teenagers is running at 14 per cent. Its prevention requires a whole-system approach, so I will concentrate much of the remainder of my speech on early years, childhood, adolescence and young adulthood, which are stages at which, as the Government's paper says, we need to respond quickly and improve short and long-term outcomes.

We have had two expert reports that indicate clearly what the Government's general direction of travel should be. The Christie commission clearly pointed to a major shift to prevention and was in line with the work of the chief medical officer, Sir Harry Burns, on early years and children. I believe that, with limited resources, it is necessary to focus any new resources on children and young people

We need to tackle the issue of mental health in the antenatal and post-natal stages. Issues ranging from serious and enduring illness to problems with drugs and alcohol and post-natal depression all contribute, if untreated, to a poor start for the child. At present, mothers are discharged from supervision in the post-natal phase at around eight weeks, whereas post-natal depression maximises at twelve weeks. That is a problem. Treating those adults—ensuring not only that any mental illness is diagnosed but that the mothers achieve the highest level of mental wellbeing—is critical to a good start for the children.

We know that about 125,000 young people in Scotland experience mental health problems that interfere with their daily lives. How many of those cases could be prevented if the measures that I have outlined were put in place?

I believe that four groups should be given greater prominence in the strategy. The first is looked-after children, around 50 per cent of whom will have a mental health problem. That is a significant area. As we know, the number of looked-after children has grown from just over 11,000 to nearly 15,000. It is an increasing problem for us. The second group is children of offenders in custody, who are at particular risk. The third group is pupils in primary settings who face general familial problems, rather than those problems that require the intervention of the specialist child and adolescent mental health services. The fourth group is young offenders.

Along with Barnardo's and others, the charity PIace2Be focuses on preventive work in primary schools in deprived areas, encouraging problem-solving skills and providing a place to talk. In the schools where the charity has intervened, its services are used by 70 per cent of the children annually. It also supports the teachers and parents, where appropriate. That early identification prevents child and adolescent mental health services, which are undercapacity, from having to deal with the problems that would develop if a situation were left alone. I believe that the Government should establish clear targets and put in place systems to measure the outcomes for the most disadvantaged children and young people in general terms as well as the outcomes for those accessing CAMH and pre-CAMH services.

The commitment in "Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011" was that

"NHS Scotland will work with key stakeholders to develop a set of national indicators for children and young people's mental wellbeing, mental health problems and related contextual factors"—

all of which are relevant to the area that I have just discussed. Will the minister tell us whether that work is complete and whether it has been published?

The fourth group that I mentioned is young offenders. If the Government is looking for efficiency savings, it might want to address that area, because research estimates that those in contact with the criminal justice system are three times more likely than those in the general population to have a mental health problem. If we address the problems with young offenders in particular, we will be able to prevent people from going into prison, which will reduce our costs.

I visited Cornton Vale last week and found that many of the young people there had mental health problems. I was also told that many of them abused alcohol. There is a lack of screening for and detection of such mental health problems at present, which needs to be addressed.

I know that there are problems of capacity in CAMH services, which is why the 18-week target is set for 2014, but it is not acceptable that children have to wait 18 weeks for treatment. I know that the Government agrees and I appreciate the difficulties that it faces.

Students' mental health is important, so I welcome the emphasis on it in "Towards a Mentally Flourishing Scotland". I welcome the fact that 200 students and staff have now been trained in the think positive programme and that 10 universities and colleges have signed up to the healthy body healthy mind awards in recognition of the importance of sport and exercise. Siobhan McMahon will talk a bit about that, as well as about health inequalities.

As far as mental health in minority groups is concerned, I think that addressing mental health in the lesbian, gay, bisexual and transgender community is important. I hope that that will be part of the see me programme in future, and I ask the minister to confirm in summing up whether it will be. I ask him also to undertake discussion with the higher and further education sector and the NHS to make sure that counselling services in colleges and universities are not cut, because they are vital to promoting good health.

I do not have time to look at drugs and alcohol today, but I want to contrast the Government's approach on drugs, where we have a cross-party consensus and are moving forward almost as one—there is slight criticism, because progress is slow, but we are nevertheless on the same pathway—and the approach on alcohol, where we do not seem to have a meeting of minds at all. I hope that the alcohol bill will be broad enough to allow others to make a significant contribution.

The minister mentioned smoking. Given that 80 per cent of people with schizophrenia smoke and there are high levels of smoking among people with other severe and enduring mental illnesses, I hope that the move to smoke-free zones in hospitals will happen. I praise the state hospital, which is the only hospital that has achieved smoke-free status overall.

I will conclude as I began, by welcoming the consultation and expressing this party's support on a range of issues, on which we will work with the Government. We will also continue to scrutinise closely what is happening, given the need to move to prevention at a time when mental health services are under enormous pressure and are being subjected to the same sort of cuts as the rest of the health service.

I move amendment S4M-00949.2, to insert at end:

"and recognises that the strategy should embrace action to support positive mental health in the community and in employment and seek to invest in preventative spending and protect local mental health services from cuts that impact adversely on the local community."

15:13

Alison McInnes (North East Scotland) (LD): One in four adults will experience mental ill health in their lifetime. Mental health problems place enormous burdens on individuals, their families and the Scottish economy. Mental health is not just an NHS issue; it is at the core of Scotland's wellbeing. Without action to improve it, action on education, employment, criminal justice and poverty will fail.

In our manifesto, we committed to bringing forward a comprehensive and ambitious new mental health strategy for Scotland to tackle the problem across all age groups. It is therefore very welcome that the Scottish Government is also now consulting on a new strategy.

The Government's emphasis on encouraging people to take responsibility for their own mental health is sensible, but it will succeed only if personalisation and joint working between agencies become a reality and new ways of delivering services are promoted. My amendment addresses the need to recognise that and I hope that all parties will support it.

The new strategy should also recognise that, although specialist mental health services play a key role, they should not take a referral to a mental health team before an individual can discuss their mental health. We want a more holistic approach, less reliance on drug therapies and greater priority given to the provision of mental health services across all age groups.

We must ensure that those who are affected by mental health problems have access to the help that they need in the community. Improving the provision of services by increasing the access to psychological and emotional support and reducing waiting times should be a priority. Investing in prevention and mental wellbeing, rather than focusing on treating severe and enduring mental illness, will be effective in the longer term.

Some of my earliest casework involved waiting times for mental health services for children, and I am still shocked that children and young people are likely to face a staggering wait for access to such services. Like Richard Simpson, I acknowledge the progress that the Government has made. However, a child's mental distress is felt across the family and can have significant repercussions on other siblings' behaviour, so I would like the Government's target of a 26-week referral for CAMHS by March 2013 to be even more ambitious.

The Scottish Government must increase access to psychological therapies. It must take steps to increase the number of qualified psychologists in order to tackle long waiting times and the variations in provision in different NHS board areas. It should also work with voluntary organisations to explore the capacity in the voluntary sector to provide more people with faster access to psychological therapies and emotional support.

I want more community-based support services to be available, so that GPs can refer people to local services rather than reach for the prescription pad. Many GPs do not feel confident about providing information on mental health, so I ask the Government to ensure that the strategy includes a commitment to offer them continuing professional development opportunities in positive mental health.

Although more than 10 per cent of Scots make daily use of antidepressants—a worrying statistic—individuals' treatment is not regularly reviewed to ensure that antidepressants are still the best way to help them to recover. It should be made clear that people who receive mental health treatment, particularly drug treatment, should have

regular reviews to ensure that there is a focus on recovery.

Suicide is devastating and leaves its mark for generations. It continues to be a leading cause of death among people under 35. Although progress has been made, there is still a way to go. Ending the silence around it, reducing the stigma of mental illness and building an understanding that responsibility for prevention reaches far beyond the health service will all help in the short term. In the longer term, fostering self-esteem and mental resilience in our young people will pay dividends.

When the state has a direct role, it must lead by example. Whether for looked-after children, those who receive compulsory treatment, dementia patients in hospital or prisoners, much more that can be done must be done. I support Barnardo's Scotland, which has called on the Government to ensure that the children and young people who are at greater risk of mental health problems, such as looked-after children and young offenders, are identified, supported into services and provided with treatment.

The Equal Opportunities Committee reported earlier this year that it was deeply concerned about the lack of advocacy for prisoners with mental disorders. It believes that their legal entitlement to advocacy is failing to be delivered. It was chilling to read the recent report on Cornton Vale by Her Majesty's chief inspector of prisons. I will quote briefly from it:

"Nowhere is the mental health issue more stark than in the euphemistically-named 'Management Suite' in Ross House. This segregation area is more colloquially known as the 'back cells'. These cells are utterly depressing and are an unsuitable environment in which to hold very vulnerable girls and women. It is my view that these cells are used primarily as a control measure. Staff are insufficiently trained to deal with the women held there.

I conclude that the treatment of vulnerable women with mental health issues must improve."

I urge the minister to discuss that with his colleague the Cabinet Secretary for Justice.

The Mental Welfare Commission's "Not properly authorised" report highlighted significant failings in the proper authorisation of, and obtaining of consent to, medication for those who receive compulsory treatment. Its "Starved of Care" report, which we discussed in the Parliament, described the treatment of Mrs V, an 80-year-old patient at Ninewells hospital, as degrading and unnecessary and said that it may have breached her human rights. Those examples underline how far we still have to go to ensure that people who have mental health problems are treated with dignity and respect. Ending the stigma and discrimination that currently exist around mental health problems, improving access to good, responsive community-based mental health services and fostering a nation of people with good self-esteem and mental resilience are among the best investments that we could make.

I move amendment S4M-00949.1, to insert at end:

"and believes that, in moving forward, greater personalisation, better joint working and a focus on prevention and mental wellbeing are key to achieving better, more efficient services."

15:19

Mary Scanlon (Highlands and Islands) (Con): The Scottish Conservatives welcome the publication of the Scottish Government's consultation document on a new mental health strategy, and we support the motion and the two amendments. I agree with the Scottish Association for Mental Health, which has stated:

"Without good mental health, Government strategies on education, poverty, employment and many other areas ... cannot succeed."

The consultation document is very NHS focused, but good mental health is not all about additional legislation or NHS treatments. I therefore hope that the recommendations of the McManus review of 2009 will be looked at again and implemented and not repeated in the consultation process.

It is important to consider some figures on mental health, to put the debate into a health and financial context. The latest social and economic costs of mental health issues in Scotland are £10.7 billion, which is nearly one third of the Parliament's budget. More than one third of GP visits are for mental health issues. In Scotland, 47 per cent of people on incapacity benefit and 50 per cent of looked-after children have a mental health problem. Seventy-nine per cent of people with mental health problems are unemployed and £1 million is lost every day in Scotland as a result of sick leave for mental health reasons. Up to 70 per cent of the prison population has mental health problems. Given that, from next month, the NHS will have responsibility for providing mental health care in prisons, has additional resource been given to the NHS or will the resource for the estimated 5,000 mental health patients who are prisoners be taken from the current NHS budget?

Last year, 10.4 per cent of our population aged over 15 took antidepressants daily. This year, the figure is 11.3 per cent. I do not know how many pills they took, but the percentage is up according to the Information Services Division. Surely a review should be carried out of the 75 per cent of people in care homes who are given psychoactive medication daily, not only to reduce the amount of drugs but to ensure that people get the right medicine for their condition.

Between 50 and 70 per cent of people who are addicted to drugs taken and alcohol have a mental health problem. Although they do not always get the sympathy that they deserve, their addiction is often a form of self-medication. Between now and 2014, all recipients of incapacity benefit in Scotland will be reassessed to find out whether they are fit or unfit for work. It is reasonable to say that many could be fit for work, but only if they get the right diagnosis and the appropriate care and treatment when they need it and are given the necessary support.

Two of the best visits that I have made in the past year were to projects that cost the NHS nothing. They are social enterprises that support people with mental health issues. Rag Tag 'n' Textiles in Balmacara provides a place for people to discuss their issues and focuses on bringing out creative skills. It successfully produces goods from donated materials such as old Harris tweed jackets, which last for ever, and sells them in its shop.

I also praise the project at Redhall walled garden in Edinburgh, which I visited last winter with David McLetchie. The project, which is run by SAMH, brings people out of their homes to work in the garden. Each trainee is given a set of goals, which can be as basic as turning up at 9 o'clock for the first three weeks. For people who have chaotic lifestyles in which night is turned into day and there are no weekends, that gives a structure to their lives. We met trainees at Redhall who spoke of their isolation for years and their worsening condition prior to attending. They were able to talk to people and regain self-respect and confidence. Many people leave Redhall to go into paid employment, and there is a waiting list to join the project.

According to Barnardo's, 70 to 80 per cent of people with mental health problems recover. We always speak about postnatal depression as a temporary problem, but more could be done to empower patients with other mental health issues to believe that they can get better. Also, the workforce need to reinforce a much more positive message.

When a Government places waiting targets on one patient group and not another, the resource inevitably follows the targets and leaves the rest to languish. Despite the Government's new target for psychological therapies for children and adolescents, children still have to wait more than two years to have their target waiting time for mental health services reduced to six months.

The consultation document also talks about dementia. As I said when I intervened on the minister, the key to implementation is to train and support the workforce that is working with people who have dementia. Better bereavement counselling is also needed, as is more work with health visitors—I am moving on quickly because I am conscious of the time.

Outcome 9 in the document is critical of the reach of mental health services. Surely we should be trying to keep people in work rather than allowing them to become chronically and severely ill, unemployed, depressed and more isolated. That can be done through self-help groups and NHS 24.

Outcome 13 says that "change is complex". A change of attitude from can't do to can do is not complex and is very cheap.

15:26

Dennis Robertson (Aberdeenshire West) (SNP): I welcome the debate and am positive about it. I welcome many of the minister's comments, and Alison McInnes's amendment.

There is a lot to be done, but a lot has already been achieved, not just by the current Government but by the previous Executives. We have to applaud the work that has been done by the Government and Parliament. However, we recognise that there is still a lot to do, which is why the new strategy and consultation document has come out.

I thank Barnardo's, SAMH and the National Union of Students Scotland for their briefing for the debate. I also commend their websites, which help us to understand mental health issues.

We all have mental health. Many of us—the majority of the population—have good mental health. I liked the mental health sliding scale that SAMH used in its briefing. We will all have issues in our lives that will impact on us from day to day. Some will have a short-term impact, and some will make us very sad or happy. I remember my elation at being elected on May 6, but it was tinged with sadness because my daughter had died earlier this year. That brought home to me the issue of mental health and wellbeing.

