The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

MEETING OF THE PARLIAMENT

Thursday 24 January 2013

Session 4

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Scottish Parliament

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[The Deputy Presiding Officer *opened the meeting at 11:40*]

General Question Time

Concessionary Fare Scheme (Edinburgh Trams)

1. Kezia Dugdale (Lothian) (Lab): To ask the Scottish Government whether the Edinburgh trams will be included in its concessionary fare scheme. (S4O-01729)

The Minister for Transport and Veterans (Keith Brown): The matter is under consideration and we will announce our decision shortly.

Kezia Dugdale: Surely,

"It would be absurd if pensioners and disabled people could not use the trams for free ... Instead of being able to travel on a free and regular bus, they would be forced on to an expensive tram, and that would be totally unacceptable."

Those are not my words but the words of Kenny MacAskill, as printed in the *Evening News* in February 2007, but I could not agree more. Will the minister back the *Evening News* campaign and ensure that pensioners in Edinburgh get a fair deal, or must he insist on pushing grannies off the tram?

Keith Brown: Of course I am more than happy to listen to Kezia Dugdale and I certainly would not disagree with her view about the trams being very expensive.

As well as listening to Kezia Dugdale, I will listen to Strathclyde Partnership for Transport, which has written to me asking, if there is concessionary travel on the trams, whether that will also apply to the tube. I will listen to Lesley Hinds, who has asked for more money for concessionary travel for both buses and trams. I will listen to the other Labour MSPs around Scotland, who have given their views on whether money should be taken away from bus concessionary schemes for the tram scheme in Edinburgh. I will listen to Johann Lamont, who has said that such schemes need to be sustainable and that there is a something-for-nothing culture in Scotland. I will listen to all those points from the Labour Party, but my difficulty will be in trying to make sense out of the contradictory, politically expedient and opportunistic nature of the representations that have been made. [*Interruption*.]

The Deputy Presiding Officer (Elaine Smith): I call Marco Biagi, who has a supplementary question.

Marco Biagi (Edinburgh Central) (SNP): Presiding Officer, I am sorry I did not hear you over the fanfare.

I have a question about what was said in 2003, when the then transport minister in the Lib-Lab Executive, Nicol Stephen, stated that local authorities have the power to establish local travel concession schemes for local transport facilities. Is that still the case? Is the minister willing to provide assistance to City of Edinburgh Council if it follows the example of other authorities, such as Angus Council, which operate such schemes on top of the national entitlement scheme?

Keith Brown: Marco Biagi raises a very good point. The power could be used not just in the instance that he mentioned but by SPT, which I referred to previously. The City of Edinburgh Council can of course apply a subsidy or support.

In terms of Government additional support, all that I will say is that we are looking very closely at how we can maintain and improve the support that we give for bus services. Overwhelmingly, people in Scotland travel on buses. We cannot magic more money. Any money for an additional concessionary scheme, whether for trams or for any other scheme, will need to come from the pot of money that we currently use for buses. We will need to look carefully at the issue and protect the interests of people the length and breadth of Scotland who use bus services.

First World War (Centenary)

2. Nigel Don (Angus North and Mearns) (SNP): To ask the Scottish Government how it plans to commemorate the centenary of the outbreak of the first world war. (S4O-01730)

The Cabinet Secretary for Culture and External Affairs (Fiona Hyslop): As I told Parliament in November, the Scottish Government is working with a range of organisations on proposals to commemorate the centenary of the conflict. Today I can announce that I have appointed Norman Drummond to lead our commemorative programme. Mr Drummond has served as a chaplain in the Parachute Regiment and the Black Watch. He is currently chaplain to Her Majesty the Queen in Scotland. He founded Columba 1400, which is a highly regarded education leadership programme on the Isle of Skye that seeks to maximise the potential of young people. He was previously a BBC national governor for Scotland and he brings with him considerable expertise and leadership ability. He will chair the Scottish commemorative panel. I will announce details of the panel and further plans for our commemorations in due course.

As part of such commemorations, on 14 January the First Minister announced an additional

£1 million towards the upgrade and maintenance of war memorials in our communities.

The Deputy Presiding Officer: I ask for order in the chamber, please.

Nigel Don: I thank the minister for her response. I draw her attention to the fact that this year is the centenary of the Montrose airfield, which played an enormous part in training Royal Air Force pilots through the first war and, indeed, through the second. Does the Government have any plans to ensure that help is available for places such as Montrose airfield so that we can commemorate their importance and significance in the first war and beyond?

Fiona Hyslop: The impact of the first world war was felt extensively across Scotland. Clearly, there will be commemorations in every village, town and community during 2014 to 2018.

I am aware of the centenary exhibition at Montrose air station heritage centre. Unfortunately, I could not accept the offer to come to the opening, but I intend to visit the exhibition in the course of the year.

It is important that Mr Drummond and the panel, in assessing the range and depth of the commemorative activity, reflect on the range and depth of experience across Scotland. I am sure that everybody will want to be aware of what is happening in their local villages and towns and across Scotland so as to ensure that we have a fitting tribute to, and commemoration of, Scotland's important experience during the first world war.

NHS Borders

3. Christine Grahame (Midlothian South, Tweeddale and Lauderdale) (SNP): To ask the Scottish Government when it last communicated with NHS Borders and what issues were covered. (S4O-01731)

The Cabinet Secretary for Health and Wellbeing (Alex Neil): Scottish Government ministers and officials communicate regularly with all health boards, including NHS Borders. I met national health service board chairs, including the chair of NHS Borders on 14 January. We discussed Scottish Government priorities for the national health service and matters concerning the health of the population.

Christine Grahame: Other than meetings, what discussions has the cabinet secretary had about the delivery of paediatric services in the Borders general hospital? It would be detrimental to my constituents if they had to travel to Edinburgh for children's services.

Alex Neil: The Scottish Government has been in regular contact with all boards in the south-east region—which, of course, includes the Borders area—about the delivery of their paediatric services. All boards have assured us that they are fully committed to maintaining 24/7 paediatric services.

We have made clear to NHS Lothian, NHS Fife and NHS Borders that we expect them to engage fully with the public and other stakeholders to ensure that children and babies get the best services available in the south-east region. No final decisions have been made by the boards about the future configuration of paediatric services. We will support every effort to ensure that the best-quality paediatric services are maintained.

Claudia Beamish (South Scotland) (Lab): What interim arrangements will there be? I understand that, in NHS Borders and other parts of the south-east and Tayside, the Scottish Government has required the boards to introduce plans to move to a non-training-grade workforce by August. Will the cabinet secretary assure us that families in the Borders will have sufficient out-of-hours paediatric and neonatal care in the meantime?

Alex Neil: Absolutely. As I said in my answer to Christine Grahame, 24/7 cover is essential at all times. The Government and the boards are determined to ensure that that continues.

Hospital Transport (Care Home Patients)

4. Fiona McLeod (Strathkelvin and Bearsden) (SNP): To ask the Scottish Government what transport options are available for care home patients who are discharged from accident and emergency departments at night and what guidance is given to national health service boards regarding this. (S4O-01732)

The Cabinet Secretary for Health and Wellbeing (Alex Neil): There is no specific guidance or protocol for residents of care homes who are assessed as ready for discharge from accident and emergency departments at night. Each case is treated according to the circumstances, such as the availability of family and carer support, as well as specialist patient transport. No vulnerable patient should be discharged without adequate arrangements for onward transport being in place.

Fiona McLeod: Is it worth developing guidelines and distributing them to care homes?

Alex Neil: I agree that it would be helpful to develop guidelines with and for all interested parties to ensure that vulnerable patients who are discharged from accident and emergency late at night are given safe passage to their place of residence, be that a care home or a private dwelling. We will be taking that agenda forward.

Scottish Court Service (Meetings)

5. John Lamont (Ettrick, Roxburgh and Berwickshire) (Con): To ask the Scottish Government when it last met representatives of the Scottish Court Service. (S4O-01733)

The Cabinet Secretary for Justice (Kenny MacAskill): I met the then interim chief executive of the Scottish Court Service, Eric McQueen, on 14 November 2012. We discussed a number of current civil and criminal justice policy issues. I am due to meet the Lord President, who is chair of the SCS board, this Friday. The chief executive of the Scottish Court Service will also be present. Officials from the Scottish Government are, of course, in regular contact with officials of the Scottish Court Service on a range of issues.

John Lamont: The cabinet secretary will be aware that the Scottish Court Service has proposed the closure of Duns sheriff court and justice of the peace court in my constituency, as well as the closure of neighbouring Peebles and Haddington sheriff courts. If the closure of the Duns court goes ahead, victims and witnesses will have to travel 30 miles to Jedburgh, which is a journey of almost two hours by public transport. Does the cabinet secretary share my concern that the proposals will place great strain on existing stretched court services, which will seriously harm access to justice and cause further delay to cases?

Kenny MacAskill: I am aware of the member's concerns, about which he has been in contact; doubtless, he contributed them to the SCS consultation, which has now closed. Clearly, the Lord President and the chief executive will consider the factor to which the member refers. Matters such as public transport arrangements and the number of people involved have been looked at. The Scottish Court Service will have to weigh up such factors before it is required to make its final decision.

Neil Findlay (Lothian) (Lab): When the cabinet secretary met the Scottish Court Service, did it raise with him cuts to the Procurator Fiscal Service and the closure of courts and the resultant lack of court time? If it did so, what was his response?

Kenny MacAskill: Responsibility for the Procurator Fiscal Service lies with the Lord Advocate and the Crown Office and Procurator Fiscal Service. The service is entirely separate from my jurisdiction and, indeed, that of the Lord President, so I do not think that it would have been appropriate to raise that matter with him.

Scottish Household Survey (Volunteering)

6. Stewart Stevenson (Banffshire and Buchan Coast) (SNP): To ask the Scottish Government what its position is on the recent Scottish household survey suggesting that up to 30 per cent of adults volunteer. (S4O-01734)

The Cabinet Secretary for Finance, Employment and Sustainable Growth (John Swinney): The Scottish household survey captures the percentage of adults in Scotland who volunteer in a formal way. We know that many people also volunteer in an informal way through helping friends or neighbours. In reality, the percentage of people who volunteer will be higher than the survey suggests.

Stewart Stevenson: I am delighted to hear that the figure may be even higher. In the past year, we have had very successful volunteering around the Olympic games. The 2014 Commonwealth games will soon start recruiting its team of volunteers. What lessons can Scotland learn from the volunteering practices of the Olympic games and how can that serve to encourage others to involve themselves in volunteering at community level in general?

John Swinney: On the specific point around the lessons learned from the London 2012 experience, the 2014 organising committee has worked closely with the London Organising Committee of the Olympic and Paralympic Games to learn lessons from the London experience. That has flowed through into the opening of the volunteer recruitment programme for the Glasgow games in 2014, which has got off to a really good start in terms of the interest and involvement of members of the public. Clearly, we would encourage more individuals to volunteer for the Commonwealth games, which will be a tremendously exciting and dynamic opportunity for volunteering, as were the London games.

In general, of course, the Government values enormously the contribution that volunteers make to the provision of services and support to individuals in our society and recognises the significant contribution that individuals make in that regard.

Fiona McLeod (Strathkelvin and Bearsden) (SNP): I and some other members of the Scottish Parliament have volunteered to be volunteers at the Commonwealth games. Will the cabinet secretary join me in encouraging employers to help folk to attend training for being volunteers for the wonderful opportunity in 2014?

John Swinney: I certainly echo those sentiments. I can confirm that the Scottish Government has amended its staff special leave policy to allow staff to take up to five days special leave to volunteer at the games. Although it is not within my province, I understand that the Scottish Parliamentary Corporate Body has taken a similar decision. The games are such a unique opportunity for Glasgow and the people of

Scotland that a positive response from employers would be very welcome. From my experience of encountering volunteers who participated in the London games, I know that it was clearly a landmark occasion in their lives. I encourage employers to make volunteering for the Commonwealth games possible and practical for members of their staff in Scotland.

Welfare Reform (Housing Benefit)

7. Mark McDonald (North East Scotland) (SNP): To ask the Scottish Government what impact the proposed so-called bedroom tax reductions to housing benefit will have on Scotland's housing associations and local authorities. (S4O-01735)

The Deputy First Minister and Cabinet Secretary for Infrastructure, Investment and Cities (Nicola Sturgeon): The introduction of underoccupancy deductions, or the bedroom tax, will reduce housing benefit income for social landlords by an estimated £60 million to £65 million annually. I am obviously concerned about the impact on Scotland's most vulnerable children and families. An estimated 105,000 households in the social sector will lose an average of £600 a year. The Scottish Government has been consistent and very clear in our opposition to this United Kingdom Government reform.