I welcome many of Dr Richard Simpson's comments, and I understand that many children, particularly looked-after children and certainly those who are going through the criminal justice system, need to be prioritised and need the support of the Government and Parliament.

When the minister considers preventative spending, I urge him to look at training. Training helps to ensure that those who work in the care home sector, local authorities, the criminal justice system and hospitals have the appropriate training so that we can identify mental health issues and intervene much earlier, as such intervention is extremely important.

Alison McInnes made an important point about integrated services and, in the social care debate last week, Dr Simpson asked about joint futures. That is the way to go. We need to work together to ensure that everyone in our society benefits from the knowledge we have even within the tight resources that are available.

I welcome many of the comments that have been about child and adolescent mental health services. We are moving forward and I welcome the Government's spend of £6.5 million for additional staff in that workforce. I also welcome the additional £2.5 million to try to ensure that those services are taken out of a clinical or hospital base. After all, such locations are not the right or the most appropriate places for most of our children. I agree with Dr Simpson and, I think, Alison McInnes that we need to look at community-based locations where our young children can attend appointments and have the therapies that they require.

Much has been said about prescription drugs and prescribing by GPs. The fact is that that is their job; they make a clinical assessment and judge what their patient requires at that time. Nevertheless, the practice needs to be monitored and measured. I believe that we are moving in the right direction towards a more integrated approach with the psychological services that are available and I know that that will be welcomed.

I welcome NUS Scotland's comments about its think positive campaign. University and college students feel a great deal of stress and anxiety; of course, some of that is to do with leaving home for the first time. Indeed, many parents experience the same emotions—although I have to say that they can also feel a sense of relief. However, I share the concern that, for LGBT groups in particular, there is still a lot of stigma attached to this issue and that we need to focus on moving away from that. Discrimination is neither warranted nor needed; young people must be able to live the lives that they wish to lead and I would welcome any move by the Government and the Parliament to ensure that resources are available to allow our young students to move positively through their education and beyond.

I also welcome the third sector's initiatives. Many of those agencies have been working together to provide mental health first-aid training; indeed, I and many of my colleagues in the social care sector have benefited from it. I have already mentioned training—and will probably raise the issue in Parliament many times—but the fact is that if we are to move towards preventative spending, we have to examine the training base. People must have the appropriate training to provide the outcomes that are necessary and towards which we are all striving.

As I have said, we all have mental health. As Alison McInnes made clear, one in four of us will find ourselves in a situation that goes beyond our everyday mental health. As Dr Simpson pointed out, people are being prescribed drugs normally used to treat conditions beyond mild and moderate depression. We need to educate people about the fact that depression is not a singular thing but takes many forms. We do not know the root cause of it. We know why some people can feel depressed—

The Deputy Presiding Officer (Elaine Smith): Mr Robertson, I wonder whether you could come to a conclusion. You are over your time.

Dennis Robertson: In that case, Presiding Officer, I will conclude.

15:33

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I generally welcome the draft mental health strategy, which builds on previous and continuing work and suggests 14 distinct outcomes that define the actions that the Scottish Government will endeavour to take over the next four years. However, I will have time to consider only the first two.

I am very pleased that up front, at number 1, is the key issue of protecting and promoting mental health. Ten years ago, there was a major drive to develop a mental health improvement agenda, which was spearheaded by the see me and choose life campaigns. It has always been a matter of regret to me that the Scottish public has never fully appreciated the groundbreaking nature of that work, a central part of which has been to combat stigma. In that regard, I pay tribute to the continuing work of see me, which during mental health week in a couple of weeks, will have 250 stalls across the country.

As a recent study by see me showed, stigma can manifest itself in the kind of disgust that prevents sufferers of conditions such as anorexia and bulimia nervosa, for example, from seeking the support that they need. Broader society still misunderstands those life-threatening mental illnesses, so in broaching the subject and forcing it into public discourse, see me does an immense service for the hundreds of young Scots who suffer in silence every day. It gives information to family and friends on how best to intervene safely, and its material highlights the severity of the conditions. Without raising awareness of the complexity of mental health problems, we would find it impossible to achieve the objective of removing stigma; only when we have broken down the stigma surrounding poor mental health will we truly realise the potential of our community

services to provide a route out of social exclusion and marginalisation.

Clinical treatment is only half the solution. Often, what is needed most is the knowledge that someone to whom a person can relate understands their situation and is ready to talk and listen. That is the worth of community-based services, and I hope to have time to mention some that are based in my constituency.

That community focus is also relevant to the suicide prevention strategy called choose life, which, like see me, was developed in 2002. It aims to equip organisations that have direct links to sufferers of poor mental health with the skills to detect suicidal tendencies and to offer appropriate assistance. By training a proportion of the population, it will ensure that more skilled and confident helpers are available to explore thoughts of suicide and to intervene. In that connection, I note the recommendation of SAMH that suicide prevention training should be expanded beyond the statutory sector to encompass people who work in the community.

In its "Foundation Stone" document, SAMH makes the important comment that a mental health strategy should not be located solely within the health department, because mental health is fundamental to wellbeing, to the ability to remain in employment, to criminal justice, to social work and to many other areas. What appeared to me to be a slight weakness of the Government's draft strategy as I moved to outcome 2 is that, although a great deal of work is being done and is proposed for the early years, none of it is joined up with the CAMHS focus of that section.

The CAMHS work is essential for those who need intensive services, but it must be complemented by greater investment in early intervention across communities. I warmly welcome the £500 million for preventative spend that was announced last week, but I would have preferred that the majority of that money be spent on the early years, particularly nought to three, rather than being spread too thinly across a range of areas. As Dr Philip Wilson told the Health and Sport Committee in 2009, work in America suggests that it is possible to predict by the age of three as many as 70 per cent of the children who will end up as in-patients in psychiatric hospitals or in prison.

On the detail of outcome 2, I note the reference to the very important standards for integrated care pathways, but there is no mention of implementation support, whereas question 13, which refers to adult services, asks:

"What support do NHS Boards and key partners need to put Integrated Care Pathways into practice?"

If integrated care pathways were implemented in CAMHS and adult services, many of the other questions that are asked in the document would be answered.

I note, too, that although the overarching improvement challenge 2 refers to "developmental disorders", no definition is given. The implication seems to be that it refers to such disorders in adulthood. It is certainly the case that no mention is made under outcome 2 of important disorders that affect children, such as attention deficit hyperactivity disorder, developmental co-ordination disorder and autistic spectrum disorders. It is not clear, either, why £10 million has been set aside for autistic spectrum disorders alone, rather than for developmental disorders more generally.

As I said earlier, there are some great community projects based in my constituency, which I now want to mention. The stress centre in West Pilton is an outstanding example of a project that is user led and which keeps services in the community. Along in Royston is women supporting women—another superb project that, unfortunately, has had its budget decimated over the past few years. I fully understand the financial problems of local authorities, but I remind them of their duties under sections 25 and 31 of the Mental Health (Care and Treatment) (Scotland) Act 2003, which require them to provide care and support for, and to promote the wellbeing of, people with mental health problems.

In Leith, there is the crisis centre where the minister launched the strategy a couple of weeks ago, which was campaigned for by the Edinburgh Users Forum over many years. AdvoCard on Leith Walk does individual and collective advocacy work. At this point, I should mention the concerns of advocacy organisations that the strategy contains nothing on advocacy, even though advocacy is essential, as well as being a requirement of the 2003 act. Also in Leith is the Junction—a superb base for young people which, over and above the wider health work that it does, offers a safe and friendly environment for young people to talk about difficulties that they may be experiencing. I should also mention Saheliya, which is an outstanding example of a community-based organisation that recognises the specific issues that affect the wellbeing of ethnic minority communities and is therefore directly relevant to outcome 9.

The Deputy Presiding Officer: I would be grateful if you could conclude now.

Malcolm Chisholm: I pay tribute to all those excellent voluntary sector organisations in my constituency. Without them, the work of the statutory sector would be far more difficult than it already is.

The Deputy Presiding Officer: I reiterate that speeches must be of six minutes, as we are tight for time.

15:40

George Adam (Paisley) (SNP): I hope that comment was not directed at me. [*Laughter*.]

The subject is close to my heart and I appreciate the minister's comments that, although much work has been done, there is so much more that we can and will do. I never had experience of mental health issues until I became an elected member of Renfrewshire Council and dealt with some groups—although I think that that may not have been the case, because the stigma of mental health means that, without knowing it, I probably did have dealings with people who were suffering from various forms of mental ill-health. It either affects you or your family: my son James was diagnosed as being on the autistic spectrum last year. We have had to deal with it.

I welcome the consultation on the mental health strategy, which includes 14 high-level outcomes to measure the success of what we can achieve. It will ensure that we can close any gaps that exist. The existing work and further actions should be prioritised to reach the challenge.

The minister is correct that the Scottish Government's first dementia strategy was published in 2010. I had met someone in the Renfrewshire Carers Centre and I came across him again on Saturday night in a licensed premises. His wife has dementia and he was there because he was able to spend some time on his own—which is down to the Scottish Government. He was proud of my being his MSP, he was pleased with what had happened and he wanted to know whether I would sing a song—which showed what his major problems were at that stage. I was more concerned with the problems that he had to deal with daily. My wife has since told me that I must deal with my work during my working day and not take it home with me—it had a profound effect on me. I have noticed it in my colleagues on Renfrewshire Council, such as Lorraine Cameron in Paisley and Provost Lawson, who were working with survivors of bereavement by suicide in Renfrewshire, and whom we met at a tree they planted outside Renfrewshire Council's Paisley headquarters at Renfrewshire house. It makes it so much more real and emotional when we see people who have suffered because of these issues.

I welcome the target of a 20 per cent reduction by 2013. It is important to set targets. We are dealing with real people with real lives and real issues.

We must move away from there being a stigma attached to mental health. My colleague Dennis Robertson said that we all have mental health and that the issue is how healthy is our mental health. Since my election, I have met so many people in Paisley who have suffered because of the problem. They include a Scrabble champion who, along with his wife, suffers from depression. It took him longer to admit it because Paisley men do not get depression. Another example is the woman who would not leave her home because of her fear of everything, but who now enjoys writing poetry and other artistic pursuits. Another Paisley example is a woman who has become a writer. It is proof that, when working with local authorities and partners in our communities, we can make a difference in small ways to help these people's lives.

Neil Bibby (West Scotland) (Lab): I hear what the member is saying. I also speak to people in Renfrewshire who are very concerned about cuts to educational psychology services by the SNP administration in Renfrewshire. Is that something George Adam would like to address and reverse?

George Adam: In an effort to have a Renfrewshire Council debate in this chamber, I will respond by saying that I could take the member's question more seriously if his group had taken on the question of whether it would have a budget and say what it would do. His group had no budget, no answers and no future for anyone in Renfrewshire. I am sorry, but I will not take anything from the Labour Party in Renfrewshire.

We need to build on the progress that has been made and the early recognition of mental distress and prevention of illness. The importance of being included in local planning is highlighted by the issues I have mentioned. Working with families on dementia has been fantastic, and planning around the families and carers is important. That not only makes it better for the families, but in difficult times for local authorities we can save money.

It is important that we get the stigma out of mental health. The Scottish mental health arts and film festival is on at the moment, and Renfrewshire is doing its bit. I am going along to an event on 1 October, and Mr Bibby would be welcome to come and spend some time with these people. The brochure states:

"The Renfrewshire Festival Team is proud to present this 4th programme as part of the national Scottish Mental Health Arts and Film Festival."

Therefore, it is not all gloom and doom. There are various events, such as talks in pubs in Paisley, the "Memories and Dreams" art exhibition, and comedy and poetry events featuring people who have suffered from various mental health issues.

Although we live in difficult financial times, a lot is being done within our communities. We are dealing with real people, their families and the organisations that they represent across Scotland. I, for one, will encourage them all to engage with the consultation process.

The Deputy Presiding Officer: Thank you for finishing on time, Mr Adam. My remarks about speeches being six minutes were, of course, for everyone in the chamber. I call Margaret Burgess.

15:46

Margaret Burgess (Cunninghame South) (SNP): Thank you, Presiding Officer. I hope that I will keep within my time.

I welcome the opportunity to participate in the debate. Promotion of good mental health should be important to us all—that has come through clearly from throughout the chamber from everyone who has spoken. There is a consensus that we want to do something and to improve our mental health strategy. That is to be commended.

It is right that our mental health strategy is focused on the individual, but it must also be effective and operate in a culture of continuous improvement. That is why we are looking at the strategy again at the start of this new session of Parliament.

Many members have spoken about the briefings that we have had from Barnardo's, SAMH, and Action for Smoking and Health Scotland. They are helpful and useful, and I hope that they will inform the debate and the strategy that we will finally agree.

As the minister said, we should recognise that significant improvements have already been made. There has been a reduction in psychiatric admissions; we have the national dementia strategy; there has been an increase in dementia diagnosis by GPs; there has been a reduction in deaths by suicide; there has been a recognition of the role of families and carers in the treatment process—my colleague George Adam mentioned that; and more people are being treated in the community.

The one thing we have all agreed is that we have not tackled the stigma completely. We should not beat ourselves about the head too much about that, because we are tackling generations of stigma about mental health; it is not just something that has occurred in the life of this Parliament. I remember 40-odd years ago a member of my family being diagnosed with a serious mental illness. It was not talked about and we were not allowed to mention it. My parents died and it was never spoken about in our family. That is sad, because there was no shame in it. I know, and always knew, that there was no shame in it, but we just did not talk about it—not in the house and not outside. That is what we are tackling, but we have moved a long, long way since then. I can stand up here and say that my father had a serious mental illness, and there is no shame in it. That is the message that we must get out to all the communities. I therefore support the see me campaign, what it has done in the field and the support that the Scottish Government has given it.

I will concentrate the rest of my remarks on external factors that have a significant impact on mental health. We cannot have a debate on mental health that does not link with the social and economic issues, such as deprivation and poverty, that all impact on mental health. For me, the best illustration is my constituency in North Ayrshire. North Ayrshire community health partnership has a higher than average percentage of people living in deprivation, and it has the highest unemployment and youth unemployment of any community health partnership area in Scotland. It also has a higher than average number of patients who are being prescribed drugs for depression, anxiety and psychosis; a higher than average number of patients with psychiatric hospitalisation; and a higher than average number of deaths by suicide.