Mark McDonald: With reference to the impact on families, a report went to last week's meeting of Aberdeen City Council's housing and environment committee on the impact on kinship carers. Regarding underoccupancy, the report states:

"Rules for kinship carers are not so straightforward. Kinship carers of a not looked after child will not be affected but for those of a looked after child it will depend on whether or not the child counts as part of the family ... The legislation is complex and in the absence of a test case or clarification from the UK government, interpretations vary."

Does the cabinet secretary agree that we urgently need clarification from the UK Government, given the huge impact that that could have not just on kinship carers but on the ability to recruit kinship carers in the future?

Nicola Sturgeon: I welcome the report that Mark McDonald cited. It certainly shows the damaging nature of the sweeping reforms by the Department for Work and Pensions and the fact that they simply do not take account of the impact on our most vulnerable families.

We in the Scottish Government are taking action to mitigate the effect as far as we can. We are in discussions with the DWP about the way in which discretionary housing payments will operate in Scotland to ensure that kinship carers can be prioritised for any support, in addition to foster carers. The Minister for Children and Young People announced to the Parliament in September a review of the financial support that is provided to kinship carers, and that review will report this year.

The Deputy Presiding Officer: Question 8 has been withdrawn for understandable reasons.

Access to Culture (North Glasgow)

9. Patricia Ferguson (Glasgow Maryhill and Springburn) (Lab): To ask the Scottish Government what recent discussions it has had about widening access to culture for people in north Glasgow. (S4O-01737)

The Cabinet Secretary for Culture and External Affairs (Fiona Hyslop): The Scottish Government is committed to widening opportunities for everyone to access, engage in and benefit from cultural activity. The Village Storytelling Centre in Glasgow, for example, received funding as part of the year of creative Scotland so that it could work with young carers in the wider Glasgow and west of Scotland area, including in Maryhill, through its creative sparks project.

The Glasgow 2014 organising committee, with Creative Scotland and Glasgow Life, recently announced a £4 million open fund for the 2014 Glasgow cultural programme, and the Minister for External Affairs and International Development has been involved in discussions to ensure that it will offer new opportunities for audiences across Scotland to see, experience and participate in our vibrant culture.

Patricia Ferguson: I am delighted to hear of the progress that is being made, particularly in connection with 2014. However, the cabinet secretary might be aware that there is a mood within north Glasgow that suggests that a Sistema Scotland project would be welcome in the area, and there have been some preliminary talks and discussions with the organisation about how that might be facilitated. Would the Scottish Government support that and, if it would, in what way?

Fiona Hyslop: I was delighted that the Scottish Government was able to support the expansion of Sistema Scotland into Glasgow and Govanhill in particular. I am sure that all members will congratulate the organisation on that. However, the funding that we provided is not just for Govanhill. It is actually about how Sistema Scotland could expand the big noise orchestras progressively across future years.

In terms of the legacy that we have, there are lots of different ways—music is undoubtedly one of them—in which we can enrich the lives of our young people. The Government is very committed to that. I will continue my positive discussions with Richard Holloway and the excellent team at

Sistema Scotland. I am sure that all members in the chamber will be pleased to congratulate the organisation on the work that it has done to expand in Glasgow, and particularly in Govanhill.

The Deputy Presiding Officer: I will take question 10, but I need very brief questions and answers.

Child Trafficking

10. Jenny Marra (North East Scotland) (Lab): To ask the Scottish Government, in light of the figures recently released by Barnardo's concerning the rest of the United Kingdom, whether it will carry out research into the scope of child trafficking in Scotland. (S4O-01738)

The Cabinet Secretary for Justice (Kenny MacAskill): The figures that were released by Barnardo's relate to children within its services who indicated that they had been trafficked for the purposes of sexual exploitation. The national referral mechanism collates United Kingdom data on suspected and confirmed cases of trafficking. The gathering of accurate, reliable data on this clandestine activity is complex and difficult. For that reason, we recently commissioned the University of Bedfordshire to research the scale and nature of child sexual exploitation in Scotland and how child trafficking relates to that.

The Deputy Presiding Officer: Very briefly, Jenny Marra.

Jenny Marra: Does the cabinet secretary agree that a review of the legislation in Scotland is required as the crime of human trafficking is not clearly provided for in Scots law, with current provisions straddling two acts, and that, if detection is to increase, police need a clearly defined—

The Deputy Presiding Officer: I am sorry. You need to conclude your question.

Jenny Marra: —crime to work to?

Kenny MacAskill: We have indicated the restriction on Government time, but there is a willingness to bring in an aggravation offence for trafficking. That is being promoted by the Lord Advocate and will give law enforcement more powers to ensure that those who are involved in this evil trade are brought to account and brought to justice.

The Deputy Presiding Officer: Before we come to First Minister's questions, members will wish to join me in welcoming to the gallery the Speaker of the Northern Ireland Assembly, William Hay MLA.

First Minister's Question Time

12:00

Engagements

1. Johann Lamont (Glasgow Pollok) (Lab): To ask the First Minister what engagements he has planned for the rest of the day. (S4F-01134)

The First Minister (Alex Salmond): Engagements to take forward the Government's programme for Scotland.

Johann Lamont: Last week, the First Minister told the BBC's "Today" programme:

"we're going into talks with President Barroso and the European Commission."

When will those talks take place?

The First Minister: Johann Lamont will have seen the European Commission's viewpoint, which states that it has not expressed an opinion on a specific situation regarding Scotland. So, according to the European Commission, all the stuff that we heard before Christmas was not about Scotland at all.

However, the European Commission offered a route forward. It said that, if the member state wanted to ask for an opinion, that opinion could be provided. We have made it clear to the United Kingdom Government that we could go jointly to the European Commission and find out, with interest, what its viewpoint is. That seems to me to be an entirely reasonable suggestion. Perhaps Johann Lamont will depart from her colleagues in the coalition Government and support the Scottish Government's positive suggestion.

Johann Lamont: I think that we can work out that the First Minister did not answer the question. Putting aside what he is asked and talking about something else might be an interesting thing to do, but it is not what he is supposed to do in this chamber.

The First Minister said that he was going into talks with President Barroso. Since he made that assertion before the Deputy First Minister had even received a reply to her letter asking for talks, what was the basis on which the First Minister said that he was going into talks with the European Commission? Was it the same basis on which he said that he had legal advice when he did not—that is, he just made it up?

The First Minister: The basis was that we asked for talks with the European Commission on what seemed to be the viewpoint that it stated in December and which was widely reported, which applied to the case of Scotland. The European Commission has now replied saying that it said no

such thing and was not talking about a specific case. However, I think that it would be useful for the European Commission's viewpoint to be heard. I want to hear its opinion. That is why the Deputy First Minister has indicated that we will go jointly, with the UK Government, if it agrees, to find out what the European Commission thinks.

Of course, since December, we have had some other important opinions on this matter from people such as Sir David Edward, a former judge in the European Court of Justice and, only this week, from Professor David Scheffer. Professor Scheffer seemed to profoundly support the Scottish Government's viewpoint, which we have stated many times, that we will negotiate our position from within the European Union, and stated his opinion that there should be two successor states with equal status with regard to each other.

Those profound and important legal opinions tend to give weight to the Scottish Government's point of view. I am sure that Johann Lamont has read and understood them and will want to take account of them as we pursue this debate.

Johann Lamont *rose—*

The First Minister: It would be interesting—if Johann Lamont would give me a second—to have an indication from the Labour Party—[*Interruption*.]

The Deputy Presiding Officer (Elaine Smith): Order.

The First Minister: It would be interesting to have an indication from the Labour Party of whether it, along with its colleagues in the Tories, is heading towards the exit door of the European Union.

Johann Lamont: Forgive me for not allowing the First Minister his sound bite before moving on.

Although President Barroso has not spoken about the specific issue of Scotland, he has said that current treaties do not apply to a new state. I can only assume that, although the First Minister has trimmed on the monarchy, the currency and the regulation of the banks, he still thinks that an independent Scotland would be a new state. He can correct me if I am wrong in that regard.

Of course, President Barroso has said that he cannot comment on Scotland's application to join the European Union, but the Czech foreign minister has done so. The Czech Republic will have a veto on an independent Scotland's EU application, and Karel Schwarzenberg, the Czech foreign minister, has said that Scotland

"would have to apply for ... membership"

and went on to say that it would get "a worse deal" because

"a much smaller country with much lesser economical importance has less weight".

Why is the Czech foreign minister scaremongering like that?

The First Minister: Actually, Scotland is approximately the same geographical size as the Czech Republic.

I have the comments from the Czech foreign minister in front of me. When he was specifically asked whether he would want to block Scotland's entry into the EU, he said no. Even the Czech foreign minister, speaking before he realised that the UK is heading for the exit door under Cameron's leadership, thought that he would not want to stop Scotland's membership of the EU. He does not want to stop Scotland's being a member of the EU, so why is the Labour Party seeming to cast some doubt on it?

The events of the past 24 hours are very interesting in this debate, are they not? They indicate that the threat to Scotland's continued membership of the European Union comes not from this Parliament, this Government or the people of Scotland but from the banks of the Thames with a Tory coalition Government that is heading towards the exit door and a Labour Opposition that has still to clarify what on earth it thinks about it.

Johann Lamont: I know that it is the First Minister's stock-in-trade to miss the point, but the Czech foreign minister's point is not about whether the Czechs would block Scotland but the price that they would extract for Scotland's membership of the European Union.

The fact of the matter is that Alex Salmond and David Cameron are like peas in a pod. They will always put—[*Interruption*.]

The Deputy Presiding Officer: Order.

Johann Lamont: They will always put—[*Interruption*.]

The Deputy Presiding Officer: Order!

Johann Lamont: They will always put—[*Interruption*.]

The Deputy Presiding Officer: Order!

Johann Lamont: They will always put their parties' interest before the interests of the people of this country.

There is nothing quite so negative as trying to mislead the country, which is perhaps why support for independence is at its lowest since devolution. Perhaps the people who hear the First Minister say that he has legal advice when he does not do not believe him any more; maybe the pensioner lying on a trolley in a freezing corridor does not believe him when the First Minister says that he is

doing a great job with the national health service; and maybe when the First Minister says that he is doing everything he can to create jobs and then goes on a half-million pound trip to the golf, people do not believe him.

The reality is that Alex Salmond cheered the Tories into Downing Street. [*Interruption*.]

The Deputy Presiding Officer: Order!

Johann Lamont: He sees Tory welfare cuts as an opportunity for his party and celebrates Tory mistakes on Europe. In fact, is it not the case that he loves the Tories so much that he has taken— [*Interruption*.]

The Deputy Presiding Officer: Order!

Johann Lamont: Let me try it again so he definitely hears it.

In fact, is it not the case that he loves the Tories so much that he has taken support for independence down to Tory levels of popularity?

The First Minister: I think that Johann Lamont should try it many times in order to get it right. I am not the one who is hand in glove with the Conservative Party in the better together campaign.

Amid all that fluff and nonsense, there was a serious point about the national health service. I want to make it clear that it is not acceptable in the NHS for any patient, let alone an 84-year-old man from Glasgow, to wait eight hours. However, I point out that the NHS conducts 1.5 million accident and emergency admissions in a year; indeed, the figure has gone up about 6 per cent over the past few years. I have been looking back at the figures, because not all of those admissions are conducted in the manner that we would like them to be. That is inevitable in any human-led organisation.

That said, one can measure whether the health service is improving or not. The facts are that when we took office, 90.3 per cent of patients in September 2006 waited less than four hours in accident and emergency across the national health service, while in September 2012, 95 per cent of patients waited less than four hours. Those are facts about improvement in the health service, which must be driven forward to ensure that we do not have individual cases of 84-year-olds waiting eight hours.

I have dealt with Johann Lamont's alliance with the Conservative Party. [*Interruption*.] If those on the Labour benches do not like it, they should not be hand in glove with the better together campaign.

The point about the European Commission is not that it says that it is not going to comment on the Scottish situation; it says that it has not commented, but it allows the opportunity for the member state to find out its opinion. I would like to hear the European Commission's opinion, which is why the Deputy First Minister has indicated that we are willing to do that in a joint submission. Unfortunately, Johann Lamont's allies in the Conservative Party, and for that matter in the Liberal party, do not seem to have any enthusiasm for that. I wonder why. Is it because the proposition from the unionist parties that somehow energy-rich, fish-rich and renewables-rich Scotland would not be welcomed with open arms into the European Union is absolutely incredible? In contrast to the anti-European attitudes that prevail in the House of Commons, many people across the continent would welcome a pro-European Scotland into the community of nations.

The Deputy Presiding Officer: I call Johann Lamont again, because I expect any member in the chamber to be allowed to be heard when they ask their question.

Johann Lamont: Thank you, Presiding Officer. I have two brief points. The SNP's position on Europe seems to have changed from, "Of course we would be a member," to, "Why wouldn't we be a member?" We need certainty.

On the health service, it is not good enough for a First Minister to come here and say that everything is fantastic or for policy to shift and be driven by a newspaper and a journalist raising questions. [*Interruption*.]

The Deputy Presiding Officer: Order.

Johann Lamont: It is about time that the First Minister got his health minister to ensure that the NHS is safe, rather than simply responding to scandal stories that have to get into the papers for action to be taken.

The First Minister: The record will show that I never said anything of the sort; on the contrary, I pointed out that there were 1.5 million admissions to accident and emergency and that, as with any human-led organisation, some people will not be treated as we would like. That is not acceptable. I specifically made the point that it is not acceptable for an old person to wait that length of time on a trolley in a Glasgow hospital or anywhere across the national health service.

The point that Johann Lamont did not like is that, through the statistics, we can see the improvement in accident and emergency in the national health service. If it is unacceptable now for anybody to be in that position—as I say it is—was it not more unacceptable in 2006, when the Labour Party was in power and many thousands more people were in that position in the national health service? A national health service that deals with 7 million treatments in a year, 1.5 million of which are in accident and emergency,

should be seen as a health service and its workers performing in the interest of the nation.

I have one last point about accident and emergency: thank goodness that the Ayr and Monklands accident and emergency units are still open and have not been closed, as the Labour Party would have done.

Prime Minister (Meetings)

2. Ruth Davidson (Glasgow) (Con): To ask the First Minister when he next plans to meet the Prime Minister. (S4F-01132)

The First Minister (Alex Salmond): I have no plans to do so in the near future.

Ruth Davidson: Despite the First Minister's protestations, there is clear blue water between us and Labour on many things, not just Europe. The difference is that we are sound on Europe and the Labour Party is not; we would give Scotland a say and the Labour Party would not—and nor would the First Minister, it seems. Why is that? When the research shows that twice as many Scots want a Euro referendum than want Scotland to leave the United Kingdom, why in his Scotland would he not give them their say?

The First Minister: I am delighted that there seems to be an implicit acceptance that the independence cause will win the referendum and put forward a position. The reason why the SNP advocates that position is that we do not want to leave the European Union. Therefore, we do not argue for a referendum on that case. The Conservative Party's extraordinary position is that David Cameron says that he wants to stay in the European Union—indeed, when he talks to other European leaders, he says that he is the great reformer who is going to save Europe—but when he is running scared from his Eurosceptic back benchers, he says that it is an in-out referendum. The interesting point is that the negotiations will take five years. Where is the urgency to have the European referendum that there was to have the Scottish referendum? [*Interruption*.]

The Deputy Presiding Officer: Order.

The First Minister: If the negotiations fail, will Ruth Davidson line up to campaign against the European Union, or did David Cameron not bother to consult her before he made his speech yesterday?

Ruth Davidson: I saw his speech both this week and last.

The difference is that the Prime Minister is ready to negotiate a better deal for the UK and that European leaders such as Angela Merkel are lining up to sit down with him for talks, whereas this First Minister cannot get through the door in Brussels for a simple meeting.

I am grateful to the First Minister, because this week something has become crystal clear. If people vote to stay in the UK, they will have a chance of a say on Europe, whereas if people vote for independence, the First Minister is telling them that they should pipe down and leave it to him.

From yesterday's Scottish social attitudes survey, we all know which way Scotland is going. We also know that the First Minister is old enough to have had his say on Europe—decades ago—[*Interruption*.]

The Deputy Presiding Officer: Order.

Ruth Davidson: No one in Scotland under 55, however, has ever had their say on Europe and, in this First Minister's world, they never will. The First Minister needs to explain to them why he would deny them their say. Can he explain? Why does he not trust them?

The First Minister: I will take Ruth Davidson through this. In her first question she seemed to imply that she was at least admitting the possibility and perhaps even accepting that yes, I was going to win the referendum. In her second question she seems to have conceded the first elections for an independent Scottish Parliament.

In May 2016, Ruth Davidson and her party, if they so wish, can go to the Scottish people on the platform of heading towards the exit door of the European Union and they can have the exactly the same position as David Cameron will have in 2015. Implied in her question was the acceptance that somehow Ruth Davidson has come to the conclusion that, even under her dynamic leadership, the Conservative party will not be threatening too many polling stations with victory in 2016.

The circumstances of the past few days have fundamentally changed the independence debate in Scotland. The negative, scaremongering, better together Labour-Tory campaign has rested on the assumption that uncertainty would be created about Scotland's position in Europe. It is now obvious to any reasonable person that the uncertainty about Scotland's position in Europe comes from the Conservative Party, which is led by the nose by Eurosceptics, and the compromises that David Cameron has had to make to hold on to his job.

I doubt very much that the Scottish situation—never mind the Scottish Conservative Party—was any part of the Prime Minister's calculations. That is why Scotland is safer with independence as a European nation.

The Deputy Presiding Officer: Hugh Henry has a brief constituency supplementary question.

Hugh Henry (Renfrewshire South) (Lab): On Monday night there was a major fire at a recycling

plant in Johnstone, next to residential properties in the town centre. Some local residents were evacuated and rail services to Ayrshire were halted.

Will the First Minister consider a review of legislation to ensure that such operations are not located in such public areas and will he ask his minister to come to Johnstone to meet me and relevant agencies to discuss a way forward?

The First Minister: I am certain that Keith Brown and the Deputy First Minister would be happy to arrange a meeting to discuss the matter. A discussion to understand the circumstances is the right way to proceed. A decision should then be made on what action needs to be taken as a result of the meeting.

Cabinet (Meetings)

3. Willie Rennie (Mid Scotland and Fife) (LD): To ask the First Minister what issues will be discussed at the next meeting of the Cabinet. (S4F-01141)

The First Minister (Alex Salmond): We will discuss issues of importance to the people of Scotland.

Willie Rennie: The First Minister has been an advocate of the Scottish Parliament for all his political life. I understand why he might not want to give up his ambition of an independent Scotland but, if Scotland votes no, would he engage with other parties on further powers for the Parliament? [*Interruption*.]

The Deputy Presiding Officer: Order.

Willie Rennie: Nicola Sturgeon has urged us all to work together if Scotland votes yes. Will the First Minister work with us if Scotland votes no?

The First Minister: Willie Rennie's position is extraordinary. My certain memory of this is that he was desperate to avoid devo max or federalism on the ballot paper in the referendum. I go into the referendum campaigning to win, as does the yes campaign. That is how we see Scotland's future. I have absolutely no idea, given the Liberal Democrats' multifaced alliances with the anti-European Tories and the no-further-devolution Labour Party, where on earth the Liberal Democrats now stand.

Willie Rennie: The First Minister knows that the referendum is about whether Scotland stays part of the United Kingdom. Even his own consultation rejected a second question. I do not quite understand why he is so shy about this. The Liberal Democrats have published our plans for home rule in a federal UK. Reform Scotland has produced devo plus and the Institute for Public Policy Research's devo more will be out tomorrow.

A consensus on more powers is emerging from all those plans and it seems to be endorsed by members of the public. Will the First Minister at least consider working with me and others on a new constitutional future if Scotland votes no? His deputy wants partnership. That is reasonable. Why does not he?

The First Minister: I accept one thing. The Scottish social attitudes survey shows strong support for the Scottish Parliament increasing its powers. It also shows strong support for the Scottish Parliament having full powers and majority support for the Scottish Parliament controlling matters such as social security, which I do not think has even featured in any of the Liberal Democrats' proposals.

I find this attitude surprising. The Liberal Democrats were extremely coy and reluctant to have a referendum at all at one point, and then to have anything else on the ballot paper. Now, apparently, we should revisit that in some way or try to rearrange the furniture. I do not see how that is tenable. The Liberal Democrat party would not go into alliance with the Scottish National Party at one point because we wanted a referendum on independence. Now it is in alliance with the Conservative Party, which wants a referendum on Europe.

If the Liberal Democrats are willing to traduce their European principles because they have office in the House of Commons at present, I do not think that many people will regard them as the most reliable allies in the Scottish self-government cause. My proposition to Willie Rennie is this: given that, in the past at least, Liberal Democrats have expressed strong support for Scotland having the strongest possible powers, why does he not desert the Europhobic Conservatives and the no-further Labour Party and come and join the yes campaign? [*Applause*.] We can then campaign jointly to take the Scottish people into a position of real self-government.

Defence Spending

4. Bill Kidd (Glasgow Anniesland) (SNP): To ask the First Minister what the Scottish Government's position is on the recent report in *The Scotsman* that Scotland is receiving less than its population share of defence spending. (S4F-01144)

The First Minister (Alex Salmond): The freedom of information request on which the article in *The Scotsman* is based reports that between 2007-08 and 2011-12, Scotland received £1.9 billion less than its population share of Government spending on major European Union-exempt projects.

The Scottish Government's position is that Scotland's interests would be best served under independence and if this Parliament could take decisions on such matters, allowing our defence and shipbuilding industries to flourish. I notice that that was backed by Ian Godden, former chairman of defence industry leader ADS, who recently said in evidence to the Scottish Affairs Committee:

"Scotland can maintain its position in defence interests because there is an industrial and engineering capability that Scotland has got which makes it attractive."

Bill Kidd: The First Minister will be aware that the Ministry of Defence announced earlier this week that up to 5,000 job losses are expected as a result of further Army redundancies. Will the Scottish Government raise that issue with the United Kingdom Government and seek clarity on how Scotland might be affected by those redundancies? Does the First Minister think that instead of wasting billions of pounds on the obscenity of nuclear weapons, the money would be better spent on maintaining the front line?

The First Minister: I do think that, and I think that the Conservative-led Government, which has regarded defence as a major issue in the constitutional debate, should explain why people who have been on the front line, fighting in Afghanistan, will potentially come home to P45s. Most human beings would find that prospect, under the Conservative Party, disgraceful.

On Trident, I also note a correction in *The Herald* newspaper. It seems that the previous jobs estimates that were quoted were based on double and triple counting.

Given the real redundancies in defence that are happening under the Conservative-led Government—[*Interruption*.]

The Deputy Presiding Officer: Order.

The First Minister: —and the waste of billions of pounds of expenditure on a system of mass destruction, it would be far better if those areas were under Scottish control.

Rhoda Grant (Highlands and Islands) (Lab): The First Minister will be aware that *The Scotsman* report did not cover all Ministry of Defence spending in Scotland, including the cost of extensive world-class protection for our oil and gas rigs in the North Sea. Can he tell me how that protection would be provided if Scotland was to leave the UK?

The First Minister: It would be provided by the Scottish conventional defence forces and the advantage would be that we would have conventional forces—[*Interruption*.]

The Deputy Presiding Officer: Order.

The First Minister: We would have conventional forces protecting Scotland's interests in partnership with our allies, as opposed to wasting billions of pounds on an unwanted, unusable system of weapons of mass destruction that the vast majority of Scottish MPs, and the overwhelming majority of MSPs in this chamber, have voted against.

If Rhoda Grant believes in this Parliament and in the views that have been expressed by many people in the Labour Party, how on earth can she accept a situation in which billions of pounds of expenditure are wasted on Trident, while conventional defence forces are being run down? With the system of public spending cuts that we see across the UK, how can she possibly defend those billions going into weapons of mass destruction? She should look to her conscience and come up with a different answer.

Life Expectancy (Deprived Areas)

5. Drew Smith (Glasgow) (Lab): To ask the First Minister what the Scottish Government's response is to the Joseph Rowntree Foundation's report suggesting that a boy born in one of the most deprived 10 per cent of areas in Scotland has a life expectancy 14 years below one born in the least deprived areas. (S4F-01148)

The First Minister: The report and the member both make a profound point. I think that health inequalities are a huge priority, as they should be across the chamber.

I draw attention to the fact that, within a report that makes serious reading for us all, there was the welcome confirmation that the child poverty rate in Scotland

"dropped 10 percentage points in the decade to 2011, from 31 per cent to 21 per cent".

That is still far too high, but it represents a significant measure of improvement.

Drew Smith: The First Minister is right that previous Governments—both the Scottish Government and the United Kingdom Government working together—have been able to lift a third of children out of poverty. The current coalition Government's policies make that task harder, but they are not excuses for despair.

Does the First Minister agree with the authors of the Joseph Rowntree Foundation report, who were in Glasgow on Monday and who were straightforward in saying that Scottish ministers already have the powers that are needed to make a real difference to health inequalities? The authors were clear that the poor cannot and should not have to wait for a referendum, so does the First Minister further agree that the young boy described by the JRF authors, and many like him,

including in my city of Glasgow, need the Scottish Government's help now? Can we expect any change in the First Minister's policies or priorities as a result of the report, which recognises that some initiatives, particularly in public health, help the better off most?