Malcolm Chisholm mentioned the work of the choose life strategy, which has had an impact on the suicide rate in North Ayrshire. The rate is still above the average, but has come down dramatically and is now at a 12-year low. I hope that that trend will continue. It is the work of the see me strategy and that of local groups and organisations, which are not all health-centre based but which work collaboratively for the common aim of reducing the number of suicides. That has worked in North Ayrshire and it must continue, and the strategy that we develop should take that into account.

NHS Ayrshire and Arran has exceeded the 50 per cent HEAT target for suicide prevention training of front-line staff. I agree with other members that that training should go beyond health service staff to any public services and voluntary organisations that come into daily contact with people with mental health issues.

We cannot hide from the fact that poor living conditions, worklessness and financial problems are contributory factors to or, sometimes, are the cause of the more common mental health problems. The spending review that the Cabinet Secretary for Finance, Employment and Sustainable Growth announced last week looked to the long term in setting up new enterprise zones in deprived areas, the more choices, more chances programme and the social wage, which will prevent some of the minor mental health

issues that we see just now from occurring. All those programmes are designed for long-term stability.

For those who have more complex and enduring mental health problems, we still need a very integrated service, because external factors will impact on them. Changes to the benefits system, for example, will impact on people with mental health problems. They can be sorted out and their conditions can be stable, but having no money can have a knock-on effect and can have them back receiving more intensive treatment. Such external factors must be considered in any strategy.

I support the motion in the name of Michael Matheson and look forward to seeing all the responses to the consultation.

15:52

Mary Fee (West Scotland) (Lab): I am glad to take part in the debate and I hope that the Scottish Government will listen to all voices and to issues that have been raised by members from all sides.

Last week the Cabinet Secretary for Finance, Employment and Sustainable Growth presented his budget for the forthcoming year, in which there is the statement:

"Good mental and physical health and well-being is vital for individuals to participate fully in economic and social life."

I agree fully with that and support it 100 per cent. However, on further reading of the health budget in the section entitled "What the budget does", I found no specific mention of how the Scottish National Party plans to create good mental health. There are plenty of promises aimed at tobacco and alcohol use, dental treatment for children and sexual health in Scotland, but no statement on how to improve mental health and wellbeing among our population.

It is critical for the benefit of future generations that we address the mental health problems that face our society. To a certain extent, last week's budget will start to address those issues through Mr Swinney's increased investment in the early years framework, which is action that I fully support.

It is estimated that around 130,000 children In Scotland have mental health problems. If we can address such problems early, a child will be less likely to develop chronic mental disorders in adulthood. It is also believed that half of all looked-after children in Scotland suffer from poor mental health, and they are some of the most vulnerable children in our communities.

It is for that reason that I back calls by Barnardo's Scotland to provide

"more mental health training for front-line staff in universal services dealing with children and young people on a day-to-day basis"

I hope that the Government will take on board that call when it implements the increased budget for early years. Such front-line staff, such as teachers and carers, will be able to find problems in a child quicker and should be able address the problems earlier.

It is clear that one of the biggest reasons for poor mental health in children and young people can be their background—many of the poorest children in society suffer from significant mental health problems that stem from the behaviour of their parents or from substance abuse. Under this Scottish Government, child poverty has worsened. If it wishes to improve the life chances of every generation, it is failing miserably as more and more children end up in poverty.

It must be said that the Con-Dem cuts in Westminster have contributed to child poverty rates, but the figures still show that child poverty has been on the increase since the SNP came to power in 2007, three years before we were landed with a Tory Government.

Important as it is to focus on the mental health of our children and young adults, it is equally important that we treat problems in the many adults who suffer from poor mental health. They might be forced out of work and end up on benefits, and they might suffer long-term illness. Parents with mental health issues should be given the best possible treatment so that they can overcome problems that could have a negative impact on the care and wellbeing of children.

Two stories caught my attention during the past week and gave me cause for great alarm about how well the Government is tackling mental health in Scotland. First, the Government released figures that show that the number of Scots on antidepressants has increased and that one in 10 Scots over the age of 15 takes antidepressants.

Secondly, a Royal College of Nursing survey found that 75 per cent of nurses in Scotland think that stress has increased in their workplace. Like many members, I do not think that nurses are alone in thinking that there is more stress in the workplace. The stresses of modern life, particularly in times of economic uncertainty, have contributed greatly to the rise in antidepressant use. The Scottish Government must take some blame for nurses' stress and low morale, because 4,000 nurses have been lost since it came to power in 2007. It continues to add to that number.

Increased pressure on workforces throughout Scotland creates a worrying picture. Pay freezes, job cuts and general uncertainty about job security all contribute to the rise in medicinal treatment of

mental health problems, as do the cuts to CAMHS and third-sector organisations such as RAMH, which I congratulate on its delivery of services in Renfrewshire and the west of Scotland for the past 21 years.

I stress the importance of the services that RAMH and other organisations in the west of Scotland provide to people who have mental health problems. RAMH's chief executive, Stephen McLellan, told me that the biggest challenge that RAMH faces is to do with not being heard at national level by the Government and health service, even though every week the organisation works with 670 people in the west of Scotland who have mental health problems. If we did not have third sector organisations such as RAMH, the cost to our health service would be much greater. As I have said before, there must be a better working relationship between national Government, health boards and social care providers, to help to meet the challenges that we face in society.

I will talk about mental health for the elderly—members might have noticed a running theme in my speeches. A few months back, I received a letter from a constituent, whose mother has been living with dementia for some time. The mother had been receiving weekly support and had been attending mental stimulation classes until Renfrewshire Council reassessed her case without explaining its decision. The gentleman who contacted me explained that his mother, who is in her early 80s, has had to resort to private care. He said that he is lucky enough to be in such a financial position as to be able to provide the extra care that his mother requires, but for many dementia sufferers no such resource is available. It saddens me to hear of cases in which cost-cutting measures of local authorities such as Renfrewshire Council have a detrimental effect on the mental health and wellbeing of not only the dementia sufferer but the family, who are left to pick up the pieces.

The Deputy Presiding Officer: You must conclude, please, Ms Fee.

Mary Fee: Yes. I will finish by quoting from Mr Swinney's spending review document:

"Providing high quality care and support for older people is a fundamental principle of social justice and is an important hallmark of a caring and compassionate society."

If only the SNP would show that care and compassion, I would believe that it was sincere in making that statement.

15:58

Fiona McLeod (Strathkelvin and Bearsden) (SNP): Like other members, I welcome the publication of the consultation document on a new mental health strategy, which will allow many people in Scotland to contribute to the debate.

As members said, one in four of us will experience mental ill health at some point in our lives, but mental ill health is still one of the most hidden illnesses in Scotland. I join members in thanking the see me campaign and in welcoming and supporting its work to try to end the stigma of mental ill health. I should perhaps also say: "See me? I've been there."

I have been a bit disappointed by the number of members who talked about the increasing prescribing of antidepressants as if that is a problem. As Dennis Robertson said, medicines—antidepressants are medicines—are prescribed by doctors to patients who need them.

Jackie Baillie (Dumbarton) (Lab): Does Fiona McLeod accept that GPs seek alternatives to medication? The point is about access to psychological therapies, on which I think we can all agree.

Fiona McLeod: We must all agree that doctors, and not ministers, prescribe. Jackie Baillie has led me nicely to the main part of my speech, which is on the evidence base for alternatives to medication. Those alternative therapies can be used to support the medication rather than being used on their own.

I will focus on the evidence—of which I am aware from my days as a health librarian—for using physical activities to support people with mental problems. Those include t'ai chi and yoga, which I do daily. I point members towards the evidence that such activities reduce blood pressure and stress, and that the more one does them, the more cumulative the effect is.

The effect is similar with more vigorous forms of physical activity: we are all aware of the evidence that exercise releases endorphins, which many of us will know as the happy hormones. They are always lacking in people who suffer from depression, which is one of the reasons why we must prescribe medication for them.

There are other forms of activity that people with mental ill health can look towards, such as mindfulness and meditation. There is evidence that regular use of mindfulness as an attitude to life cuts relapse rates for depression in half.

One of the areas that I particularly like is animal-assisted therapy. Many folk will know of the evidence that ownership of a pet, especially a dog or a cat, lowers the risk of heart disease and high blood pressure. I encourage members to turn on the National Geographic Wild channel and watch the dog whisperer Cesar Millan, who is one of my heroes. It is all about being a calm and assertive leader when you are training a dog. If that is not

the foundation of good mental health, I do not know what is.

Those are all proven therapies, and—as members might expect, given my background—they are all based on evidence such as randomised controlled trials and meta-analyses. I am talking about those therapies today not only because they are good when one has a mental illness; they are also tools to use in periods of wellness. They are long-term therapies, so they need long-term support rather than just an eight-week prescription. Perhaps all of us, rather than just those of us who have mental health problems, should practise such therapies day in, day out for a calmer and better life.

Mary Scanlon: I—along with other members—am not advocating that everyone should suddenly come off antidepressants, but that people should have a choice of other therapies, which they are asking for, and that they should receive the support and advice that Fiona McLeod has outlined today. I also want prescriptions to be reviewed every three or six months or every year, as many people are on antidepressants for decades.

Fiona McLeod: Again, I refer Mary Scanlon to the fact that prescriptions are given by doctors, who will review the medication, when necessary, for each patient.

I have a small amount of time left, but there are two areas on which I want to pick up. One is mental health in old age. I am delighted to see the dementia strategy, but we must not forget that dementia is not the only mental illness of old age. Too often, depression can be dismissed as being just an adjunct to old age, but those with mental health problems in old age must be viewed in the same way as anyone else with a mental health problem.

I turn to the Welfare Reform Bill that is currently going through Westminster, to which my colleague Margaret Burgess referred. The SAMH briefing that members have received states that

"sweeping changes to the benefits system will impact people with mental health problems",

that

"over 46 per cent of incapacity benefit recipients in Scotland have a mental health problem",

and that

"the work capability assessment"

that recipients must undergo

"has been shown to be flawed and mechanistic and unable to capture the impact of mental ill-health on a person's ability to work."

I have experience of that with the lovely company Atos Healthcare, which asked me when I was on incapacity benefit with depression whether I could touch my toes. I am not quite sure how that showed whether my mental health was well.

I look forward to a mentally healthy Scotland, and I hope that members on all sides of the chamber can work together to ensure that the Westminster Government clearly recognises the problems that the Welfare Reform Bill will bring to those with mental ill health.

The Deputy Presiding Officer: Once again, I make a plea for six-minute speeches; otherwise, I may have to drop the last speech.

16:05

Siobhan McMahon (Central Scotland) (Lab): As the motion states, over the short lifetime of the Scottish Parliament "significant progress" has been made in the way in which we perceive and deal with mental health issues.

I am pleased with the emphasis in the consultation document on collaboration and co-operation in the provision of mental health services. A preventative approach to mental ill health—an approach predicated on good education and early intervention—is essential, especially when it comes to diagnosing and treating behavioural conditions and mental distress in children and young adults.

I admit to being somewhat deflated by the fact that any debate on mental health inevitably involves the discussion of stigma, discrimination and prejudice. The health of the mind is no less important than the health of the body, but society has a tendency to prioritise the tangible, such as a broken arm or leg, a deep wound or the external manifestations of cancer or heart disease. We know that those things exist and are real because we see the havoc that they wreak on the body, whereas an ailment of the mind is more elusive. Mental illness may have a very marked effect on personality or behaviour, but its lack of an easily discernible cause or concrete physical manifestation means that it is often not afforded the same respect and importance as physiological illness. However, as modern life becomes increasingly pressured and demanding, and as medical advances continue to ensure longer life spans, the number of people who are affected by mental health issues will continue to rise.

A recent study revealed that, every year, 38 per cent of European Union citizens suffer from some form of psychological or neurological disorder, with 14 per cent suffering anxiety disorders, 6.9 per cent experiencing depression and 5.4 per cent having dementia. With an ageing population leading to an increase in neurological conditions such as Alzheimer's and dementia, and with 90 per cent of anxiety disorders occurring for the first

time in children under 18, it is possible to envisage a crisis at both ends of the age spectrum. Other than the positive suggestions that are already contained in the consultation document, what can be done to avoid such a crisis? We must view the causes and effects of mental ill health across a broad canvas. The curriculum for excellence should include training for teachers that helps them to identify children who may be suffering from anxiety disorders. That could be usefully combined with other recommendations in the consultation document, such as that there should be greater integration of and communication between local authorities, schools and social and health services.

Equality and inclusion are vital to improving mental health. Those who are in mental distress often feel isolated, abandoned and alone. That is partly a product of their illness, which encourages insularity and self-absorption, but it is also partly a product of residual misconceptions, stigmas and prejudices. Many people in mental distress have a negative attitude to their condition and suffer from self-loathing and low self-esteem. To help them to escape that pernicious cycle, we must demonstrate that we, as a society, care about them and value them. Evidence has shown that the healthiest and most equal societies are also the happiest. Conversely, symptoms of inequality such as poverty, abuse, substance misuse, unemployment and homelessness all contribute to a downward spiral of depression and hopelessness. A truly co-ordinated and preventative approach is one that recognises that and takes action to eradicate poverty and ensure equal opportunities for all.

Equality of access to sporting, educational and artistic opportunities can alleviate mental health problems, as can exposure to green spaces and positive physical environments. Regular employment can be of considerable benefit, both as a route out of poverty and as a means of providing a sense of meaning and purpose in life. It is, therefore, imperative that the forthcoming welfare reforms do not allow people with mental health issues to slip through the net. We should utilise the immense natural resources at our disposal. Scotland has some of the most beautiful and evocative scenery in the world, regular exposure to which would greatly enhance our physical, emotional and mental wellbeing. Involvement in group sports encourages positive contact and interaction with other people, and the recuperative power of art and literature should not be discounted.

If we are to end the stigma of mental illness, we should also attend to the language that we use in daily life. Many members will remember *The Sun*'s "Bonkers Bruno" headline, for which it got little more than a slap on the wrist. Unfortunately, such phrases are still used with alarming regularity, feeding into the language and perpetuating misconceptions of mental illness.

If press outlets persist in belittling mental illness with flippant and irrelevant references to "psychos" and "schizos", severe and appropriate action must be taken. The approach is outlined in clause 12 of the Press Complaints Commission's code, which is on discrimination. As with the casual use of sectarian language, ignorance or lack of intent is no excuse.

We need to take an empirical approach to prescribing treatment. Prescriptions for antidepressants are on an upward curve. The danger is that pills will become the default solution to problems that could be solved through discussion-based therapies that encourage individuals to question established patterns of thought and behaviour. GPs and other health professionals must be aware of the different forms of treatment that are on offer, whether they are provided by the NHS, local authorities or the third sector.

We must remember that mental distress, especially in its severest manifestations, does not just impact on individuals. We must widen access to post-bereavement counselling to ensure that those who have lost a relative or friend to suicide are afforded the help and support that they need.

In a civilised democracy, individual rights and freedoms are cherished. We must empower people to take ownership of their lives and to be an active part of the solution to their problems. As anyone who has suffered from mental distress knows only too well,

"The mind is its own place, and in itself
Can make a heaven of hell, a hell of heaven."

16:11

John Wilson (Central Scotland) (SNP): Mental health is a vital issue that deserves to be discussed, particularly given the growing recognition that one in four people in Scotland will experience a mental health problem in their lifetime—a figure to which some members have referred.

In its "What's it worth now?" report, SAMH estimated that the cost of mental health problems in Scotland rose to £10.7 billion in 2009-10, which marks a 26 per cent increase since 2004-05. The Scottish Government's figures show that depression and other affective disorders were the fifth most common conditions to be reported in GP consultations in 2009-10. Given the significant social, economic and health consequences that are associated with mental health concerns, it is essential that the Scottish Government and others continue to consider the most effective ways to

diagnose, monitor and find solutions to prevent, where possible, mental health conditions.

In recent years, we have without doubt witnessed a vast improvement in the delivery and availability of mental health services, but much more must be done to ensure that the best-quality care is provided in Scotland. I am glad to note that the Scottish Government is looking to improve matters further and to build on the work that has been done in previous years to promote a safe and effective person-centred approach to services.

I recognise that the consultation seeks to build on the quality strategy, which focuses on how care and treatment are provided for each patient, and to develop a meaningful conversation between patients, carers, families and healthcare providers. That should include not relying solely on prescription drugs as the automatic default position for treating those with mental health conditions.

As part of the consultation exercise, it should be noted that people who live with family members who suffer with mental health conditions are not always provided with the necessary support, which can, and often does, leave them vulnerable.

To provide a comprehensive approach, it is crucial that local authorities and other public agencies work closely with local services on the early detection and treatment of mental health issues, particularly in the education system. The 2009 Audit Scotland report on mental health services noted that one child or adolescent in 12 has a mental health problem.

A focus must be placed on implementing effective preventative measures for young people who are at a higher risk of developing mental health problems, who include those who live in deprivation, children who are in care and young offenders. More must be done to recognise vulnerable children and to ensure that, when they are identified, adequate child and adolescent mental health services are provided. The NHS Health Scotland children and young people's mental health indicators that are due to be published later this year might well provide useful insight into that.

Training people in the education system to recognise and support young people who display signs of mental health conditions would be an effective way of ensuring that quick referrals are made to the relevant services and would provide familiarity at what is already an anxious time for young people.

The need to continue to consider the range of services that are available for the prevention of suicide remains apparent. Through the choose life programme, organisations such as SAMH are working with the Scottish Government to reduce the suicide rate by 20 per cent by 2013. Suicide rates have been on a downward turn, but there continues to be a significant problem, particularly for males. In 2010, the male suicide rate in Scotland was just under three times that for females. SAMH has drawn attention to the fact that suicide prevention training should be expanded beyond the NHS to include the wider community, given that people who attempt suicide may not necessarily have been in previous contact with the mental health system.

It is important to keep in mind that the Scottish Government's strategy for the future is being developed despite substantial cuts at Westminster. Therefore, attention must also be paid to the effects that changes to the welfare system may have on those who suffer from mental health problems in Scotland.

In 2010, a report by the University of Glasgow entitled "Scotland Incapacity Benefit Claimant Profile" said that 45 per cent of incapacity benefit claims were made on the basis of a mental health condition. The changes brought about by the UK Government's Welfare Reform Bill will have a significant impact in areas such as North Lanarkshire, where an estimated 19,900 people claim incapacity benefit. Of that total, 8,620—or 43 per cent—have been identified as having a mental health condition.

In a letter that was printed in *The Guardian* on 31 May 2011, leading mental health charities and senior consultants from the Royal College of Psychiatrists expressed serious concerns about the rapid rate of incapacity benefit reassessment resulting in a huge amount of undue distress to people with mental health problems. There are real dangers that the complex nature of mental health problems will not be accounted for through work capability assessments, and it is crucial that everything that can be done is done to alleviate those concerns.

I welcome the debate and the contributions that have been made across the chamber, and look forward to our developing a strategy that encapsulates all the issues that members have identified.

16:17

Roderick Campbell (North East Fife) (SNP): I welcome the debate. Historically, mental health was often thought of as the Cinderella of the health service. I hope that those days are gone for good, but mental health needs to be kept at the forefront of health policy. We need to recognise that it concerns all of us—young and old; rich and poor; men and women. Our nation has been recognised by other countries and the World Health Organization for its work, but there is still

much that can be achieved to ensure that Scots are able to lead fulfilling and positive lives.

Members should welcome the Scottish Government's consultation document, which builds on the progress that has been made. However, there is no room for complacency. The strategy identifies four priorities, one of which is improving access to psychological therapies. As we are all aware, depression can strike anyone. I do not want to get hung up about the statistics for the prescription of antidepressants, but I agree with others that the search for alternatives to drugs must remain a priority. I welcome the target of an 18-week referral period for psychological therapy treatments from December 2014, but wish, of course, that that target could be improved. Unless we can take significant strides in talking therapies, we will find it difficult to reduce prescriptions for antidepressants. To do so, we need more trained counsellors and psychologists, or at the very least to make better use of existing staff. If preventative spending is to mean anything, surely that is one area in which it could have an effect.

Mental illness has social and economic impacts, of course. Employment improves self-esteem; unemployment may seriously damage a person's mental health. We must create a society in which people are able to create self-worth. Mental illness is detrimental to personal income, and the ability of ill persons as well as their carers to work is likely to be substantially impaired. However, it would be a simplification to say that only our economy is hit by mental illness; as Mary Scanlon said, society is also harmed. It is revealing that the overwhelming majority of the prison population have some form of mental disorder.

We must recognise the role that carers play. As the carers strategy indicates, we need to continue to recognise the importance of families and carers, balancing the need to inform, consult and support them with an individual's basic human right to confidentiality about their illness or treatment.

Many speakers have talked about the issue of stigma. Well-publicised statistics from the see me Scotland campaign show how wide-ranging mental health problems are. Research last year showed that those with mental health issues felt that most negative attitudes came from friends and family. Such a perception alienates the vulnerable from those whom they need the most. Acceptance boosts self-esteem and worth and reduces readmission rates for those with mental illnesses and aids faster recovery. Progress is being made in the reduction of stigma, but we should not forget that prejudices have been acquired over a long period of time and will not disappear overnight. Continuing effort is required, and I welcome the NUS Scotland paper in that regard.

One of the other key priority areas of the strategy is the prevention of suicide. In Fife, fully 5 per cent of the budget that was delivered through the choose life project was dedicated to raising awareness of suicide prevention services. A number of projects were supported, such as Penumbra's early response self-harm project and the Link adolescent befriending project. We need to continue to support such projects.

Simply giving people the opportunity to speak to someone who will listen is essential to making people feel that they are supported and cared for. That is particularly important, given that the choose life survey for NHS Scotland showed that 46 per cent of Scots would not directly ask someone whether they were feeling suicidal. We need to encourage a culture in which people have the ability to call out for help and are able to find it.

A Scottish Government research document that was published in 2008 highlighted the fact that sport can reduce suicidal tendencies in adolescents and that older generations benefited from supportive families and close community links.

For those who have become isolated or simply feel isolated, funding for groups that help them to connect and are willing to listen without judgment is essential.

We should not forget the importance of peer support in mental health recovery. We might wish to consider the extent to which peer groups can provide a role as independent advocates. I might have missed it, but I did not see any reference to peer support in the consultation document.

We need to exercise care when returning long-term patients to the community. A few weeks ago, I was at a hospital in my constituency where preparations are in hand to return about 45 long-stay patients to the community. However, that represents an ordeal for many of those patients. The comfort of the institution has helped them to recover, but the fear of the wider world could potentially have a detrimental effect on their mental health, if not handled sensitively.

On dementia, it is right that implementation of the strategy remains a priority—with our rapidly ageing population, that surely goes without saying. I welcome the strategy's recognition of the importance of the role of families and carers in supporting people with dementia and their involvement in decision making. We need to ensure that the promoting excellence programme is continued right across the care setting.

On children and adolescents, we must continue to recognise the importance of good mental health. During a recent visit to the Playfield institute in my constituency, I was struck by the valuable work that is going on to train staff to deal

with mental health issues that affect children and adolescents. I very much welcome the additional spending in this area in recent times, and the 33 per cent increase in the size of specialist mental health services. We need to build on that. Again, money spent at this stage can really be viewed as preventative spending.

I commend the consultation document to the Parliament.

16:23

Kezia Dugdale (Lothian) (Lab): I have read the mental health strategy and, like Mary Scanlon, I was a little disappointed to find that it was so NHS-focused, and that there was no reference to drugs or addiction. I appreciate that it is a consultation, and I would like to take the opportunity today to discuss the relationship between drugs, mental health and inequalities.

I think it was Mary Scanlon who said earlier that addiction is self-medication. That is right, but I would say that addiction is also a form of self-harm. Figures from the Scottish Drugs Forum show that 40 per cent of mental health service users have addictions but only 5 per cent of them access treatment. We must remember that mental health services play an important role in referring people to other services in the health service that they might need. In the light of the Christie commission's report, that fact shows that an emphasis on prevention and addressing failure demand should be absolutely at the heart of the mental health strategy—I hope to develop that point during my speech.

I have spent some time as an advocate in Edinburgh for three people with complex and multiple needs who had problems with their homelessness situation. Those individuals had a background of homelessness, but they also had complex needs relating to learning disabilities, a history of abuse, addictions, numerous mental health conditions—some really difficult life stories. I was very privileged to work with them over the past couple of years—it absolutely changed my life; through having them share their experiences with me, I have understood how the state systematically fails people with chaotic lifestyles. There is a huge human rights issue in that, but there is also a huge issue for the public purse—I will develop that point.

I would like to see more of the Christie commission principles around shared working, community empowerment and addressing failure demand at the heart of the mental health strategy. In that regard, I will take a moment to concentrate on why people take drugs. In my experience, people take drugs to escape life. There might be a multitude of factors involved in that, but that is the reason why they do it. Drugs offer people a crutch. When we ask people to stop taking drugs and step on to a pathway towards recovery, we see the end point of that recovery as their no longer taking drugs. We ask them to return clean to the same community from which they chose to escape by taking drugs. We fix their medical and psychological dependencies, but in doing so we stir up a lot of emotions that they have sought to sedate for years and years by taking drugs. We do not leave them with the support mechanisms to cope, remain clean, sustain a tenancy, pay bills, seek and retain work, and live the life that so many of us take for granted. Without specialised mental health support that is not clinical or medical, we are setting those people up to fail. The inability to cope with life as they see it without drugs leaves them to go round the corner to score drugs again and to go back on that pathway to escape a life with which they simply cannot cope.

We need to focus on the fact that there is an immense social and human cost to relapse. We see people who relapse in our prison cells, our police stations and our accident and emergency departments. Those costs can easily be evaluated, but what we do not see is the collateral damage that a relapse causes to a community that is already beset by drugs. That impact is very hard to evaluate, but it is so deep.

There is also a personal consequence for people who relapse. A relapse leads to even poorer mental health. In that, there is an issue about a lack of self-worth and people not feeling that their life is worth living, which increases suicide rates. The Scottish Drugs Forum has in the past questioned overdose statistics, asking how many of the people who overdosed did so intentionally. The answer is that we do not know the difference between somebody having an accident and someone deliberately choosing to overdose in such situations.

People in recovery need access to support for their mental health. That is a social point, not a clinical point and I would be very grateful to the minister if he would comment on it in his response to the debate.

16:28

Alison McInnes: This afternoon's debate has been timely and worth while and I think that the minister will take heart from its consensual tone. There is very much that unites us and I look forward to a future debate on the finalised strategy, which I hope will be able to take on board some of the positive suggestions, not only from within the chamber but from trusted organisations such as SAMH and Barnardo's.

SAMH estimates that the economic and social costs of mental health problems amount to around £8.6 billion per year—more than the total NHS budget—so it is clear that investment in preventive action and early intervention will be money well spent.

I think that everyone agreed that progress has been made over the years, but that there is much more to do, so we must guard against complacency. We should keep challenging injustice and discrimination wherever we encounter it.

Scottish Liberal Democrats agree with the main thrust of the consultation document and wish to work constructively with the Government to deliver change. We stress that a holistic approach is essential. Integrated services, investment in community-based solutions and greater personalisation will ensure that we make best use of scarce resources. We must also drive down waiting times for access to psychological services.

It is clear that local health and care services are not nearly sufficiently joined up. A SAMH survey found that, on average, each service user was receiving services from 14 different agencies. That cannot be a good use of resources, and it leads to poorer levels of care for individuals.

The spending review sees the mental wellbeing budget remain unchanged at, I think, £6 million a year. The Public Audit Committee's report in May 2010 recognised

"the value of mental health services provided by voluntary organisations and that the current financial constraints"—

that is, the financial constraints last year—were

"already impacting on funding for local and national voluntary organisations."

That is likely to become an even more serious and pressing issue.

Last week, we learned that the Scottish Government had passed many of the tough choices about cuts on to local authorities in the spending review. It will be difficult to deliver improvements to mental health services against that backdrop, so it is all the more important to clarify what the priorities are and to ensure that resources are invested wisely. It would be useful to learn from the minister what discussions, if any, he has had with councils on this vital service area under the single outcome agreements.

There were many good speeches. Mary Scanlon detailed in great depth the economic and social impacts of mental health problems. That was a useful pen picture to have at the start of the debate. She also spoke highly of the role of social enterprises in the provision of mental health services. I echo her support for that.