The First Minister: I understand that the Deputy First Minister spoke at the conference. Therefore, we treat the report and its contents seriously. Drew Smith is going to have to come to terms with what is an unavoidable fact: there is no question but that a major determinant of the immediate causes of poverty is what is available in the social security system. That system is run at Westminster at present and, as far as I know and understand, the Labour Party supports it being run from there. [*Interruption*.]

The Deputy Presiding Officer: Order.

The First Minister: The report details the substantial threat to the incomes of families in Scotland from the changes that are going through in social security at the moment. Drew Smith should be aware of the measures that the Scottish Government, supported in this chamber, has taken to try to ameliorate some of the very worst effects of those social security changes. However, would it not be a fantastic position if, instead of embarking on amelioration, we controlled these issues in Scotland and could decide on and dictate policies and could try to turn back the threat to some of the poorest families in our land?

Christina McKelvie (Hamilton, Larkhall and Stonehouse) (SNP): Last week, the Child Poverty Action Group said that the Westminster Government's policies—and, let us not forget, a welfare reform policy that was started by Labour—would result in a staggering 1 million more children being dragged below the poverty line by 2020. On a simple population share, that means 85,000 Scottish children being pushed into poverty by a Government that we did not vote for. Does the First Minister agree that the only way to protect those children is independence, and that we really are not better together?

The First Minister: I agree that those on the Labour benches who bemoan, and say that they oppose, what the Westminster Government is doing should at some stage come to the conclusion that, if they support the Westminster Government having the power over Scotland in these issues, they are implicated in the decision that that Government takes to reduce people in Scotland to penury.

There is no escaping the fact that, if Labour members want different policies for social protection in Scotland, those policies must be controlled by this Parliament. Perhaps at some stage the Labour Party will catch up with the attitudes reflected in the social attitudes survey and support social security coming under the province and power of this democratic Parliament in Scotland.

Cervical Cancer

6. Dennis Robertson (Aberdeenshire West) (SNP): The First Minister is probably aware that this is cervical cancer awareness week.

To ask the First Minister what action the Scottish Government is taking to improve awareness of the screening and symptoms of cervical cancer. (S4F-01130)

The First Minister (Alex Salmond): As Dennis Robertson has indicated, it is certainly correct that the earlier a cancer is diagnosed, the better the chance of a complete cure.

We know that screening is the best way to detect cervical cancer at its earliest stage, and every woman in Scotland between 20 and 60 is invited to be screened every three years. As well as information on screening, each invitation includes information on the signs and symptoms of the cancer. This week is cervical cancer prevention week. The message from the Government, and I am sure from the whole chamber, is that anyone who experiences those signs and symptoms should see their general practitioner straight away.

Dennis Robertson: I am sure that, like me, the First Minister will congratulate Jo's Cervical Cancer Trust on the awareness that it brings to women throughout the country. However, what co-ordination among the health boards can the First Minister ask for in relation to awareness raising? There has been a decline in the number of women who attend screenings.

The First Minister: Dennis Robertson raises an important point. There is a £30 million detect cancer early programme, which obviously highlights the screening programmes that are available. We also work with NHS boards, including on their responsibility for publicising screening in their areas, and GPs play a pivotal role in highlighting the benefits of screening to their patients. Nationally, the information that we provide through NHS Health Scotland is key to allowing women to make an informed choice.

I would be delighted to arrange a meeting between the Cabinet Secretary for Health and Wellbeing and Dennis Robertson to take forward the issue and to look in particular at the worrying indications that the information is perhaps not getting through to the fullest extent.

The Deputy Presiding Officer: That concludes First Minister's questions. Before we move on to the next item of business, I will allow a short pause

to allow members who are not participating in the next debate to leave the chamber, and to allow the public gallery to clear.

Cardiac Rehabilitation (Clinical Standards)

The Deputy Presiding Officer (John Scott): The next item of business is a members' business debate on motion S4M-04623, in the name of Helen Eadie, on clinical standards for cardiac rehabilitation. This debate will be concluded without any question being put.

Motion debated,

That the Parliament welcomes the publication of the British Association for Cardiovascular Prevention and Rehabilitation (BACPR) *Standards and Core Components for Cardiovascular Disease Prevention and Rehabilitation 2012*; acknowledges that the aim of the standards is to ensure that cardiac rehabilitation programmes are clinically and cost effective and achieve sustainable health outcomes for patients; understands that cardiac rehabilitation is one of the most effective interventions in the management of heart disease through the prevention of re-admissions to hospital and unnecessary appointments in primary care, the education of patients and their families on where to seek advice and information and its focus on the self-management of cardiac conditions; considers that the BACPR standards and their seven core components are at the forefront of acknowledging the achievements of cardiac rehabilitation programmes in Scotland and can be used to encourage continuous improvement to patient outcomes and experience through this vital intervention in Fife and across the country, but is concerned that, despite improvements in the provision of cardiac rehabilitation for patients with acute conditions across Scotland, its provision for patients with heart failure and for angina remains very low.

12:34

Helen Eadie (Cowdenbeath) (Lab): I start by thanking all my colleagues in the Scottish Parliament and you, Presiding Officer, for enabling me to bring to Parliament this afternoon a debate on a topic about which I am very enthusiastic. The subject is very important, so I offer the motion to colleagues for their support.

Modern cardiac rehabilitation is menu based and patient centred, and it provides a pathway from diagnosis to long-term management while meeting patients' physical, psychological and social needs. It reduces all-cause mortality by up to 26 per cent and cardiac mortality by up to 36 per cent, while reducing unplanned hospital admissions by up to 56 per cent.

As members may be aware, I convene the cross-party group on heart disease and stroke. I have heard at first hand from patients and health professionals how popular cardiac rehabilitation is and how important rehab can be in aiding recovery from heart conditions.

The British Association for Cardiovascular Prevention and Rehabilitation—BACPR—presented on its standards at our last meeting in December, and made a compelling case for the

extension of cardiac rehabilitation to every heart patient who needs it.

BACPR, the British Heart Foundation Scotland and Chest, Heart and Stroke Scotland want assessment for cardiac rehab to be mandatory for every heart patient. That would cut hospital readmissions, as well as unnecessary primary care appointments. Cardiac rehab is highly cost effective, especially when compared to surgical interventions.

I have been fortunate enough to visit in my constituency a cardiac rehab class that is part of BHF's hearty lives programme. That project allowed the Fife cardiac rehab service to increase capacity by offering new programmes in different settings, including a community evening class. As a result, referrals doubled. That programme has been mainstreamed, and I hope that other national health service area boards may consider what lessons can be learned from that approach.

The NHS Quality Improvement Scotland clinical standards for heart disease from 2010 mandated an assessment for cardiac rehabilitation for all patients with the most common heart conditions. The Government's "Better Heart Disease and Stroke Care Action Plan" of 2009 also indicated that NHS boards should regard cardiac rehab as a priority.

Referrals for rehab have improved since those documents were published, but not quickly enough—especially not for long-term heart conditions such as heart failure and angina. That is possibly because much of the published evidence for cardiac rehab—at least in terms of reductions in premature mortality—focuses on the benefits for acute patients, such as heart attack and bypass patients.

However, there is a growing body of evidence that shows that cardiac rehab for heart failure patients has significant benefits in terms of reducing unnecessary hospital readmissions and is, therefore, a highly cost-effective treatment for such patients.

A small study from Australia that has been discussed at the cross-party group compared hospitalisation rates for two groups of heart failure patients: one that had access to rehab once a week and one that had no such access. The group that received cardiac rehabilitation spent, on average, 9.36 days a year fewer in hospital than those who did not receive it. The authors calculated that for every 1 Australian dollar spent on rehab, 11.50 Australian dollars were saved through reduced rehospitalisation costs. I understand that the cardiac rehab team in NHS Ayrshire and Arran is looking to replicate that study using data from that area.

It is estimated that 70,000 people in Scotland are living with heart failure and figures from ISD Scotland suggest that only 3 per cent of those patients are being referred for rehab. How much money could be saved if, as a result of referrals to rehab for heart failure patients, the NHS were to save £11 for every £1 that it spent?

I urge the minister to consider what more the Government can do to improve provision of those crucial services, especially for long-term cardiac conditions such as heart failure. In particular, I urge him to consider what steps are needed to develop a sustainable audit, by NHS board area and by specific heart condition, of the provision of rehab services, and to consider what additional policies should be employed to drive assessments for cardiac rehab across the country.

The briefing that has been provided by the Scottish campaign for cardiac rehab suggests that the Government should consider a health improvement, efficiency and governance, access and treatment—HEAT—target for referrals to rehab for all patients. I urge the minister to take that on board.

I hope that politicians of all parties, the main charities that have campaigned for improvements in cardiac rehabilitation services for years—the British Heart Foundation Scotland and Chest, Heart and Stroke Scotland, and so on—NHS boards and health professionals on the ground can work together in the year ahead to ensure that every heart patient is referred for cardiac rehabilitation as a matter of course.

12:40

Dave Thompson (Skye, Lochaber and Badenoch) (SNP): I thank Helen Eadie for securing this debate on an extremely important issue.

As vice-convener of the cross-party group on heart disease and stroke, I too have had the privilege, on many occasions, of hearing about the substantial benefits that arise from provision of cardiac rehabilitation for all heart patients. Following open heart surgery in 2006, I also have personal experience of how effective cardiac rehab can be.

Last year, the group heard a presentation from the British Association for Cardiovascular Prevention and Rehabilitation on the new standards on which Helen Eadie's motion focuses. Those standards include the goal of

"Ensuring referral of all eligible patients by cardiologists and/or specialist cardiovascular health care physicians to a prevention and rehabilitation programme as a standard (not optional) policy that is held in the same regard as the prescribing of cardioprotective medications."

That is a worthy aspiration towards which we should all be working.

The evidence base for the effectiveness of cardiac rehab is overwhelming, as Helen Eadie said. It is highly cost effective—especially compared with surgical interventions for cardiac conditions—and it reduces premature mortality and hospital readmissions.

The Scottish intercollegiate guidelines network guidelines of 2002 said that cardiac rehab should be provided for all heart attack and bypass patients, and that all patients with heart failure and stable angina with limiting symptoms should be assessed for it. Those were grade A recommendations, which is the highest category of recommendation. In addition, the Government's 2009 "Better Heart Disease and Stroke Care Action Plan" reiterated that health boards should recognise the importance of providing rehab to all heart patients.

As a result of that focus, NHS Scotland has over the past few years made good progress in improving provision of cardiac rehab, especially for people with acute heart conditions. The figures show that, nationally, 75 per cent of heart attack patients and 68 per cent of heart bypass patients were referred for cardiac rehab.

However, some health board areas still appear to be underperforming in provision of cardiac rehab. In the NHS Highland area, for example, just over 40 per cent of eligible heart attack patients were referred for cardiac rehab. It is clear that providing such services over a large rural area is a challenge, but that figure shows that there is still some way to go.

As is noted in the motion, there are particular issues to do with the provision of rehab for people with longer-term conditions—especially those with heart failure and angina—right across Scotland. In the NHS Highland area, for example, only 3 per cent of eligible heart failure patients appear to have been referred for rehab in 2011 and, nationally, the proportion of referrals of such patients is no better.

The British Heart Foundation Scotland and Chest, Heart and Stroke Scotland, which have led the campaigning work in this area over the past few years, now say that they believe that the time is right for the Scottish Government to consider what further steps it can take to drive improvements. I agree. Specifically, they feel that ministers should consider whether assessment for cardiac rehab would be a suitable candidate for a new HEAT target, as Helen Eadie said.

I am aware that ministers share the aspiration of the BACPR, the BHFS and CHSS that referral to cardiac rehab should be mandatory for all heart patients, as is the case for many pharmaceutical treatments for cardiac disease. Therefore, I would be interested to hear whether the minister believes that a HEAT target on referrals to cardiac rehab, which the charities are proposing, is something that his officials could examine.

12:44

Jackie Baillie (Dumbarton) (Lab): I congratulate Helen Eadie on securing the debate. She is very committed to the issue and has worked extremely hard over the years, as convener of the cross-party group on heart disease and stroke, to influence the thinking of Parliament and the Government. Today, she brings the Scottish campaign for cardiac rehabilitation to Parliament.

As we heard, the campaign is a collaboration between a number of significant voluntary organisations, including the British Heart Foundation and others that have been mentioned. The aim is to ensure that every suitable heart patient is given access to a rehabilitation programme. That makes sense, because people who undergo rehabilitation get better quicker. Rehabilitation can save and transform lives.

The campaign argues that patients should be offered alternative methods of rehabilitation, which might be based at home, in the community or in hospital, depending on where people are able to take part in programmes, and it argues that it is important to overcome barriers to participation. There might be barriers for people who live in deprived or remote and rural communities, because they might struggle to access services. I was struck by Dave Thompson's description of inequity in services in his area. The campaign also calls for minimum standards and monitoring, as members have said.