Dennis Robertson also spoke about social enterprises and the need for training to ensure that staff in care homes, hospitals and prisons know what the mental health issues are. That is an important message.

George Adam spoke about a lot of small, local projects, real people and how we can make a real difference locally.

Mary Fee echoed some of the comments that I made about looked-after children. We must not lose sight of the problems with them.

Siobhan McMahon spoke eloquently about the need for preventive action. We have heard that call echoed around the chamber this afternoon, and we need to press for that.

John Wilson was the only person to note that we need to support families and carers.

Kezia Dugdale—who, as always, made an insightful speech—challenged us to look behind addiction at how the state fails people and how we can start to address those problems.

There is no doubt that mental health services are ripe for spend-to-save initiatives. Prevention must be part of any new strategy. High-risk groups, such as looked-after children and young offenders, must be given more support. Vulnerable people who have no voice—those with dementia and those in prison—need us to stand up for them. Advocacy services must be readily available. In all our communities, there are people who will need to access mental health services at some point in their life, so we must ensure that, when they seek help, the help that is on offer is person centred, easily accessed, effective and timeous.

16:32

Murdo Fraser (Mid Scotland and Fife) (Con): It has been a useful and wide-ranging debate. There has been a general welcome from all parties for the Government's consultation on the mental health strategy for Scotland. Although the exact detail of the strategy needs to be worked out once the consultation has closed, it makes sense to bring the Government's actions and strategy on improvement, prevention and NHS delivery of mental health services into one cohesive document.

As my colleague Mary Scanlon stated, for too long, mental health services have been underresourced and have lacked clear strategies for early diagnosis and early intervention. There has been an unfortunate propensity to reach for the prescription pad when dealing with some mental health disorders, such as depression.

Despite mental health being championed as one of three clinical priorities of the Scottish

Government and previous Scottish Executives, there is no doubt that, notwithstanding Rod Campbell's comments, it is still seen as a Cinderella service. That is particularly concerning when we examine some of the raw statistics that underlie the debate.

Poor mental health has resulted in Scotland having one of the highest suicide rates in western Europe, with a higher rate than England and Wales. From an economic perspective, Audit Scotland estimated the wider costs of mental health problems to be more than £8 billion per year in 2009.

Those are staggering figures, but perhaps they are not surprising when we consider the ramifications that severe mental health problems have for the health, welfare and criminal justice budgets, not to mention the wider impact on families and communities.

A number of members mentioned stigma, which the see me campaign has properly identified. I join Fiona McLeod and Malcolm Chisholm in praising that campaign's work in raising awareness of the need to destigmatise mental illness.

I also congratulate, with Dennis Robertson, NUS Scotland on its work, particularly with LGBT students. Earlier in the summer, I lodged parliamentary questions to the Scottish Government in connection with awareness raising and training for medical professionals who deal with LGBT students. Professionals often seem to lack the training that is required to identify some of the problems that such students encounter.

I turn to the early years and preventative spending, which Richard Simpson majored on. In the previous parliamentary session, the Health and Sport Committee's inquiry into child and adolescent mental health services and the Public Audit Committee's report "Overview of mental health services" highlighted that there was too much emphasis on treating severe and enduring mental illnesses and not enough on preventative work and early intervention. All members recognise the importance of early childhood development and the impact of early intervention in determining future mental health, social wellbeing and educational attainment.

There is a large and growing body of empirical evidence that highlights the importance of child and parental interaction in the early years of life with regard to a child's physical and mental wellbeing. That is why the Conservatives believe that we should take more of a preventative approach to mental illness to ensure as far as possible that problems do not arise in the first place. That thinking lies behind our manifesto commitment to ensure the universal provision of health visitors and to provide better support in the early years.

Outcome 2 in the consultation document states that the Scottish Government's action will be

"focused on early years and childhood to respond quickly and to improve both short and long term outcomes."

Early diagnosis and intervention are fundamental to better mental health. Therefore, once individuals present to health professionals, treatment should be prompt and consistent, so waiting times of the length that we have are unacceptable.

There has not been a great deal of disagreement in the debate, but such as we have had has been on the prescribing of antidepressants. As Mary Scanlon outlined, our view is that, where possible, the treatment of depression and other mental illnesses should, in the first instance, involve methods other than prescribing drugs. Siobhan McMahon made that point and referred to the figures that came out last week, which show a rise in the number of prescriptions.

I understand the minister's point that that does not necessarily mean that more people are being prescribed antidepressants, but we should not forget that, after the election in 2007, a Scottish Government target was introduced to reduce by 10 per cent the use of antidepressants. That target has not been met and, in fact, it has been dropped because it could not be met. The best that we can say is that the Scottish Government has not met the target. Although the number of people who receive prescriptions might not have increased, the figures are certainly not improving.

Our underlying belief is that we should move away from the predilection to prescribe if there are other and better solutions. Cognitive behavioural therapy, psychology and psychiatry are essential, as are a range of talking therapies. Early access to those can be crucial to prevent mild depression from becoming severe and enduring. The default position of many GPs is that, if somebody comes in with depression, they are put on antidepressants and the alternatives are not considered. We need to move away from that, which would be a useful step that would have a hugely beneficial effect on outcomes for many people with mental health issues.

In the very short time remaining to me, I will touch on the number of psychiatric in-patient places.

The Presiding Officer (Tricia Marwick): You probably have about another minute and a half.

Murdo Fraser: Thank you. I can therefore expand on the point that I was about to make.

In 2005, a working group recommended that there should be 60 psychiatric in-patient places in Scotland. Today, six years on and after an entire term of the SNP Government, there are only 42 places, with a business case being developed for an additional six beds in Dundee. There is still work to be done.

If mental health is to be a priority, as the Scottish Government fairly says that it should be, a lot of work still needs to be done. I welcome the progress that is being made, but we should renew our efforts to reduce the figures on the prescription of antidepressants. I am pleased to support the motion and both amendments.

The Presiding Officer: I call Jackie Baillie, who can have a generous eight minutes.

16:39

Jackie Baillie (Dumbarton) (Lab): I always accept invitations to speak for longer, Presiding Officer.

I begin with an apology to you and to members for having had to leave during the opening speeches, along with my colleague John Wilson. As you are aware, Presiding Officer, we missed the opening part of the debate because we were engaged in a live broadcast interview. There was no intention to be disrespectful to colleagues. Of course, we rushed straight back.

I welcome the debate and congratulate the Government on proposing a new mental health strategy. This has been a useful opportunity to shape its contents.

I start where the minister did with the subject on which a number of members focused their remarks today: prescribing antidepressants. The statistics show a substantial increase in the level of such prescribing. I listened very carefully to the minister's explanation, but the numbers are still increasing and we should be troubled by the fact that the number of people who have mental health problems is also increasing.

Rather than argue with the minister about the figures, I believe that members share the view that we need to give GPs choice so that, instead of their only option being to provide medication, they should be increasing access to psychological therapies. I welcome the new target on psychological therapies but it will depend upon having sufficient capacity to meet what we know is an increasing demand. In its briefing, SAMH sensibly called for an audit of the current capacity so that we know how far we need to travel. I hope that that is a reasonable request and that the Government will accept it.

We have heard some considered speeches during the debate. Malcolm Chisholm, Margaret Burgess and Siobhan McMahon talked about the importance of tackling stigma and mentioned the valuable work of the see me campaign. Dennis Robertson talked about the need for training and Kezia Dugdale mentioned the importance of advocacy, so that people are not left speechless and their voices are heard. I look forward to Fiona McLeod leading us in a session of tai chi at the start of every parliamentary meeting.

Mary Scanlon and a number of other colleagues were right to make the point that mental health is about so much more than simply treatment by the NHS. It is about education, prevention, employment, the economy—it is about how we live our lives. The links between addiction and deprivation are all too evident. I urge the Scottish Government to widen the strategy's focus because it will get support from around the chamber for so doing.

Richard Simpson and John Wilson spoke about focusing on prevention, starting when children are newly born, and undertaking preventative work in primary schools, and I agree with all that. We know that such an approach will be cost-effective and, more important than that, it will be more effective for the individual.

That also applies to community services. We need to get the balance right between community and in-patient services.

I will start with community services. As Mary Fee pointed out, it is disappointing that some local authorities are reducing services because of reducing budgets. They are introducing things such as zero-hours contracts, which are impossible for the voluntary sector to deliver and which reduce staff terms and conditions and might cause distress because of a constantly changing stream of support workers. We also know that charges are being applied now, often for the first time, and that doing so relies upon people's receipt of disability living allowance.

Siobhan McMahon was right to talk about welfare reform. We are approaching a perfect storm. Compared with all those who are in receipt of disability living allowance, the changes are disproportionately affecting people who have mental health problems. They are losing income. What will happen when they cannot pay for services? Will that responsibility fall back on to local authorities? If we do not invest in community services, there will be more cost to the NHS in the long term.

I turn to the balance between community services and in-patient services. It is always desirable for mental health services to be available in the local area, and community mental health teams, backed by the crisis services, do an extremely valuable job. However, it is also critical

to have access to in-patient beds. There will be times when people need that degree of acute and intensive care. Unlike other specialist health services, mental health services are best delivered locally, and that also applies to in-patient services.

I will illustrate that, as I am sure that the minister expects me to do, by talking about my area. NHS Greater Glasgow and Clyde wants to close the Christie ward and it expects my constituents to travel to Gartnavel. On the face of it, that might be considered to be reasonable, but let us take a closer look. There is no space at Gartnavel, so my constituents are being sent to Lanarkshire and Ayrshire; the next available bed might be in Livingston. Those journeys are difficult for people who do not have a car, so the travel implications are enormous.

Mental health professionals warn that we are approaching a crisis. They are concerned because no beds are available, demand is increasing and plans are being made to reduce capacity to save money. We are indeed storing up trouble for ourselves. I urge the minister to be cautious in continuing to reduce capacity.

With regard to suicide prevention, although I commend the suicide training that has been taken forward in the NHS to really positive effect, I believe that we need to widen it to others in the community and the statutory sector. Given that all of us in the chamber should avoid complacency, I point out that, contrary to what has been said, suicide rates are going up. No one should take any pleasure in that and the strategy must look again at how local authorities engage and help with suicide prevention at local level.

In the few minutes that I have remaining—I realise that I might be stretching time a little—I turn to employment, which was the focus of SAMH and Action in Mind. Mental health problems at work cost Scottish employers £2 billion or an average of £1,000 per employee. Some of that is down to sickness absence, some of it lower than average work performance and some of it unemployment itself. As we know, employment plays a central role in our society. However, we also know that appropriate employment actively improves our mental health and wellbeing; that people with mental health conditions can and do pursue successful careers; and that most people with a mental health condition who are out of work say that they would like to be in paid employment. How do we sustain that? As part of the Parliament's community partnerships project—which I commend, particularly given the Presiding Officer's involvement—Action in Mind is working with employers in Stirling to develop a much better understanding of mental health in the workplace. I hope that the Scottish Government and the Parliament will learn from that work.

There is considerable support in the Parliament for a mental health strategy and I hope that the minister takes on board the very positive suggestions that have been made by members across the chamber. However, he has a responsibility to engage now. In many communities, local services are being reduced, changed and cut. That is not having a positive impact on people's lives and I hope that the minister will take on board our concerns about not just getting the right strategy in place, but protecting the local services that we all agree are critical to prevention.

16:47

Michael Matheson: This has been a very useful debate, with some very good speeches highlighting a number of important points. However, I should reassure members that we are debating a draft strategy and that it has been our genuine intention to provide an opportunity for members to engage with the process and shape the mental health policy for the next four years. I detected a note of cynicism in Mary Fee's suggestion that we would listen only to certain people in this chamber. I assure her that I am more than happy to look at good ideas from any part of the chamber.

Many members, in having only six minutes to make a speech on a very important subject, will not have been able to expand their points or to go into the level of detail that they would have liked. I encourage them, particularly the front-bench members who I am sure have a lot of experience in this field and have clear views on what should be in a strategy, to write to us. If they feel that we need to go further, they should let their views be known. Indeed, if they think that it would be useful to meet me and officials to discuss the issue, we will be more than happy to do so.

That does not mean, however, that we will always agree with members. After all, at some point, we have to decide on what will be in the strategy. However, during the consultation period, I am more than happy to have an on-going dialogue with members across the chamber, especially front benchers with experience in this issue. Indeed, I see that one of them wishes to intervene.

Dr Simpson: I thank the minister for allowing me to intervene. We will be happy to take up his kind offer, as we wish to make a positive contribution to this meaningful consultation.

Michael Matheson: I am absolutely delighted that Dr Simpson has taken up that kind offer; the pressure is now on Mary Scanlon and Alison McInnes to take it up. Time will tell.

In developing the draft strategy, we decided to bring our mental health services work and our mental health improvement work into a single strategy, because the two areas complement each other. Rather than have them operate in separate silos, it made more sense to draw together those two strands of work. Judging from the tone of the debate, I think that there is broad recognition that that is the right direction of travel.

It will be impossible for me to respond to all the points that have been made, but I have no doubt that they will be fed into the consultation process. However, I want to pick up on a couple of specific issues. A number of members mentioned choose life and the suicide prevention programme. Richard Simpson and Jackie Baillie made the point that suicide levels are increasing, but it is important to bear in mind the way in which those statistics are dealt with. They are taken on a three-year rolling basis because there will be annual variations. The overall trajectory is that suicide levels in Scotland are continuing to decline, but I recognise that more has to be done in that field. Although there has been a 14 per cent reduction in suicides since the prevention scheme was introduced, we need to ensure that we continue to make progress.

Some members raised concerns, on the back of SAMH's briefing, on the training of front-line staff in suicide prevention techniques and counselling skills. It is worth keeping in mind that the training that was done under choose life pre-2007 took place largely in the non-statutory sector—the voluntary sector—rather than in the health service. The programme that has taken place over the past four years has been a catch-up programme for NHS staff in the front line, so it is not the case that the voluntary sector and the wider non-NHS sector are being neglected. Training will continue to be an important part of our recognition of the value of choose life and there will, of course, be opportunities for staff members outwith the NHS to participate in that. I hope that that reassures members that it was not a case of one or the other; it is simply that there has been a catch-up programme for NHS staff.

I turn to child and adolescent mental health services. I was a member of the Health and Sport Committee that conducted an inquiry into that area, and it is one that I am passionate about and in which I want to see real progress being made. We have invested significantly in the workforce and other resources over the past three years. As I said in my opening remarks, we intend to continue that investment. There has been a 33 per cent increase in the number of specialist staff who work in CAMHS. If we improve the quality of those services in the community, that will feed into a reduction in the number of young people who might be being admitted inappropriately to adult mental health wards.

When the Mental Welfare Commission figures that I mentioned earlier are published, they will show that in the past year there has been an 18 per cent reduction in the number of young people who are admitted to adult wards. I have no doubt that the improving situation with regard to CAMHS capacity has contributed to that. Richard Simpson asked for the specific figures. I have them: in 2009, the level of such admissions was 184; in 2010, it dropped to 151. As I said in my opening speech, although progress is being made, not enough progress is being made. I want more progress to be made and, as a Government, we are determined to ensure that that happens. We are continuing to work with health boards across the country to ensure that the issue is addressed adequately.

Murdo Fraser made a specific point about the number of CAMHS in-patient beds that were available.

Richard Simpson *rose—*

Michael Matheson: Let me finish this point, please.

There was a report that recommended that 60 such beds should be available across Scotland. The report was revised and, if I am correct, that figure was revised to 48 beds, because of the remodelling of services in the community setting.

We now have 42 such beds and a business plan is being put forward by NHS Highland, NHS Grampian and NHS Tayside to increase capacity in the Tayside area to 48. Progress is being made on what is a very specialised type of facility. It is important that we have the right skills in such facilities to ensure that young people receive the services that they require.

There may be occasions when it is appropriate for a young person to be admitted to an adult ward. That may occur out of hours, or the risk to the person may be such that he or she must be admitted. It may also be an option if we are trying to keep the person close to his or her family. The person may have an important support network close by and, because many of these services are provided on a regional basis, it may be an option that clinicians have to take.

Dr Simpson: The figure of 48 was a reduction, as the minister said. However, the Royal College of Psychiatrists has been talking about a figure nearer 80, so 48 may not be adequate.

Will the minister give us an assurance that the figures do not represent an increase on the year before the year for which he provided the figure? In other words, are we following an upward and then a downward trend? It would be reassuring if

the trend was steadily downward. Will the minister give us an assurance that those who are admitted to an adult ward are admitted on the basis of appropriateness? If it is not appropriate, there should be an immediate and automatic referral to the Mental Welfare Commission, so that we can keep abreast of this issue. I know that, as much as I do, the minister has concerns about this.

Michael Matheson: Under mental health legislation, there is a responsibility to ensure that an admission to a mental health bed is on an appropriate basis. Health boards and clinicians already have that responsibility but work remains to be done in this field. I cannot tell Richard Simpson exactly what the figures were for 2008, but our intention is to continue to drive this down. We will continue to put the services in place to achieve that.

A number of members raised the matter of training for staff. In June 2011, we published the dementia skills framework to help to improve the level of skills of people in the national health service and within the social care setting. We have set targets on taking that forward.

The prescribing of antidepressants was the only contentious issue during the debate. Members referred to the previous HEAT target, which was to reduce the prescribing of antidepressants. That target was not met and, when it was clear that it would not be met, a considerable amount of work was done to evaluate what is happening with the prescribing of antidepressants. A considerable part of the research informs the new HEAT target on psychological services, because that was a clear area in which we needed to direct more resources. Some of that research made clear findings, to which I now refer. They included

"better identification of depression and better use of clinical guidelines may lead to an increase in antidepressant use, because it reduces the numbers of people prescribed inadequate doses for inadequate lengths of time".

The research also found that

"improved identification may lead to more people being identified as needing treatment and for many of these, antidepressants (with or without psychological therapies) will be the best approach."

It went on to say:

"experience in England, where there has been considerable investment through the Improving Access to Psychological Therapies Programme (IAPT), is that there has been an increase in antidepressant prescribing alongside rapid access to therapies. In clinical practice the combined use of antidepressants and psychological therapies is common and this practice is supported by NICE. These interventions are best seen as complementary, not as alternatives".

These are not my views, nor the views that the Government has tried to put on the figures that were released today. They are the views of the Royal College of Psychiatrists and the Royal College of General Practitioners, in a letter sent to Jackie Baillie in April on this very matter.

Depression is a clinical illness and it is appropriate for clinicians to prescribe what they see as, clinically, the most effective treatment for that condition. To say that that demonstrates a rocketing in the number of people who are prescribed antidepressants is simply wrong.

Jackie Baillie: Will the minister take an intervention?

The Presiding Officer: I am sorry. The minister is in his last 10 seconds.

Michael Matheson: Reflecting on the issue of stigma, I do not think that we would have the same nature of debate if we were talking about prescribing clinical medication for physical conditions. We have to be very careful about the tone and nature of language that is used on the prescribing of antidepressants.

I hope that members have found the debate useful. We will consider the views that have been expressed, and I encourage other members who wish to make their views known to make a submission to the consultation.

The Presiding Officer: That concludes the debate on mental health.

I apologise to the minister because the division bells went off during his speech. As members know, the division bells should not ring in the chamber. I will be asking facilities management to look at the matter yet again.

Business Motion

17:00

The Presiding Officer (Tricia Marwick): The next item of business is consideration of business motion S4M-00957, in the name of Bruce Crawford, on behalf of the Parliamentary Bureau, setting out a business programme.

Motion moved,

That the Parliament agrees the following programme of business—

Wednesday 5 October 2011

2.30 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Ministerial Statement: Fuel Poverty
followed by	Scottish Government Debate: Welfare Reform
followed by	Business Motion
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business

Thursday 6 October 2011

9.15 am	Parliamentary Bureau Motions
followed by	Scottish Government Debate: Housing
11.40 am	General Question Time
12.00 pm	First Minister's Question Time
2.15 pm	Themed Question Time Health, Wellbeing and Cities Strategy
2.55 pm	Scottish Government Debate: Digital Future of Scotland's Heritage
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business

Wednesday 26 October 2011

2.30 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Scottish Government Business
followed by	Business Motion
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business

Thursday 27 October 2011

9.15 am	Parliamentary Bureau Motions
followed by	Scottish Government Business
11.40 am	General Question Time
12.00 pm	First Minister's Question Time
2.15 pm	Themed Question Time Culture and External Affairs; Infrastructure and Capital Investment
2.55 pm	Scottish Government Business
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business—[*Bruce Crawford.*]

Motion agreed to.

Decision Time

17:01

The Presiding Officer (Tricia Marwick): There are three questions to be put as a result of today's business.

The first question is, that amendment S4M-00949.2, in the name of Richard Simpson, which seeks to amend motion S4M-00949, in the name of Michael Matheson, on mental health, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

For

Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Dugdale, Kezia (Lothian) (Lab)
Eadie, Helen (Cowdenbeath) (Lab)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Henry, Hugh (Renfrewshire South) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Rutherglen) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
Macdonald, Lewis (North East Scotland) (Lab)
Macintosh, Ken (Eastwood) (Lab)
Malik, Hanzala (Glasgow) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McDougall, Margaret (West Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McLetchie, David (Lothian) (Con)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)
Park, John (Mid Scotland and Fife) (Lab)
Pearson, Graeme (South Scotland) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (LD)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, David (Highlands and Islands) (Lab)

Against

Adam, Brian (Aberdeen Donside) (SNP)
Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Aileen (Clydesdale) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Eadie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
Finnie, John (Highlands and Islands) (SNP)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lochhead, Richard (Moray) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
Mackay, Derek (Renfrewshire North and West) (SNP)
Mackenzie, Mike (Highlands and Islands) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West Scotland) (SNP)
McAlpine, Joan (South Scotland) (SNP)
McDonald, Mark (North East Scotland) (SNP)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McLeod, Aileen (South Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
McMillan, Stuart (West Scotland) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)
Russell, Michael (Argyll and Bute) (SNP)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Sturgeon, Nicola (Glasgow Southside) (SNP)
Swinney, John (Perthshire North) (SNP)
Thompson, Dave (Skye, Lochaber and Badenoch) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Urquhart, Jean (Highlands and Islands) (SNP)
Walker, Bill (Dunfermline) (SNP)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)

Wilson, John (Central Scotland) (SNP)
Yousaf, Humza (Glasgow) (SNP)

The Presiding Officer: The result of the division is: For 55, Against 63, Abstentions 0.

Amendment disagreed to.

The Presiding Officer: The next question is, that amendment S4M-00949.1, in the name of Alison McInnes, which seeks to amend motion S4M-00949, in the name of Michael Matheson, on mental health, be agreed to.

Amendment agreed to.

The Presiding Officer: The next question is, that motion S4M-00949, in the name of Michael Matheson, as amended, on mental health, be agreed to.

Motion, as amended, agreed to,

That the Parliament recognises the significant progress that has been made in mental health services, mental health improvement and mental health law in Scotland, but notes that there is still work to be done and in that regard welcomes the publication by the Scottish Government of a consultation document on a new mental health strategy for Scotland that builds on previous and continuing work and establishes the priorities and actions for the next four years in support of a healthier and fairer Scotland, and believes that, in moving forward, greater personalisation, better joint working and a focus on prevention and mental wellbeing are key to achieving better, more efficient services.

Alcohol Misuse

The Deputy Presiding Officer (John Scott): The final item of business is a members' business debate on motion S4M-00181, in the name of James Dornan, on battling Scotland's drinking culture. The debate will be concluded without any question being put.

Motion debated,

That the Parliament welcomes the publication of the British Medical Association's survey on the impact of alcohol on patients who had visited GP practices in Glasgow and across Scotland on one day in April 2011; is alarmed that GPs and practice nurses reported that there were more than 5,500 consultations in which it was considered that alcohol was a contributing factor to the visit; understands that this equates to an estimated more than two million consultations per year, costing the NHS in excess of £42 million; believes that further action must be taken to curb Scotland's drinking culture and raise awareness of the long-term damage to health that might arise from regular heavy alcohol consumption, and would welcome the urgent development of a package of measures to address this problem.

17:04

James Dornan (Glasgow Cathcart) (SNP): I start by thanking the British Medical Association for putting together its "One Day" alcohol motion briefing, and much of what I am about to say comes from that briefing. As the motion says, on one day in April 2011, 5,500 consultations took place with a general practitioner or practice nurse in which alcohol was a factor. Over one fifth of those consultations, 1,200, took place in the NHS Greater Glasgow and Clyde area, which covers my constituency and home city.

Those statistics extrapolate to 1.4 million consultations a year in Scotland in which alcohol is a factor, which cost in excess of £28 million and account for around 6 per cent of all consultations in general practice. Hundreds of thousands of lives are affected by alcohol, countless families are destroyed and many communities are torn apart in a nation that I believe has struggled for far too long to face up to the demon in its midst that is our love affair with alcohol.

There is no silver bullet to kill off the disease that is alcohol abuse. To defeat it, we need to use all the weapons at our disposal, including education, early intervention and labelling of alcoholic products. However, we would be fighting with one hand tied behind our back without the introduction of minimum pricing; other measures just tinker around the edge of the problem. Without it, we will continue to have the fastest-growing liver cirrhosis rates in western Europe. In addition, conditions such as chronic pancreatitis—my mispronunciation of that shows that it affects

language as well—diabetes and heart disease are made much worse by each sip of alcohol.

On any given day, alcohol will cost Scotland £97.5 million in terms of health, and crime and violence. It will kill five people and cause 98 people to be admitted to hospital with an alcohol-related condition and 23 people to commit a driving offence. It will lead to 450 victims of violent crime perceiving that their assailant is under the influence of alcohol. That does not include all the problems that low-level drinking can cause, such as breast cancer, colon cancer and so on.

We do not need to be a raging drunk to suffer from the effects of alcohol. Regular imbibing can do it for us just as well. Sometimes we are so caught up in the headline killers associated with alcohol that we forget that there are other dangers out there, such as the mental effects of drinking too much. I am sure that I am not alone in the chamber in having lost friends I grew up with to liver failure, heart disease and many other of Scotland's killers that are all alcohol related. Many of those people were lost at a disturbingly young age. I have also seen childhood friends grow from being the life and soul of the party to being insecure loners because of their love affair with the bottle. We have all seen the changes that it can make to people's personalities and we should keep that in mind during this debate.

Since the mid-1990s, the affordability of alcohol has increased in leaps and bounds to the ludicrous stage now where, in some circumstances, cheap, powerful cider can be bought for less than the price of water. How can that be right and how is that good for society? That is why I welcome the Government's Alcohol etc (Scotland) Act 2010, which comes into force this week. There are a lot of useful measures in it, such as banning quantity discounts on off-sales purchases and banning the supply of an alcoholic drink free or at a reduced price when purchasing another drink. The measures will help to make alcohol more acceptably priced. However, for us to have maximum impact, we need minimum pricing.

Too often, the opponents of minimum pricing have claimed that they are against it because of a lack of international evidence to stand alongside the Sheffield study. Well, no longer can they use that shield. Let us take the experience in British Columbia, where Professor Tim Stockwell completed a study that shows categorically that a 10 per cent increase in the minimum price of alcohol resulted in a 3.4 per cent reduction in the consumption of alcohol. If we accept that world-renowned expert's findings, surely we can accept that his research shows that a similar action will result in a similar drop in consumption here in Scotland. Just think of the gains that such a move could bring to Scotland: a drop in hospital admissions, a reduction in liver disease, a reduction in alcohol-related crime and huge social benefits for our hard-hit communities. Let us remember that, although alcohol abuse knows no boundaries and can affect anyone in any social class, most of its victims are from less well-off areas. We do them a huge disservice if we refuse to accept scientific evidence for some specious political reason.

Members may be interested to know that Professor Stockwell has been researching alcohol misuse problems for most of his academic career. He has seen and heard it all from all over the world. However, such is the extent of Scotland's drink problem that even he was surprised and shocked not just by the volume of alcohol consumption but by the pattern of drinking that has become culturally acceptable here. I am sure that we all agree that the fact that we can shock a leading international academic in that way is not something that Scotland should be proud of.

Jack McConnell once said that he believed that his duty as First Minister was to leave Scotland better than he found it—and he was right. His willingness to change his position on a smoking bill was the act of a big man—I think he is big but, for most of you, he is probably not. He brought forward the best piece of legislation that the Parliament has passed to date. My proudest act in politics is to have played a small role in the passing of the Prohibition of Smoking in Regulated Areas (Scotland) Bill. I worked for Stewart Maxwell when he proposed his member's bill on smoking, which the then Executive took and strengthened into the act that we now have. Jack McConnell should be rightly proud of what he did. I know that Stewart Maxwell is proud of what he did, and even I, who had such a minor role to play, am proud of what I did.