We know that adopting such an approach to cardiac rehabilitation can transform lives and, at the same time, save money, which is no bad thing in a time of austerity. I understand from the campaign briefing that rehabilitation has reduced death from heart disease by more than a third in just over 10 years. That is a considerable achievement.

The campaign points out that rehabilitation can help to prevent the need for much more costly treatment. A heart bypass costs in excess of £5,000 whereas rehab costs less than £2,000. Cardiac rehabilitation has also cut readmissions to hospital by as much as 30 per cent. The figures make for interesting reading. Cardiac rehabilitation is clearly worth doing, whatever measure we use to consider its effects.

I visited a cardiac rehabilitation group in Dumbarton. The participants had nothing but praise for the physiotherapists and nurses who

worked with them. There were a couple of grumbles about what the physios made patients do, but by and large everyone realised that they are fortunate to have good access to an excellent rehab service, which is not the case for everyone in Scotland.

When I met that bunch of people, I could not get over how full of life they were. They might all have had heart attacks, but that was not going to stop them. They were very much looking forward, and having great fun as they did so—the group was filled with laughter. I want that quality of cardiac rehabilitation not just for people in Dumbarton but for everyone in Scotland. The Government needs to spread good practice to every health board and every corner of the country.

I congratulate the NHS on what has already been achieved. The action plan is a positive step forward and staff in many areas have embraced it and are working to implement it. That is evident from the 60 per cent fall in the mortality rate for heart disease.

We know that we can do more and that we can accelerate the pace of change. Members of this Parliament do not often all sing from the same hymn sheet, but we are doing so today as we ask the Government to consider a HEAT target, accelerate the pace of change and ensure that monitoring arrangements are in place, so that the aims of the campaign can be met and cardiac rehabilitation services can improve not just in one or two areas but throughout the country. I hope that the minister will be able to tell us that that will happen.

12:49

Dennis Robertson (Aberdeenshire West) (SNP): I congratulate Helen Eadie on bringing this debate to the Parliament. I, too, am a member of the Parliament's cross-party group on heart disease and stroke.

Members will not often hear me say that I will sing the same tune as Jackie Baillie is singing—whether we are singing from a hymn sheet, a song sheet or whatever. However, Jackie Baillie's point about preventative spend made good sense.

Helen Eadie mentioned the payback of 11 Australian dollars for every Australian dollar spent on rehabilitation, but the issue is much more important than that. It is about saving lives, enhancing lives and ensuring that, when rehabilitation is given, people can generally lead, more often than not, a normal life. That is the important factor.

I am sure that the Government will not miss the fact that providing the appropriate rehabilitation—whether it is hospital based, community based or domicile based—is cost effective. Domicile-based and community-based rehabilitation is certainly much preferred in our remote and rural areas—I think that Dave Thompson alluded to that.

The percentage of people who receive rehabilitation is far too low. We know that people themselves have a role to play in that. Diet and exercise are important, but structured formal rehabilitation is by far the best way of saving lives.

We need to congratulate all the charities involved. We have heard about the British Heart Foundation Scotland, and Chest, Heart and Stroke Scotland, but many other local charities are trying to assist and provide good guidance and peer support for people with heart conditions. Helen Eadie mentioned the psychological aspect of people and families who are coping with heart conditions. I believe that there is sufficient evidence for the Government to take action on appropriate rehabilitation for our patients in Scotland.

12:51

Jackson Carlaw (West Scotland) (Con): The distance between Fife and Troon, where, respectively, Helen Eadie and I live, is probably as great as the distance between her and me politically on almost every issue, but in my time in dealing with her I have never thought her to be anything other than enormously big hearted. She is the convener of the cross-party group on heart disease and stroke, and her commitment to the issue has been sustained over a considerable period of time.

I, too, congratulate Helen Eadie on the motion that she has lodged. If more members had heard some of what she had to say and what has been said subsequently, it would have been to their benefit. I hope that, as some of those members may one day benefit from the work and efforts of the cross-party group, the British Heart Foundation and all the other campaigning groups, they will be a little better informed on the issues at hand.

My contribution will be relatively brief, as many points have been made.

We all celebrate advances in healthcare as they are made. The establishment of the national health service after the war essentially brought equality of access to healthcare to everybody in the United Kingdom.

It is interesting that there are two competing challenges for our generation. One is the enormous responsibility that falls on the health service to cope with our emerging lifestyle conditions and an ageing population. The second is how we respond to the extraordinary advances that are being made in healthcare and the

consequences and responsibilities that fall from them.

When he was the Secretary of State for Scotland in the mid-1990s, Michael Forsyth—I have to find a way to bring him into debates sometimes—established a material shift in Scottish cardiac care. It may have been Michael Forsyth who did that, but the change enjoyed cross-party support at the time. Even to those who are not his natural admirers, Voldemort has his redeeming qualities. Fifteen years later, we can see a 60 per cent fall in mortality from cardiac incidents.

I suppose that it could be argued from the national health service's point of view that that is not a financial success. It may have taken the view—not the individuals in it, but from a bottom line—that if people were not there, they would not represent an on-going cost to the national health service. In celebrating that significant reduction in mortality, the responsibility emerges. Thereafter, the question is: what do we do to provide cardiac rehabilitation to those whose lives have been saved?

There is no dispute or concern in relation to the principle or understanding that we need to make advances in cardiac rehabilitation, but a look at the hard facts suggests that whereas the rates of referral to cardiac rehabilitation for those who have had heart bypass operations are considerable—albeit less than the minimum that we might wish for—across health boards in Scotland there is an underperformance on referrals thereafter. There is also a very considerable underperformance, given where we are today and where we need to be, on affording universality of access to cardiac rehabilitation.

In a way, it is tragic if we save lives but leave people with a deteriorating lifestyle thereafter because we do not offer them the support, advice, education and subsequent intervention to ensure that the life that we have saved is a life that remains meaningful. Within a huge institution such as the health service, it is sometimes difficult to ensure that those cross benefits are achieved.

I support the campaign and the essence of Mrs Eadie's motion, and I look forward to hearing from the minister on whether, in order to provide an impetus, there needs to be a HEAT target to ensure that material progress is made.

12:56

The Minister for Public Health (Michael Matheson): Like others, I congratulate Helen Eadie on securing time for what has been, although short, a very interesting debate focusing on a couple of specific issues. I had not anticipated that the debate might include the possibility of a Robertson-Baillie duet or the spectre of Michael Forsyth, but I am more than happy to acknowledge the work that Michael Forsyth undertook when he was in a position to do so.

Jackie Baillie: If Michael Forsyth is Voldemort, is the minister Harry Potter?

Michael Matheson: I would obviously need to get the glasses, but I will take that as a compliment.

Heart disease has been a clinical priority for the Scottish Government and for NHS Scotland for more than 15 years now. Over that period, thanks to the dedication of the staff within the NHS, we have achieved a dramatic 60 per cent decrease in the number of premature deaths from heart disease. As I am sure everyone agrees, that has been achieved through the fantastic efforts of our NHS staff.

Jackson Carlaw is correct that such achievements bring additional challenges. As more people survive heart attacks and live with heart disease, there is a need for more access to high-quality rehabilitation and support. Those needs have been recognised both within the NHS and by campaigning organisations such as Chest, Heart and Stroke Scotland and the British Heart Foundation, which have a long-standing commitment to cardiac rehabilitation.

The key messages from those organisations' campaigns were incorporated into our "Better Heart Disease and Stroke Care Action Plan", which places a greater emphasis on the importance of proper support following an acute episode of treatment. The action plan recognises the wealth of evidence supporting the clinical effectiveness and cost-effectiveness of cardiac rehabilitation, which several members have referred to. The importance of cardiac rehabilitation is also echoed in Scotland's SIGN guidelines and in the clinical standards for heart disease.

Put simply, cardiac rehabilitation is an inexpensive treatment that saves lives. We want everyone who could benefit from cardiac rehabilitation to get appropriate access, and we want to ensure they have the best possible chance of a full recovery.

In recent years, we have been making excellent progress towards achieving that goal. According to ISD Scotland, uptake of cardiac rehabilitation for people with either myocardial infarction or a cardiac intervention has increased from 45 per cent in 2006 to 65 per cent in 2011. Equally impressive is the evidence that shows the high quality of services now being delivered in Scotland. Most areas have a full range of psychosocial, health, lifestyle and medical risk

management provisions in place—all areas that were recently highlighted in the BACPR standards.

The audit findings have triggered a range of improvement works in services, and I want to see evidence of further improvements by all boards when further audit results are published later this year. Like BACPR, we want to ensure that cardiovascular prevention and rehabilitation services are safe, effective and person centred. The revised BACPR standards emphasise the need for rehabilitation to be provided in a way that meets an individual's needs. That fits the Scottish Government's person-centred approach to the delivery of healthcare, and it is reassuring that the audit found that many NHS boards already offer a menu-based approach to cardiac rehabilitation.

The national advisory committee on heart disease has already identified cardiac rehabilitation as a priority. As part of our heart disease programme, we have supported the most comprehensive audit of cardiac rehabilitation ever undertaken in Scotland; provided some £20,000 funding to the Angus activity programme for people with a long-term condition; and funded the development of an online version of the Lothian heart manual.

There remains much more to do. Helen Eadie is correct to highlight that the clinical standards for heart disease are clear that all people with heart failure and acute angina should be assessed for their suitability for cardiac rehabilitation. We know that referral rates for those groups continue to be low. Rehabilitation services in NHS Scotland are working to address that through service redesign. They are implementing a menu-based approach, anticipating that that will enable an increase in service capacity. I expect the work, which is being developed by boards, to achieve improved outcomes for patients.

We also need to look at the rehabilitation services that can, and should, be made available for people with heart failure and unstable angina. Only a proportion of heart failure and angina patients will be suitable for cardiac rehabilitation programmes that are based in secondary care. It is essential that people with heart failure and angina get the support that they need in their homes and communities.

Clearly, there remains further scope for promoting exercise for people with cardiovascular disease and, indeed, other long-term conditions within the community, particularly within our leisure centres. There are several examples of excellent programmes, including one in Lanarkshire, and I want to see those approaches explored further and rolled out elsewhere.

In terms of our next steps, I have asked our national advisory committee to consider, at its next meeting in February, how we ensure that people with heart failure and acute angina get the support and rehabilitation that they need. The establishment of a new heart failure group will support that process. The development of a HEAT target proposal for cardiac rehabilitation is one of the options that I will ask the group to consider.

The revised BACPR standards make clear the importance of on-going audit. The enthusiasm for the previous audit was extremely heartening. We have therefore explicitly committed NHS Scotland to the on-going monitoring of the provision of cardiac rehabilitation. A further audit report will be issued later in spring.

We have provided substantial funding to Chest, Heart and Stroke Scotland, the British Lung Foundation and the British Heart Foundation Scotland on a programme aimed at supporting people with conditions, including those with heart failure and acute angina, to access appropriate exercise and support. I expect to provide further information to Parliament on that later in the year.

I thank NHS Scotland staff for all the work that they have done to improve the care of people with heart disease. I restate the Government's commitment to supporting on-going improvements in cardiac services, including rehabilitation services.

13:04

Meeting suspended.

14:30

On resuming—

Mental Health Strategy

The Deputy Presiding Officer (Elaine Smith): Good afternoon. The first item of business this afternoon is a debate on motion S4M-05444, in the name of Michael Matheson, on Scotland's mental health strategy.

The Minister for Public Health (Michael Matheson): We published Scotland's mental health strategy—"Mental Health Strategy for Scotland 2012-2015"—in August last year, and I will use this opportunity to set out some of the priorities and commitments in that strategy. I also want to hear from members about their views on the strategy and the feedback that they have received on it from other stakeholders.

Mental illness is one of the top public health challenges in Europe. The challenge that we face in improving mental health and mental health services in Scotland is great. However, it is not that different from the challenge anywhere else in the western world. Across a range of mental health indicators, Scotland is broadly in the middle.

The picture is similar with the rates of suicide, and mental disorder is strongly related to suicide. The average annual suicide rate in Europe is 13.9 per 100,000; in Scotland, in 2010, the rate was 14.5. That puts us a little above the European average, but our suicide rate has continued to fall. It is also worth noting that the prevalence of mental illness does not seem to have changed significantly over time.

In Scotland, we have made good progress in closing the treatment gap and ensuring that people with mental health problems are more likely to seek help, get a diagnosis and receive evidence-based treatment. In particular, we have had success with depression and alcohol misuse. However, the bigger challenge is in the detail under the headline figures.

Mental ill health affects our communities unequally. People from our most deprived communities are much more likely to experience mental illness. Again, Scotland is not unusual in that, as the picture is similar in other countries in Europe.