We now have another opportunity to be proud of ourselves in this chamber—let us be honest, we do not get many of those. I am extremely encouraged that there are strong signs that we may achieve cross-party consensus on the issue in this parliamentary session, although I suspect that Ken Macintosh's figure of 75p per unit came as a shock to everyone.

Let us, as the old saying goes, seize the day and agree to support minimum pricing when it comes to the chamber, and let us make our country proud. Sláinte.

17:10

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I congratulate James Dornan on securing the debate.

It is interesting that the BMA has repeated its statistic of 5,500 general practitioner consultations

a day but says that that equates to 1.4 million consultations annually, at a cost of £28 million. It is not at all clear to me where James Dornan got his figures from.

When the BMA originally published the statistic, it acknowledged that it was based on 3 per cent of practices and should be treated with caution. I agree; a study that is based on 127 consultations across the whole country should be treated with considerable caution. However, the motion throws caution to the four winds. Nigel Hawkes, of Straight Statistics, who I think has e-mailed most members, accused the BMA of abusing statistics to create a moral panic to justify a minimum unit price. He went on to say that the trends are in the right direction, which confounds the Sheffield modelling.

There is no doubt that Scotland has a significant problem, which we all have a duty to try to tackle. The Government has a majority in the Parliament—plus the backing of the Liberals—so it will achieve minimum unit pricing. However, I strongly urge it to do two things. First, the University of Sheffield should be invited to remodel its data on the basis of the most recent statistics, to ascertain whether the model produces the results retrospectively. The evidence is that that is not the case, and it ill behoves us to introduce a measure that could be misleading if the figures do not prove that the outcomes are correct.

In the latest brief from Scottish health action on alcohol problems, discounting and its effects are compounded with the effect of a minimum price—albeit at only 40p. Given that the discounting ban will have a greater effect than a minimum unit price of 40p will have, it is important that evidence that we collect when minimum unit pricing comes in shows that the measure has been effective, before we herald it across the world.

Secondly, I hope that members agree that it will be important to have a prospective randomised controlled trial. That will be perfectly feasible, because Scotland will introduce the measure and England will not do so. It will be possible to examine harmful and hazardous drinkers in the two contexts, to determine whether minimum unit pricing is having an effect, given that most of the other variables will be common to both contexts.

Fiona McLeod (Strathkelvin and Bearsden) (SNP): Dr Simpson perhaps missed a fantastic briefing last night, which was hosted by Malcolm Chisholm and Willie Rennie, in which Professor Tim Stockwell showed us the evidence on minimum pricing over 20 years in Canada.

Dr Simpson: The Health and Sport Committee in the previous session of the Parliament took evidence from a number of people in Canada, where there is an absolute Government monopoly. I do not think that even this Government is proposing that there should be a Government monopoly on sales. In addition, social responsibility pricing, which is what happens in Canada, is not identical to minimum unit pricing.

I have always said that the arguments are balanced. There is not an absolute yes or an absolute no. However, the Government has failed to answer this point: minimum unit pricing affects only the lowest three income deciles; it does not affect the majority of hazardous drinkers—hazardous drinkers, not harmful drinkers—who are to be found in the top 30 per cent.

The argument is about culture—James Dornan's motion is correct in that regard. We have not answered the question on why the clear and undisputed increase in consumption that followed reduction in price in Finland was not mirrored by a proportionate decrease in consumption when the price increased again. We do not know why there has been a decrease in consumption in France from a level that was equal to the current Scottish level to a level that is half the current Scottish level, although the price of alcohol in France has not gone up. There are issues to do with price that make the matter much more complicated than is suggested by the simplistic approach that has been adopted.

17:15

Fiona McLeod (Strathkelvin and Bearsden) (SNP): I thank James Dornan for lodging his motion and for bringing the debate to the chamber. I am glad that Dr Simpson agrees with us on one thing: that this is a health problem. We can talk about the issue in terms of politics and which party says what; in terms of culture, including why Scotland drinks through the long dark night; or in terms of economics, with regard to who can tax and who will make a profit. However, at the end of it all, we must admit that Scotland is drinking itself to death.

The evidence is irrefutable. We are grateful to Malcolm Chisholm and Willie Rennie for holding the briefing last night, which I mentioned in my intervention. Dr Peter Rice's statistics were stark and terrifying. Between 1970 and 2006, deaths from cirrhosis of the liver in Scotland rose sevenfold, yet from 1971 to 2007, which is approximately the same period, all other deaths—including those from the big five, including heart disease, cancer and stroke—fell.

We must ask ourselves what we should do, and what the solution is. I urge members to turn to the evidence that minimum pricing is the answer. Professor Tim Stockwell made it clear last night from the work that he has done that, in the 20 years in which Canada has had minimum pricing,

it has had a phenomenal result. Meta-analysis shows that those are the facts. A Gallup poll in 2007 found that if there was a 10 per cent rise in the price of alcohol, there would be a 5 per cent drop in consumption and in the harm caused by alcohol.

Kezia Dugdale (Lothian) (Lab): Does Fiona McLeod recognise, after attending the meeting last night, that the Canadian model is completely different? There is different unit pricing for different types of drinks, and even within drinks, so she is not comparing apples with apples.

Fiona McLeod: As Ms Dugdale was there, she will remember that Professor Stockwell said very clearly that minimum pricing is the answer to reducing consumption and the harm caused by alcohol.

Dr Simpson might want to look at another piece of evidence that we were shown last night: the 2009 study by Meier et al, which said that young people and high-risk drinkers are most responsive to pricing strategies. Minimum pricing reduces the harm that alcohol causes.

My contribution is short, but I will finish with something that Professor Stockwell said last night. He said that we should never doubt for a moment the scientific evidence that raising the price of alcohol leads to a fall in consumption and harm. Let us stop the dialogue of death and the refusal to accept the evidence and, when we next meet to vote on minimum pricing in the Parliament, let us ensure that the vote is unanimous in order to tackle Scotland's health problems.

17:18

Liam McArthur (Orkney Islands) (LD): I declare an interest as the patron of the Orkney Alcohol Counselling and Advisory Service, and as I am off to the Scottish Beer and Pub Association challenge 25 reception after the debate. That highlights the different contributions and extensive range of policy measures that we need to bring to bear on tackling what members have acknowledged today is a serious blight on this country.

I congratulate James Dornan not only on bringing this very welcome debate to the chamber but on the tone of much of what he said. He is right that minimum pricing, which was the focus of many of his remarks, is not the silver bullet, although I distance myself a little from the suggestion that everything else without minimum pricing is simply tinkering around the edges. I certainly echo the sentiment that he sought to convey in much of his speech.

During the scrutiny of the previous legislation, the Liberal Democrats were opposed to minimum pricing, and we have made clear the reasons behind our shift on that position. In building a consensus, there are still questions to be answered in relation to how we set a level and the impact that it will have. Although I disagree with quite a bit of what Richard Simpson said, he is right about the impact that removing supermarkets' ability to discount alcohol can have on the prevalence and uptake of drinking. There is no doubt that price has a part to play, but availability is also a key determinant.

I read with interest the BMA report, which provides some staggering statistics. Although my constituency was not included in that snapshot, the figures in the report would not be out of step with what we are seeing in many rural parts of the country. Alcohol is a problem in relation to crime and the efficiency of our economy but, at root, it is a health problem. I am sorry that I was not able to follow the minister's lead and spend the afternoon listening to the debate on mental health. There are particular issues relating alcohol abuse to mental ill health. Through the work that I have undertaken with OACAS, I know that the counselling service that it provides in schools in Orkney has demonstrated the extent of the problem that is faced with depression, bullying, stress and anger manifesting themselves in alcohol abuse.

As James Dornan rightly pointed out, alcohol abuse at an early stage, which is often a response to home circumstances, manifests itself later in life in a complete character shift. That is why, although much of the debate over the next few months will inevitably focus on price issues, we should not lose sight of the fact that the interventions that we can make through early detection of depression, stress, bullying, anger, relationship breakdown and so on need to be the focus of our attention. We cannot rein back on the efforts that we have made through the various counselling services throughout the country, which give us a better insight into the causes of alcohol abuse.

I welcome James Dornan's motion and the debate, and I look forward to participating in future debates on this and related issues over the months ahead.

17:22

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I congratulate James Dornan on securing the debate in a week in which there has been an amazing concentration of health debates and meetings, including the one last night to which members have referred, which I shall mention in a moment.

The reason why I have become increasingly concerned about the issue was shown on the

graph to which Fiona McLeod referred, which Peter Rice used last night. It showed a 700 per cent increase in chronic liver disease in Scotland over the past 25 years and, in particular, a steep rise over the past six or seven years, demonstrating that alcohol is an even greater public health issue now than it was a decade or so ago.

We ought also to remember the association between violence and alcohol. I recently visited the Scottish violence reduction unit and asked the experts there, whom I greatly admire, what percentage of violent crimes were associated with alcohol. With a straight face, the wonderful Karyn McCluskey said, "All violent crimes." I feel that must be a slight exaggeration, but the point stands.

We need a range—a jigsaw—of measures to deal with our serious problems with alcohol abuse, and I hope that the forthcoming alcohol bill will allow a range of actions to be taken. I believe that minimum pricing is the necessary glue to hold the pieces of the jigsaw together.

Some interesting additional evidence was provided by Professor Tim Stockwell at the meeting last night. I accept that the situation in Canada is different—Richard Simpson pointed to the fact that the Government has a monopoly of alcohol sales in Canada—but that does not alter the effect that minimum pricing has. I also accept that, as Kezia Dugdale said, there are differences in the detail, some of which are quite interesting. For example, in Canada there has been a much bigger increase in the minimum price of strong beers than in the minimum price of light beers, which has led to an astonishing 52 per cent reduction in the consumption of strong beers in Saskatchewan. That reinforces the general point rather than weakening it.

Professor Stockwell started with the general point that hundreds of studies link price, consumption and harm. As Fiona McLeod said, his final words were, "Never doubt that evidence." I do not imagine that anyone in the chamber doubts the generality of that evidence, to which he added recent research that he has conducted in Canada on the effect of minimum pricing, particularly in British Columbia and Saskatchewan.

I should point out that the man is a world expert in his field. I had to stop reading his curriculum vitae before I got to the end, or I would still be reading it. He has worked for the World Health Organization and for various health bodies in Canada and Australia. He made it absolutely clear that the research that he has done in Canada not only substantiates the general point about the link between price, consumption and harm but shows that raising the minimum price has a direct effect on consumption. For example, raising the minimum price by 10 per cent in Saskatchewan produced a 5 per cent reduction in consumption.

A body of evidence shows that those who drink harmfully tend to gravitate towards cheaper forms of alcohol, so the effect is even greater among such groups. In the debate in June 2010, I referred to a study by Dr Jonathan Chick and others at the Royal Edinburgh hospital that showed that the lower the price a patient who was a harmful drinker paid per unit, the more units of alcohol they consumed.

Dr Simpson: Will the member take an intervention?

Malcolm Chisholm: I do not know whether I have time.

The Deputy Presiding Officer: Malcolm Chisholm is in his last minute.

Malcolm Chisholm: I have only 10 seconds left.

My last point is about culture, to which the motion refers. I argue that price is a part of culture. Cheap alcohol affects the culture, as was said last night. To change the culture, we must do something about the price.

17:26

Patrick Harvie (Glasgow) (Green): I add my congratulations to James Dornan on bringing the motion to the chamber. I am a member of the only Opposition party that backed minimum unit pricing in the previous session, and I look forward to it being brought back. Rather than simply that measure, I will address the wider issues to which the motion refers.

I welcome the general sentiments in the motion, but I did not sign it. That was not so much because of what is written in the motion—I do not disagree with much that is in it. My decision related to some of my discomfort with past alcohol debates in the chamber. Some debates about alcohol and alcohol policy have involved some hypocrisy. That relates partly to the economic impact—everyone wants to preserve the whisky industry and other industries for export, without necessarily taking account of the health impacts—and partly to our personal behaviour.

At stage 3 of the bill on alcohol in 2005, on the last day of the bill's passage through the Parliament after years of consultation, back benchers from several parties lodged last-minute amendments and made what were, frankly, sanctimonious speeches about saving their communities from the demon drink. At about half past 6, after a delayed decision time, we all trooped down to the garden lobby, where huge trays of free booze awaited us at the evening

reception. How we debate alcohol involves a degree of doublethink and hypocrisy.

I will set myself a wee personal rule about motions. I would like to support motions about alcohol that do not ignore the harm or the positive—what is or could be good about a healthier drinking culture. Our aspiration should be not to curb our drinking culture but to change it—to try to achieve a better, healthier and more positive drinking culture that is safer, calmer and worth celebrating.

What would such a culture look like? Over the past few decades and throughout my lifetime, the industry has changed slowly and gradually, largely because it is too often regulated as though it was just any other industry. Gradually, control of the industry has been handed over to smaller numbers of much more powerful organisations—multinationals and large multiples and chains. That applies to production, serving and selling—to on-sales and off-sales. It was irresponsible of our society to hand over control of this recreational drug to multinationals. Meanwhile, we must recognise that some companies out there—including many in Scotland—are proud to make their profits from quality and not from volume.

Something that was worth having and which we have destroyed are the links and the responsibility that local community pubs have to the people they serve. Locally owned, independent pubs have lower staff turnover and more connection with the people they serve. Some of the manufacturers that make their profits from quality instead of volume sales are struggling compared with the Diageos, the Wetherspoons and the vertical drinking establishments in our cities. Companies that should be worth celebrating are struggling—they have been marginalised.

I say yes to minimum pricing and to a range of other measures that I hope we will get consensus on. I also say that, fundamentally, we need a better drinking culture that we are willing to talk about in positive terms. We must not buy into the idea that alcohol must always and only be seen as a problem.

17:31

Bill Kidd (Glasgow Anniesland) (SNP): Like other members, I congratulate James Dornan on bringing this important debate to the chamber.

The World Health Organization's European charter on alcohol proposes that each member state should

"Promote health by controlling the availability"

of alcohol

"for example for young people, and influencing the price of alcoholic beverages, for instance by taxation."