Scotland has much to be proud of in how seriously the country takes mental health. It is telling that the Parliament has debated mental health issues on a number of occasions. Those debates have been initiated by the Government, by committees and in members' business. That demonstrates the progress that has been made in tackling stigma and being able to talk about and debate mental health issues openly and frankly.

Although the challenge is big, we have made some significant changes in recent years, and I will mention a few of those. Each is an area that the Scottish Government set as a priority and in which it supported delivery of the change. However, one of the key messages is that the change and improvement were delivered locally by national health service boards, local authorities and the third sector working with service users and carers.

I want to carry that theme into how we implement the new mental health strategy. I want to build consensus on what to prioritise and to work in partnership with those who wish to support change.

John Pentland (Motherwell and Wishaw) (Lab): Given that the strategy builds on existing Scottish Government policy, why has the Lanarkshire mental health services plan—which was in line with the strategy and approved by Nicola Sturgeon, when she was Cabinet Secretary for Health, Wellbeing and Cities Strategy, in August last year—still not been implemented? Is the minister aware that, since 26 September, when the minister took over responsibility for the plan, Alex Neil has continued to be involved as Cabinet Secretary for Health and Wellbeing and that he wrote to Pamela Nash MP on the matter on 5 November?

Michael Matheson: As I mentioned, the changes and improvements are delivered locally. It is for the NHS board to make any changes that it thinks are appropriate and to refer to ministers any matters that must be referred to ministers. As the cabinet secretary has made clear, if there are any changes that require ministerial input, I will consider them at the time, when NHS Lanarkshire brings them forward.

There has been a steady reduction in the number of people who are discharged from hospital and then readmitted. Between 2004 and 2009, there was a 25 per cent reduction in the number of readmissions. Being admitted to hospital has social and economic implications, so reducing the number of readmissions is important. The reductions have been delivered through work to improve the quality of in-patient and community services, and by improving discharge planning. We intend to build on that as part of the new strategy, in which we will look to develop better indicators of the quality of community services.

Another area in which progress has been made is the prevention of suicide. Between 2000 to 2002 and 2009 to 2011, there was a 17 per cent reduction in the suicide rate. That figure is based on the three-year rolling average. I will discuss

how we intend to do further work to reduce the incidence of suicide and self-harm in Scotland later in my speech.

I want us to continue to work to deliver our existing commitment to offer faster access to specialist mental health services for children and young people, and to psychological therapies. I want to capitalise on what we have achieved and to deliver a set of commitments that are designed to increase the pace of change across the system. To do that, we need to focus on a number of areas. For example, we must reduce variation in the availability of good-quality mental health services, such as intensive home treatment and first-episode-psychosis services. We will build on the prevention agenda by placing a greater focus on the first years of life, and we will work with other policy areas, such as employment, justice and the early years, in which mental health has an important contribution to make.

There are two areas in which we are making developments outwith the mental health strategy, the first of which is dementia. We are in the middle of an engagement process to develop a successor to Scotland's first dementia strategy, which will be published in June. We have also made a commitment to engage on a new suicide and self-harm strategy that will follow on from the suicide reduction and choose life work that has been done to date. That engagement will start in the next few weeks.

We had a great response to our consultation on the mental health strategy. We received more than 340 responses to the written consultation, and people attended our national event and numerous local events. Seven themes emerged from the consultation, which we have used to describe the way in which we want to deliver the commitments in the strategy. Those themes, a few of which I will mention, support the quality ambitions that healthcare should be person centred, safe and effective.

Families and carers have an important role to play in providing support to people with mental illness, but they can often feel excluded from making the contribution that they would like to make. Learning from suicides tells us that better work with families can lead to safer care and better outcomes, so we are working with VOX—Voices of Experience—and others to identify how we can increase the involvement of families and carers in mental health service delivery.

Another key theme that has come through in the consultation is tackling discrimination. Through the see me campaign, Scotland is internationally recognised for tackling the stigma of mental illness. As part of our work with the Scottish Association for Mental Health and other partners to continue to develop our anti-stigma agenda, we will work to reduce the discrimination and exclusion that many people with mental illness experience.

Mary Scanlon (Highlands and Islands) (Con): I did not read all the consultation responses, but I looked through the strategy, and I do not think that it mentions personality disorder. Will the minister consider improved diagnosis, treatment and care in relation to personality disorder?

Michael Matheson: If Mary Scanlon will bear with me, I will come on to that issue.

As well as the themes, we identified four key change areas. I will talk a little about each one. The period between pregnancy and four years is a crucial period in shaping children's life chances. Secure attachment and competent and confident parenting are significant protective factors, which provide a child with confidence, resilience and adaptability. Poor attachment in infancy has been linked to a number of severe mental health problems in later life.

Evidence-based parenting programmes, such as incredible years and triple P—the positive parenting programme—are powerful ways of addressing conduct disorders and produce long-term benefits for the child and for society. They take a positive, assets-based approach to strengthening parenting competency. NHS Greater Glasgow and Clyde and Glasgow City Council are in the process of making triple P available to all parents in Glasgow and, through NHS Education for Scotland, we are starting a national roll-out of triple P and incredible years to the parents of all three and four-year-olds with severely disruptive behaviour.

Mark McDonald (North East Scotland) (SNP): As part of that, will the minister consider issues to do with postnatal depression and its diagnosis? Postnatal depression can have an impact on attachment, which can lead to the disruptive behaviour to which he referred.

Michael Matheson: That is part of the wider, holistic approach that we must take, to ensure that we address issues that might affect a child in the early years, such as the mother experiencing postnatal depression.

I want continued improvement across child and adolescent mental health services. We have supported a 35 per cent increase in the specialist CAMHS workforce since 2008. As a result, there have been significant improvements in access to services. The most recent data show that 89 per cent of children and young people are being seen within the existing 26-week target and that the average wait is eight weeks. The 26-week target is to be replaced by an 18-week target by the end of 2014.

We have not seen the scale of change that I hoped for on reducing admissions of young people to adult beds. There has been progress across Scotland, particularly in the south of Scotland, where the development of new models of care in the community has created additional capacity in the in-patient unit and significantly reduced admissions of young people to adult beds. I want the rest of Scotland to perform at a similar level.

Another key change area is to do with rethinking how we respond to common mental health problems. How people access treatment services is an important aspect of addressing the challenge in that regard. There is evidence of significant health service delivery in relation to psychological therapies, which is why it is right that we focus on improving that part of the system. Scotland is the only country that has introduced a waiting times target in the area.

We want a system in which psychological therapies are readily available to the people who require such support. We also want a wider range of services to be available, including social prescribing, self-help and peer-group support, so that people can get the service that best meets their needs and addresses their mental health issues.

A well-functioning mental health system needs a range of community, in-patient and crisis services. We set out a range of areas in which we intend to build on developments in services, to ensure that we implement the strategy effectively.

A strong message that emerged from the consultation was about the importance of employability. A person being in the right work can have a benefit on their health, quality of life and wellbeing. That is true for people with mental health problems, too, so we want to make further progress in the area.

Drew Smith (Glasgow) (Lab): Will the minister take an intervention?

Michael Matheson: I am afraid that I have very limited time and I want to cover the issue that Mary Scanlon raised.

The Deputy Presiding Officer: The minister is concluding.

Michael Matheson: Yes.

We recognise that there is a particular need for work around the justice system. The report of the commission on women offenders identified mental illness and personality disorder as key contributors to women's offending and the likelihood of their going to prison. We are building on the work that has already been undertaken in Cornton Vale to test the effectiveness of training prison staff to use a mentalisation approach to working with women with a personality disorder or women who have experienced trauma. We are already extending that work into NHS Lothian with a community-based personality disorder programme to see how we can learn from that and roll it out nationally.

I have not had the opportunity to cover all the areas of the strategy, but I am sure that all members will recognise that good progress has been made in improving Scotland's mental health services in recent years. The new strategy provides us with an opportunity to ensure that we build on the momentum that has already been achieved.

I move,

That the Parliament welcomes the publication of Scotland's Mental Health Strategy; recognises the challenges that Scotland, in common with other western nations, faces in tackling mental ill-health; notes the significant progress that has been made in mental health improvement, improving mental health services and reducing suicide, and believes that the priorities identified in the strategy will build on and increase the pace of change in mental health in Scotland.

The Deputy Presiding Officer: We are rather tight for time for the debate. Dr Richard Simpson has up to 10 minutes.

14:45

Dr Richard Simpson (Mid Scotland and Fife) (Lab): At the outset, I should draw members' attention to my membership of SAMH, the Scottish Drugs Forum and the British Medical Association. I am also a fellow of the Royal College of Psychiatrists and the Royal College of General Practitioners, and a member of William Simpson's.

I very much welcome the minister's tone and the approach that he is taking in wanting to listen to members. The new strategy for 2012 to 2015 is evidence of the Government's ability to produce strategies in which stakeholders are listened to. I hope that the Government will listen to the other parties today.

We do not intend to be highly critical of the review, which is excellent. It builds on the previous work that has been done by successive Governments, including the mental health framework report in 1997. However, there is one difference. The first framework was immediately accompanied by two things, one of which was a monitoring and supervisory implementation group. That meant that those in the field could see where the variations that the minister mentioned were and could try to address those issues.

The other good news at that time, of course, was that the framework was followed by Labour's doubling of NHS funding. It is quite clear that that is not open to the current Government. The challenges are therefore different.

That investment by Labour, the modernisation of the estate, and the increase in the number of mental health workers have changed the landscape. The number of beds has reduced and the old asylums are largely a thing of the past; even the state hospital has been renewed and its bed numbers have been halved, with medium-secure units being developed. Community care intensive home treatment and crisis interventions have increased. In particular, the level of readmissions, which I mention in my amendment, has reduced by 30 per cent. The Government and Labour take some credit for that. That is no mean feat, and it indicates the quality of the treatment that is being offered. Therefore, the Scottish National Party inherited the service in a better place.

Other factors that were external to the NHS were the positive one-third reduction in child poverty during our time, the reduction in pensioner poverty and nearly full employment. As we know, all those things contributed to a better place for mental health.

The 36 commitments are welcome, but there are things in the report that may reflect when it was drawn up. The challenges of a stalled reduction in child poverty, 20 per cent youth unemployment, increased part-time working, higher unemployment generally and a reduced standard of living for all confront us in considering where we will proceed on mental health.

In its briefing, the Royal College of Psychiatrists painted a somewhat starker picture for us. Suicide, drug misuse and alcohol, including the rapidly rising rates of alcoholic liver disease, contribute to premature mortality rates and other health inequalities in Scotland. That is now well recognised. The poor general health of people with psychiatric illness, which the report mentions, and their high rates of tobacco use have become increasingly evident as one of the causes of premature mortality. The impact of poor parental mental health and their substance misuse has an enduring effect on the development of children.

In the brief time that I have, I want to look at some of the pressure points on the system.

The minister mentioned health inequalities. The reconstitution of the health inequalities task force is an opportunity to look again at premature mortality due to poor physical health and excess smoking among those with mental illness. They have a significant effect. There is up to 10 years' loss of life expectancy for that group. I hope that the minister will assure me that that will be one of his priorities in the re-established health inequalities task force.

On the elderly, the Government is to be commended for building on the work of Irene Oldfather, the cross-party group on Alzheimer's and Alzheimer Scotland by adopting and pursuing an effective strategy on dementia, which I very much welcome. Among the elderly—the minister referred to this, but he did not emphasise the point enough—depression is three times as common as dementia. Those suffering from delirium are another important group. Among the elderly, depression is estimated to have a prevalence of around 13.4 per cent and is predicted by the World Health Organization to become the second-highest health burden in the western world by 2020. Depression is also strongly linked to disability. However, only 10 to 15 per cent of such patients are treated; unlike younger adults, fewer elderly people present to psychiatrists with depression or are diagnosed by general practitioners as having depression.

Unlike the excellent progress that has been made among younger adults, suicide rates among the elderly are almost completely unchanged over the 10-year period during which the HEAT—health improvement, efficiency and governance, access and treatment—target has been in place. Psychosis is also increasingly common because we have many more people over 85, and they are a group of people who are associated with greater levels of psychosis. However, the biggest lacuna in the strategy is the absence of a significant look at depression. Malcolm Chisholm will talk more about that following our cross-party group meeting the other day.

The main concern of addiction specialists is the level of alcohol consumption among the elderly, which is another important issue. However, I feel that not enough attention is given to alcohol-related brain damage in all groups. That is a growing problem, yet progress on achieving a joined-up approach seems to have stalled—Peter MacLeod drew attention to that in his evidence to the Public Audit Committee in 2011. Although there are excellent teams such as the one in Glasgow and support is provided by groups such as SAMH, Loretto Housing Association and William Simpson's, not enough attention is paid to the issue. One case study showed that an ARBD sufferer had 11 separate case notes—that is not integration. I urge the Government to have a further look at that area.

On services for prisoners—Mary Fee will say a little bit more about this—I welcome the work on borderline personality disorder that is being done in Cornton Vale, which has been extended to Edinburgh. However, unless we take the Angiolini report seriously across both justice and health, we will be having this discussion in another 10 years. I was the justice minister when we set up the time-out centre in Bath Street, which deals primarily with people who have a drug problem. That has never been extended and has not been tried for

men, yet many of those in our prisons have drug or alcohol problems. We have not tried extending such services to alcohol addiction, yet that is one way that we could reduce the prison population. We could reduce the need to build new prisons if we could get that group out of prison and into treatment.

On child and adolescent mental health services, the almost certain achievement of the 26-week target is welcome and the move to an 18-week target is highly commendable. The Government has done a good job on that. However, the Mental Welfare Commission has expressed a slight concern in its report that the number of admissions to adult wards has flatlined at around 140. That is the same level as in 2009, after which the numbers peaked and have since come down again. I hope that we are seeing the start of a new trend, but I have not seen any clear statement about the bed numbers. The strategy says that the number of beds will increase from 42 to 48, but the original agreement was for 56 and I do not think that the difference can be entirely due to having intensive home care work.

Although the early years strategy is very welcome—initiatives such as triple P and incredible years are excellent—we also need to work in the primary schools. For example, Place2Be provides a talking point in schools for pupils who feel under stress. That has been highly successful in Niddrie in Edinburgh and has now been extended to East Lothian and Glasgow, where it is working extremely well. Such services at a lower-tier level can prevent pressure from being put on CAMHS and help the Government to meet its target. That is not the only programme, but it is worth doing.

The suicide rate is down by 16.7 per cent, so we are moving towards the target of reducing the rate by 20 per cent. Choose life and see me have both made a big contribution to that. I also welcome the minister's announcement about refreshing the strategy. However, although we talk about percentages, we should recognise that that is still 770 deaths, which is a lot of deaths. We have 500 deaths from drugs, 770 from suicide and about 1,000 from alcohol. Those are three areas where we will need to renew our attention and renew our effort.

The achievement of the target on psychological treatment is extremely welcome. The NHS 24 online service is useful, particularly in the Highlands and Islands, although face-to-face therapy is needed. Meeting that objective will continue to be a challenge, but I agree that the Government's attempt to do so is great. The people in need of therapy are often in work, and we need a flexible approach, with appointments offered at times that will suit the workforce.

I welcome the fact that we now have a specialist deafblind community service based in Lothian, but when will the admissions to the John Denmark unit in Manchester conclude with the introduction of a unit in Scotland so that individuals do not have to travel?

The Mental Health (Care and Treatment) (Scotland) Act 2003 has not been fully implemented. I know that we will be looking at tribunals legislation shortly, but when will the Government commence section 268 of the 2003 act, giving a right of appeal against overly strict detention in non-state hospitals? The time has come for that to be implemented.

I commend Labour's amendment to the chamber. Members will note that we have drawn attention to one or two additional priorities, but we have not drawn attention to all the priorities, because we recognise the financial restrictions on the Government. However, we are not alone in calling for a clear timetable and supervised monitored implementation. SAMH makes that same point, because only then can the welcome aspirations of the strategy be fully credible.

I move amendment S4M-05444.2, to insert at end:

"; while noting that significant progress has been made since the Framework for Mental Health Services in Scotland in 1997, the Mental Health (Care and Treatment) (Scotland) Act 2003 and *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011* including improving mental health services, suicide reduction and readmissions to psychiatric units, nevertheless recognises that depression in older people, which the World Health Organization has stated will be the second greatest health burden in developed countries by 2020, the record number of drug deaths and tackling alcohol-related brain damage all merit specific commitments along with the priorities identified in the strategy, which will build on and increase the pace of change in mental health in Scotland, and looks forward to the production of a report on progress on the 22 commitments in *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011* and on the Scottish Government's response to the Public Audit Committee's 3rd Report 2010: *Overview of mental health services,* and an action plan on the 36 commitments in the new strategy together with a clear indication of how the Scottish Government intends to monitor progress."

14:56

Jim Hume (South Scotland) (LD): I welcome the opportunity to participate in the debate.

This week, the Office for National Statistics revealed a different figure for the number of suicides from the figure that has been quoted by others, with an increase of 7.8 per cent up to 2011. No matter whose statistics we use, the issue is of concern. The debate is timely, although it should be noted—as the minister did—that the strategy, while welcome, was published a number of months ago and it could be argued that we

should have discussed the issue at an earlier stage.

I note the recent slight increase in the year up to September 2012 in the number of clinical psychologists employed by our health boards. I commend the Government for that. The Scottish Government rightly recognises that faster access to psychological therapies is a key component in our efforts to tackle mental health issues. It is also key in assisting the reduction in Scotland's suicide rate. No matter whose figures are used, suicide is still a leading cause of death among those under the age of 35. I therefore welcome the decision to include access to psychological therapies as an 18-week referral-to-treatment HEAT target from December 2014.

Although the deadline for achieving that target is still nearly two years away, I was curious to see what the picture looks like. Indeed, so was SAMH, which has asked the Scottish Government to commit to an audit of the provision of, and waiting lists for, psychological therapies. I understand from the Scottish Parliament information centre that no stats exist on waiting times for access to psychological therapies, due to delays and changes in personnel at ISD Scotland. I therefore look forward to the minister confirming in his summing up whether he will consider having that audit and when ISD Scotland will be in a position to begin publishing the statistics.

The minister will be aware that, two years ago, the coalition Government announced its own strategy, backed by £400 million of additional funding, to massively widen access to psychological therapies south of the border. The aim—which I trust is one that would be supported across the chamber—is to put mental health on a par with physical health with regard to perception and treatment, and to end the stigma that attaches to sufferers. Not only is that the right thing to do, but it will result in more than £700 million of savings to the public purse. It is an example of preventative spending at its best, and I hope that the minister is keeping a keen eye on it.

When it comes to access to much-needed psychological therapy, I am afraid that there can be no doubt that something of a postcode lottery exists throughout Scotland. We are not talking about people waiting for a minor operation or a routine scan. People are often in desperate situations, experiencing real mental anguish, and they need to be treated as soon as possible.

Currently, the national average full-time equivalent figure for clinical and other applied psychologists is 11.3 per 100,000 people, with the rate increasing to 14.8 in NHS Greater Glasgow and Clyde and 15.5 in NHS Fife, but it is 10.0 in NHS Grampian, 8.9 in NHS Highland and as low as 7.6 in NHS Forth Valley. People in the NHS Forth Valley area therefore have less than half the number of clinical and applied psychologists of their close neighbours in the NHS Fife area. That seems to signpost a postcode lottery situation, which I hope can be addressed.

I highlight in my amendment the rise in antidepressant prescribing in the NHS. There is no doubt that antidepressants are a worthwhile treatment method for some and should continue to be used, but I am concerned that we have gone from dispensing 1.26 million antidepressant prescriptions in 1994 to dispensing 5 million last year.

Fiona McLeod (Strathkelvin and Bearsden) (SNP): The member talked earlier about reducing the stigma of mental ill-health. Does he think that it is unhelpful to continue to refer to antidepressants in the way that he has done, which leads to stigma? We would not have a campaign to reduce the use of insulin for people with diabetes.

Jim Hume: I could not disagree with the member about that. However, as I said, antidepressant prescriptions have increased from 1.26 million in 1994 to 5 million last year. A previous Government target to address the issue was quickly scrapped. I shall address the issue further in when I sum up.

Michael Matheson: I do not know whether the member is aware of a change in the prescribing guidance that was issued to doctors. That change was about moving away from using low doses of antidepressants over a short period of time to using higher doses over a longer period. Some of the statistics that the member mentioned actually refer to the definable daily dose, which means that the figures show not that more people receive the medication but that the level of the dose is higher, which gives the impression that more people receive the medication.

The Deputy Presiding Officer: I ask Jim Hume to begin to conclude.

Jim Hume: Okay.

The mental health strategy also highlights the benefits of people taking unilateral action to improve their own wellbeing, with physical activity offered as a specific example of such action.

The issue is growing—good mental health is at the core of the wellbeing of people in Scotland—and we will need to unite as a Parliament to address it. I believe that my Liberal Democrat amendment would strengthen the motion, so that we can move Scotland forward and away from any stigma. I would welcome support from all parties for my amendment.

I move amendment S4M-05444.1, to insert at end:

"; is concerned that antidepressant prescribing continues to rise and believes that patients must be able to have local access to alternative treatments, including talking therapies, when this is judged to be the best option for the individual; notes the UK Government's investment of £400 million over the spending review period to improve access to psychological therapies in England, which it is estimated will result in over £700 million of savings to the public purse; considers that increasing access to talking therapies for all of those who need it should be a priority for the Scottish Ministers, and recognises that mental health is not just an NHS issue but is at the core of Scotland's wellbeing and ability to flourish."

15:02

Nanette Milne (North East Scotland) (Con): For those of us who lead busy lives and who have little direct contact with mental health services or with people who are dealing with mental health problems, it is sometimes easy to forget that one in four of us will experience mental illness at some point in our lives. However, that is a fact of life that we should not ignore. I, for one, am grateful to my colleague Mary Scanlon, who consistently keeps mental health issues in her consciousness during her daily work as an MSP. She has done a great deal to raise awareness of the difficulties that are faced by those who are trying to cope with depression and other mental health problems by bringing such matters to the attention of Parliament on many occasions since 1999. I look forward to hearing her comments on the mental health strategy later in the debate.

Organisations that deal with mental health issues, such as the Royal College of Psychiatrists and SAMH—the Scottish charity that does such a lot to promote the interests of sufferers and to raise the profile of mental health issues—have also worked tirelessly to encourage Government to improve psychiatric services and to move mental health into the mainstream of health planning. The publication of the Scottish Government's mental health strategy for the period between 2012 and 2015, which builds on the strategies in "Delivering for Mental Health" and "Towards a Mentally Flourishing Scotland", has been widely welcomed, and its implementation is eagerly awaited.

The strategy's seven themes, 36 commitments and four key change areas make very interesting reading and are to be commended but, as SAMH said in its helpful briefing for the debate and as Richard Simpson emphasised, the strategy runs only until 2015. An action plan for its completion is therefore clearly needed and a timetable needs to be in place for achieving its commitments. There is no doubt that significant progress has been made in recent years in improving mental health services and in reducing suicide, although every day two people in Scotland still die from suicide, which emphasises the urgent need for effective and properly resourced crisis services within communities across the country.

Clearly, in a six-minute speech it is not possible to deal in detail with what is a comprehensive strategy document, but I will touch on the four key changes identified in the strategy, starting with child and adolescent mental health.

It is now recognised that experience in the very early years of life has an enormous influence on later behaviour and that poor parenting at this time can result in major problems throughout life, so the priority that is given in the strategy to the early years and the focus on early intervention are welcome, along with the commitments to make infant mental health training more widely available to children's services professionals and to increase the number of child psychotherapist trainees from this year. That should help to address the problems for children where aggression, non-compliance and emotional issues are likely to persist to cause school disruption, family stress and dysfunction and mental health problems, which we know can result in social isolation, drug and alcohol abuse and failure to gain employment, as well as, eventually, crime and antisocial behaviour.

Mark McDonald: I understand the point that the member makes. However, such problems also often arise as a result of parental mental illness. Does the member agree that categorising the cause as "poor parenting" does a disservice to those parents who suffer poor mental health?

Nanette Milne: I absolutely agree with that. Perhaps my choice of words was not appropriate, but I think that the member gets my intention.

The problems that I described are significant contributors to health inequalities. As the chief medical officer told the Health and Sport Committee just this week, most of the serious behavioural and mental health problems that affect young adults can be traced back to the first few years of life. The problems are complex, and solving them will require the co-ordinated efforts of the NHS, local authorities and charities and other third sector providers. Access to child and adolescent mental health services has taken far too long in many parts of Scotland. Although the waiting time target is still too long at 26 weeks, it is welcome, as is the plan to reduce it to 14 weeks from next year.

The second proposed change is to rethink how we respond to common mental health problems such as the impact of excessive alcohol consumption, debt, trauma and distress. There is a commitment to identify the challenges and opportunities that are linked to the mental health of older people, notably in relation to depression, which looks set to become a serious and

increasing problem in the next few years of rapid increase in the elderly population. Allied to that, of course, is dementia, and we look forward to the updated dementia strategy that was promised for later this year.

There is to be more focus on personal involvement in improving mental health and a drive to encourage more people to become physically active, because research has shown a clear benefit to all health, including mental health, from regular and sustained physical activity. Other areas for action include the continuing movement from in-patient to community-based services, which is proven to reduce admissions and readmissions, and the commitment to carry out an audit of those who use in-patient services and the reasons why they do so, which will, I hope, result in further progress in that area.