That was signed up to by all the member states of the European Union, including the Westminster Government, so we should, I hope, be able to look for no short measure of support from it. [*Laughter*.] Thank you. At the moment, we do not have taxation powers as a means to control the availability of alcohol, so perhaps minimum pricing has a place.

Drew Smith (Glasgow) (Lab): Perhaps one measure that might address some of the problem is the social responsibility levy. We would be able to take money back and use it for a positive purpose rather than simply giving extra money to big supermarkets' shareholders. Is it not unfortunate that the Scottish Government has completely failed to bring forward proposals to do any such thing?

Bill Kidd: I presume, of course, that the Labour Party will support the public health levy.

We should all try to be positive. We are the legislature, and we should be responsible and introduce what we are able to introduce. It would have been useful if we had been able to introduce minimum pricing during the previous session to find out whether it was a worthwhile measure. Richard Simpson mentioned that.

Politicians across the parties are coming round to the idea of trying minimum pricing, which would not be a silver bullet, but would be an extra weapon in the armoury against regular excessive alcohol consumption. Malcolm Chisholm's support was thoughtful, and Liam McArthur was sensible and thoughtful in speaking about his support. Patrick Harvie was quite right to say that it is not about excessive alcohol consumption alone; rather, it is about how we encourage responsible drinking. Drink will not disappear from our society, so we have to think about how to encourage responsible drinking.

Every year in Scotland, there are 1,500 alcohol-related preventable deaths. It has been said that liver cirrhosis rates in Europe have steadily declined since the 1980s, but they have soared in Scotland. Indeed, since 1995-96, alcohol-related hospitalisations have increased. I used to work in admissions in Glasgow's Western infirmary accident and emergency department, and I witnessed the regular carnage of drink-related damage. I witnessed bodies staggering or being carried into the waiting areas and innocent bystanders attending who had suffered violence at the hands, feet and knives of drunks.

Since the 1980s, alcohol has become more affordable, and there has been a noticeable and recorded shift from pub drinking to even cheaper private drinking at home. The domestic abuse figures shamefully mirror that. Supermarkets have moved into the mass alcohol sales market and

made it their own. The supermarket chains have often used alcohol as a loss-leader, and they have driven many of the specialist off-sales and licensed grocers out of business through selling crates of booze so cheap that even bottled water fails to compete with them. That is an outrage that is an even worse face of capitalism than Tiny Rowland's.

Why should we not use the powers of this Parliament to try to address this scurrilous state of affairs? Many studies on the issue, from Sheffield to Canada, have referred to a formula that demonstrates that an increase in price equates to a decrease in alcohol consumption.

Whether it is by education, taxation or pricing policy, we should get together and ensure that Scotland has a better future with an alcohol culture that is not the shame of Europe.

17:35

Kezia Dugdale (Lothian) (Lab): Like others, I congratulate James Dornan on securing the debate.

Before I get into the detail of what I have to say, I would like to pick up on what Bill Kidd just said about using the powers of this Parliament to tackle Scotland's alcohol problems. That is exactly why Labour has been saying that the Government has to use the social responsibility levy that is in the 2010 act. However, yesterday, Nicola Sturgeon said in response to a parliamentary question that was lodged by Jackie Baillie that the Government has "no plans" to use the levy. Perhaps Bill Kidd would like to comment on whether he would like the existing law to be put into practice.

Bill Kidd: I would like us to use every possible opportunity to change the drinking habits of Scotland. I would welcome the Labour Party lodging amendments to the next alcohol bill, so that Parliament can judge its suggestions.

Kezia Dugdale: The member still misses my point. The power is in the 2010 act. The Government has the power; it is choosing not to use it. Mr Kidd should reflect on that.

No one here questions the fundamental fact that Scotland has an unhealthy relationship with alcohol. However, the fact is that the price of alcohol is the same in Scotland as it is in England, but consumption of alcohol is 25 per cent higher in Scotland. If price is such a major factor, why is that the case?

A few years ago, when I was a researcher in this building, I attended a briefing by the BMA on minimum unit pricing. I was very open-minded—indeed, I was instinctively for minimum unit pricing. However, the briefing changed my mind, as the evidence simply did not support the policy, and a level of 40p or 45p would not make much of a difference. I accept that such a level would change the nature of what people drink. It would change what people put in their mouths, but not necessarily how much alcohol they drank—or the desired effect, which is to get absolutely plastered.

On that basis, I utterly reject the concept that Labour's position on minimum unit pricing is politically motivated. It simply is not. It is disingenuous for Scottish National Party members to assert that.

Mark McDonald (North East Scotland) (SNP): Will the member give way?

Kezia Dugdale: I would prefer to move on, if that is okay—another day.

I like to think of myself as open-minded. Last night, I went to the briefing that was mentioned earlier, to hear what we were promised would be new information around the minimum pricing model in Canada. However, I do not think that I was at the same meeting as James Dornan and others, because I still remain unconvinced after hearing that evidence. There is no doubt that price is a factor and that harmful drinkers are the most susceptible to price. At last night's briefing, Professor Tim Stockwell told us about the situation in Canada. He said that people had asked what harmful drinkers who simply could not buy drink would do, and informed us that the answer was that they stopped, and that that decision to stop drinking gets them on to a pathway to recovery. That might be a success story, but to me it seems to be a particularly inhumane approach to helping harmful drinkers get out of their addictions. It is like starving a rabbit out of a hole.

I want to move on to the issue of problematic drinkers. That is the problem in Scotland: the people who hold down jobs, have families and live successful lives but drink far too much. The problem with minimum unit pricing is that the price of wine would not change one little bit. Under the SNP's proposal, the minimum price for a bottle of wine would be around £4.50, which is still three times cheaper than a trip to the cinema, with popcorn included. That is not going to drive a major cultural change in Scotland's attitude to alcohol.

I agree with one aspect of the motion, which is that we need a "package of measures" to deal with Scotland's alcohol problems. That is why I look forward to some of the measures that are being brought in on 1 October as a result of the 2010 act, including the cutting down of major discounting, such as three-for-£10 offers on bottles of wine. That, not minimum unit pricing, is the way in which to change the price of alcohol.

The Labour Party is thoroughly committed to tackling and addressing Scotland's attitude to

drink, but the SNP must accept that minimum unit pricing alone is not going to deliver that change, and it is certainly not going to tackle problematic drinking in the way that we need it to be tackled.

17:40

Gordon MacDonald (Edinburgh Pentlands) (SNP): I thank my colleague James Dornan for securing the debate.

The World Health Organization suggests that Scotland has the eighth-highest alcohol consumption in the world. We are behind Ireland, the Czech Republic and Germany in litres of pure alcohol consumed per head, but we drink more than Spain, France and Italy.

Figures from the Office for National Statistics indicate that alcohol is nearly 70 per cent more affordable now than it was in 1980 and that, in the period since then, alcohol consumption in the United Kingdom as a whole has risen by 21 per cent, and has doubled since 1960. One reason for the increase could be—as the Campaign for Real Ale's national chairman, Colin Valentine, stated during last session's discussions on minimum pricing—that supermarkets are

"peddling cheap booze at insanely low prices."

A study called, "Drinking: adults' behaviour and knowledge" examined how often people bought alcohol from various outlets in the years 1998 to 2009. It found that the percentage who were drinking in licensed bars at least once a week had fallen from 26 per cent in 1998 to 21 per cent in 2009. Over the same period, the percentage who were purchasing from supermarkets at least once a week had increased from 15 to 20 per cent. So, why the change?

Not that long ago, we had supermarkets offering multibuy deals on three cases of beer or cider for £18, which worked out at 40p for a can of cider. At the same time, that well-known loss leader, milk—bemoaned by farmers—was selling for 50p a pint. The change might be due to supermarkets offloading stock prior to the Alcohol etc (Scotland) Act 2010 coming into force on 1 October, which will make it illegal for shops to run multibuy offers that give customers discounts for buying in bulk, but will not remove the problem of discounted alcohol.

It was reported recently in the press that the chief executive of wine merchant Majestic has written to customers to say that the company has been forced to end multibuy price discounts, but it will now charge lower than the multibuy price for a single bottle. It can do that only because this Parliament did not introduce a minimum price for alcohol last session.

The Scottish Government wants to tackle the problem of supermarkets that sell alcohol purely as a loss leader in the hope that customers will purchase other goods when they are in the store. I welcome the reintroduction of a bill that will introduce a minimum price for alcohol to tackle excessive alcohol consumption, which costs Scottish taxpayers more than £3.5 billion per year through increased crime, healthcare costs and alcohol-related deaths.

I also welcome the fact that the Scottish Government will introduce a levy on supermarkets with a rateable value higher than £300,000, which is expected to help raise between £30 million and £40 million per annum to help deal with the problems of alcoholism.

Supermarkets can easily afford that levy, given that the top four reported combined pre-tax profits across the UK of £5.2 billion in 2009. Even in this recession, last year's profits have not dipped: so far, three of the four large supermarkets have reported combined increasing pre-tax profits of in excess of £500 million in 2010.

I agree with Colin Valentine of CAMRA, who stated earlier this year:

"We need to level the playing field between pub prices and supermarket prices, in order to encourage people to drink alcohol in the sociable and regulated environment of the pub, rather than at home."

We need to do what Parliament failed to do last session, and put in place a mechanism that stops retailers selling alcohol as a loss leader so that we can rebalance our relationship with alcohol.

17:44

The Minister for Public Health (Michael Matheson): I congratulate James Dornan on securing the debate on a very important issue. The BMA survey underlines Scotland's level of alcohol misuse, which is a significant problem and one that is significantly worse than it is in the rest of the UK.

The figures are stark. At least 50 per cent of men and almost 40 per cent of women are regularly exceeding the sensible drinking guidelines. Scotland sees, on average, more than 100 hospital admissions every day due to alcohol misuse. The total cost is estimated at some £3.56 billion each year. That is equivalent to £900 for every single adult in Scotland.

Patrick Harvie is correct that we need to change Scotland's relationship with alcohol to a much more positive one, so we must be prepared to implement the measures that will allow us to do that. The Government wants a fundamental change in Scotland's relationship with alcohol, so

we have adopted a range of measures to assist in bringing that about.

Patrick Harvie: I acknowledge that point and welcome many of the measures. My question might go a wee bit beyond our existing powers, but does the Government agree in general that we need to relocalise the industry? Does it agree that ownership and control of the industry should be wrested from the multinationals and massive multiples and brought back into local communities?

Michael Matheson: From our point of view, it is important to deal with what we can at the moment through good evidence and do what we know can make a difference. That is why we have taken measures not only in legislation but under the alcohol framework. The framework has more than 40 different parts, which are about trying to change Scotland's relationship with, and behaviour in relation to, alcohol. We have provided record funding for that: since 2008, £155 million has been put into it.

We have a responsibility to take effective measures to address the problems that alcohol causes our society. I will touch on some of those that we have taken that are having an impact. We have made significant investment in alcohol brief interventions, which are about changing people's behaviour and improving individuals' health at grass-roots level. They are a great example of a preventative approach that works effectively and has a robust evidence base. We have been able to deliver 150,000 of those brief interventions through the national health service since 2008. We are ahead of schedule on that programme, and we want to take it from being a new initiative to embed it in normal day-to-day practice, so that clinicians and other practitioners do not have to think about adding it on. We will continue to drive that forward.

A couple of members referred to the Alcohol (Scotland) Act 2010, which comes into force on 1 October. It will restrict promotions and off-sales, banning quantity discounts such as the three-for-two deals and offers such as taking 25 per cent off for those who buy six bottles.

I served as a member of the Health and Sport Committee in the previous session of the Parliament and was bitterly disappointed at the approach that was taken on minimum pricing when it was considered then. All the international research is clear that three key factors drive alcohol consumption. The first is availability. That is addressed partly through our licensing legislation. Improvements can be made on that, particularly on public health, and I am keen for us to make progress.

The second is advertising. Some progress has been made on that, and we continue to work with the industry to address the issues. The other factor that needs to be addressed is affordability. I have said time and again that until we are prepared to deal with affordability, all the other measures that are designed to change our relationship with alcohol are like trying to push water up a hill. Affordability is a key component in trying to change that relationship.

I will tell members what is really disappointing. Some may think that politics was not played out in the committee's and Parliament's consideration of minimum pricing in the previous session, but some parties issued press statements opposing minimum pricing even before the Health and Sport Committee had considered a shred of evidence. That does not strike me as considering the evidence objectively and coming to an informed position. Sadly, it is exactly what happened.

Liam McArthur: I take the minister back to his point about the role that advertising can play. The BMA briefing says:

> "Mass media campaigns and public service messages aimed at countering the extensive promotion of alcoholic beverages have only been found to raise awareness and not encourage individuals to reduce their alcohol consumption or alter their drinking behaviour."

That is quite a depressing message. Have he and his officials had a chance to consider their response to that?

Michael Matheson: Education is an element of that, but there is good research, which I think was carried out by the World Health Organization, that demonstrates that in order to fundamentally change the relationship that a country has with alcohol, education is just one small element and it is not an effective way in which to drive the necessary culture change. Education is important, but it will not deliver the degree of change that we need, given the nature of the problem in our society. However, education will continue to play a part.

I hope that all members recognise that the issue of affordability must be addressed, although there might be arguments about how we should go about the process. Labour's alcohol commission did not want to consider minimum pricing and those who gave evidence to it were clearly told that, but when the Health and Sport Committee considered the mechanism that the commission came up with, that mechanism simply did not stand up.

Others have proposed that we tackle affordability through duty. Again, the experience on that proposal shows that it does not stand up. The first act of the Westminster Government was to reverse the increase in duty on cider, which is one of the cheapest drinks. To me, that does not

demonstrate a commitment to implementing the measure effectively.

There might be different views about how we should tackle the issue, but I recognise that there seems to be a growing consensus that we need to do so. I did not expect minimum pricing to become such a big issue in the current leadership debates. Jackson Carlaw has now bought into the idea, and the person who it seems will be elected as Labour's new leader in Scotland supports minimum pricing. His biggest criticism is that the Government does not want to set the minimum price high enough. It will be interesting to see how the Labour Party reacts on that issue.

The Government is determined to ensure that we change Scotland's relationship with alcohol. It is a significant problem that affects all aspects of our society and one that we can ill afford to ignore. We are prepared to take the bold measures that are necessary to change that relationship. I hope that the Parliament, when it considers the minimum pricing bill, will be prepared to join us in supporting that bold measure.

Meeting closed at 17:51.

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