The Government's work on armed forces veterans is increasingly important as more of them return to the community from arenas such as Afghanistan and face the difficulties of integrating into civilian life after the ordered life of the forces. As I have learned from my membership of the cross-party group on armed forces veterans, mental health issues ranging from depression and alcoholism to post-traumatic stress are all too common in those people.

The Deputy Presiding Officer: Dr Milne, could you conclude, please?

Nanette Milne: Yes.

I have dealt with the target for access to child and adolescent mental health services. The other targets that I would refer to are the 18-week referral to treatment time for psychological therapies, which is far from being achieved as yet, and the target to reduce the suicide rate, which is being achieved quite well.

We welcome the mental health strategy for Scotland and are happy to support the motion, but careful monitoring of the implementation of the strategy's commitments will be important. The work that has been done so far is commendable, but it is work in progress. We will follow it closely in the months ahead, hoping that the pace of change in relation to mental health in Scotland will indeed increase as a result.

The Deputy Presiding Officer: A number of members wish to speak in the debate, so I ask for speeches of up to six minutes, please.

15:09

Aileen McLeod (South Scotland) (SNP): The motion asks us to recognise the challenges that Scotland faces in tackling mental ill health. They are considerable. The minister mentioned some of the key statistics in his opening remarks. Mental ill health is estimated to affect more than a third of the population at any one time, and although Scotland's suicide rate is improving, it is still slightly above the European average. There is also growing evidence of the role that environmental and social stressors play in mental health. For example, the Government's strategy reflects on the comparatively high levels of mental illness that can be found in welfare benefit claimants.

I worry—we should all be worried—about the impact that the new welfare reforms might have on those people. I certainly fear that the reforms will result in a further widening of income inequality across the United Kingdom. That matters. In 2010, *The British Journal of Psychiatry* carried an article by Kate Pickett and Richard Wilkinson that reported data that showed that a range of health and social problems, including mental health problems, are more common in more unequal societies.

On Tuesday we heard about citizens advice bureaux funding suicide awareness courses for their advisers, and that is also highlighted in the strategy.

If we recognise the continuing and developing challenges in this area of policy, however, we should also recognise the positive achievements to date. As I said earlier, Scotland's suicide rate has decreased over the past decade. Although I agree that one suicide is one too many, I also think that an overall reduction of 17 per cent is noteworthy, although there is clearly some way to go to meet the 20 per cent target in the choose life strategy.

In addition, I warmly welcome and have been delighted to support SAMH's see me campaign. One of the key factors to securing meaningful long-term progress in delivering the mental health strategy is tackling the stigma that is, sadly, still associated with mental illness, since it can present a significant barrier to people accessing help when they need it. That point is also made in the article that I referred to. I therefore welcome the prominence that the new strategy gives to tackling that stigma and the Government's commitment to working with SAMH and other partners to keep pushing that agenda forward.

I also commend the strategy's recognition of the early intervention agenda. We all know of the argument that good parenting has a material effect on adult mental health, whereas poor attachment in infancy can be linked to severe mental health issues in adult life.

This is not simply an issue for our health service; it is one of the key messages that the late Campbell Christie urged us to recognise. Early intervention will be successful only if it is delivered

at the local level with community planning partners in local authorities and other agencies. Local social work and education departments will have a strong role to play, as they do in Dumfries and Galloway, for example, where the incredible years parenting training that is referred to in the strategy is being made available to the parents of vulnerable three-year-olds.

The inclusion of a commitment on social prescribing is also welcome. Although we should be clear that mental illness is no different from any other form of illness, and that, where medication is required, it should be prescribed, we should also investigate the possibility that there are other forms of therapy that may be effective.

Preparing for last week's debate on biodiversity, I read SAMH's submission on the 2020 biodiversity targets. It reflects on the impact that physical activity can have on promoting good mental health and improving the quality of life of people who experience mental health problems and on the importance of natural environments as part of that therapeutic benefit.

In the Stewartry, in the south of Scotland, which has a significantly higher than average elderly population, a social prescribing project that is joint-funded by NHS Dumfries and Galloway and the local authority is trying to reduce the level of antidepressant prescribing through other forms of therapeutic provision. I hope that the Government, as part of commitment 15 in the strategy, will have a look at what that project delivers and how it might link to the quality ambitions and core themes in the strategy. For my part, I hope that the project will be able to realise some of SAMH's ambitions about the use of nature to help promote mental wellbeing.

A further welcome inclusion in the Government's strategy is consideration of the issues that relate specifically to veterans. I am aware, for example, that the First Base Agency in Dumfries raises around £10,000 a year to pay for two half days a week of psychological therapy for veterans who have come to the agency looking for help. Clearly, that is a valuable service that is being funded through third sector action, but there must be a better way of funding that provision. I would argue that the Ministry of Defence has a level of responsibility in this area. It can and should be making the modest funds available to support people who have served this country under its direction and who now suffer mental ill health as a result of their experiences.

The mental health strategy represents a valuable opportunity to take stock of what has been done to date and also to include developing policy themes for the future. Fundamentally, however, it also represents this Government's commitment to providing high-quality mental health services. It is, in the best sense of the phrase, a work in progress, and one which I am pleased to support.

I support the motion in the name of Michael Matheson.

15:14

Siobhan McMahon (Central Scotland) (Lab): A report produced last year by a group of Scottish GPs who compared notes on the impact of welfare reform on some of Scotland's most deprived areas identified one overriding issue: a huge increase in the number of patients presenting with deteriorating mental health.

The patients fell roughly into two groups: those who had been well but were suffering from anxiety and depression because of job insecurity and financial pressures; and those whose welfare payments for poor mental health had been removed on reassessment. One GP described the test that his patients were subjected to as "unnecessary and avoidable" and another described the decisions reached as "medically inappropriate". The report not only revealed systemic failure but uncovered a startling absence of understanding and imaginative sympathy.

The lack of compassion for mental illness is not confined to the welfare system; it permeates society on both sides of the border. I welcome the Scottish Government's recognition of the severity of mental illness and its subsequent commitment to improving Scotland's mental health as outlined in its mental health strategy for 2012 to 2015. As the strategy states, although we have made great strides in recent years, there is still much to be done.

Mary Scanlon: Will the member give way?

Siobhan McMahon: I am sorry—I cannot do so at the moment.

If we are to make those improvements, it is essential that we listen to and act on the advice of medical professionals, mental health charities and service users. We must also endeavour to ensure that national strategies such as the mental health strategy are adhered to both in word and in action.

In January 2011, NHS Lanarkshire published "Modernising Mental Health Services in Lanarkshire", a set of proposals aimed at rebalancing the delivery of mental health services

"away from institutional models ... towards community based provision"

and as such aligned to the "long-term trend" articulated in the mental health strategy. It was recommended that the number of psychiatric beds be reduced by consolidating acute in-patient mental health services at two dedicated facilities:

the first in North Lanarkshire at Wishaw general, where an intensive psychiatric care unit would also be situated, and the other in South Lanarkshire at Hairmyres hospital. The wards would be fully equipped and resourced to provide complex treatment and care.

The proposals were influenced by an extensive consultation process encompassing health professionals, local and national politicians and umbrella bodies representing service users. The Scottish Government was also fully behind the plans, with the former health secretary, Nicola Sturgeon, stating that she was

"content that NHS Lanarkshire proceed to implement its proposals to modernise mental health services across the board area."

One individual who vocally opposed the proposals was the MSP for Airdrie and Shotts Alex Neil—and I am sorry that he is not in the chamber to hear what I am about to say.

The proposals were due to be presented to the NHS Lanarkshire board in September 2012 for approval, but that did not happen. When I investigated, I was told that the new Cabinet Secretary for Health and Wellbeing, the aforementioned Mr Neil, had

"asked for some time to review the proposals."

On 26 September, Mr Neil confirmed the delay in this chamber, stating that NHS Lanarkshire is

"revising its original proposal for ... mental health"

services

"at Monklands."—[*Official Report*, 26 September 2012; c 11895.]

When I wrote to Michael Matheson, who I was advised had ministerial competence on this issue, to query this apparent U-turn, he informed me that the Scottish Government had "some reservations" about NHS Lanarkshire's proposals.

On 19 December, I asked Mr Neil in this chamber when he, or any other individual acting on his behalf, had

"last contacted NHS Lanarkshire regarding the"

provision

"of mental health services"

at Monklands hospital. He told me he had

"decided early on in my tenure to give responsibility for that matter to my deputy Michael Matheson, as I did not want any perception of any potential conflict of interest between my role as MSP for Airdrie and Shotts—where Monklands hospital resides—and my role as cabinet secretary."—[*Official Report*, 19 December 2012; c 14922.]

I have since seen an email from the deputy performance manager at the directorate for health workforce and performance regarding the decision to delay the proposals to modernise mental health services. The email, which was sent to the head of communications at NHS Lanarkshire, states:

"Mr Neil has confirmed ... that he is reviewing the proposals before a decision is made, and that decision will be made soon."

That was sent on 15 September 2012, less than 10 days after Mr Neil was appointed cabinet secretary.

I will recapitulate: until September 2012, when Nicola Sturgeon was replaced as health secretary by Alex Neil, NHS Lanarkshire's modernisation of mental health proposals had the Scottish Government's approval. Then Alex Neil took over and expressed "reservations", and a decision was deferred while NHS Lanarkshire revised the proposals at the cabinet secretary's behest.

I find this turn of events both confusing and frustrating—and I am not the only one. I have received a letter from Francis Fallan MBE, the chairperson of Lanarkshire Links, on behalf of mental health service users in Lanarkshire, that expresses "great disappointment" at the cabinet secretary's decision to intervene to delay the proposals. The letter refers to the "rigorous" consultation that informed NHS Lanarkshire's modernisation of mental health proposals, which Lanarkshire Links supported.

The letter states:

"what is most important is that all decisions are taken in an open, honest, and informed way."

It closes by asking:

"why are we now being ignored?"

That is a very good question.

Attached to the letter are the views of some of the Lanarkshire Links members. One individual sums up matters perfectly by saying that

"Two years of consultation and hard work"

have been

"turned round"

and we are

"back to square one".

NHS Lanarkshire officials devoted time, effort and expertise to producing the modernising mental health proposals. They consulted widely. Health professionals and service users agreed with the proposals, as did Nicola Sturgeon, but Mr Neil did not agree and, because of that, the plans were shelved, apparently indefinitely.

We are left asking: does the cabinet secretary agree with the fundamental components of the mental health strategy or does he favour a piecemeal approach whereby a strategy is adhered to or ignored depending on who is the

health secretary at any given time? To quote one disillusioned member of Lanarkshire Links:

"Can we get a straight answer from Mr Neil?"

The Deputy Presiding Officer (John Scott): We are tight for time, so speeches of up to six minutes would be welcome. I call Dennis Robertson, to be followed by Mary Fee.

15:21

Dennis Robertson (Aberdeenshire West) (SNP): Thank you, Presiding Officer—I will try to accommodate that and be as brief as possible.

It is a privilege to take part in the debate, and I sincerely hope that my contribution will be one of positivity. The mental health strategy is to be welcomed, and great strides have been made towards improving people's mental health. However, we all acknowledge that there is still a lot to be done. I think that the strategy acknowledges that, and the minister has certainly done so.

Dr Simpson is absolutely right that depression among the elderly is often linked to disability. As I spent more than 30 years working in that field, I know that appropriate social care and intervention at the right time can provide positive results, especially for those with sensory impairment, who can find depression confusing and debilitating. I believe that, when the health and social care integration takes place, elderly people who are suffering from depression will have the facilities and resources at hand to get the services that they need at the time of need.

Jim Hume made a point about the number of antidepressants that are being prescribed. I feel that there is a degree of positivity in that. That might sound strange, but I believe that the number of antidepressants being prescribed is perhaps a result of more people coming forward because the stigma has been removed. I congratulate the National Union of Students on the work that it does with students to bring them through difficult times during exams and through various other problems that many students have in their lives. However, it is perhaps a good thing that people turn to antidepressants to enable them to cope rather than try to hide the symptom and bury their head in shame, because it is not a shameful thing to be mentally ill. It has been said that one in four people will have some degree of mental illness in their lifetime.

Jim Hume: I accept that antidepressants are not used only for depression problems, but at the moment one in 10 Scots is using antidepressants.

Dennis Robertson: Given the minister's explanation to Mr Hume earlier and my point, perhaps Mr Hume needs to revisit his thinking on the issue.

It will come as no surprise to members that part of my speech will relate to the experience that I, my family and others have endured because of symptoms such as eating disorders. I have had positive meetings with the minister regarding the pathways for people with eating disorders and the services that are on offer. Sometimes movement is slow, but that is okay provided that we are going down the right pathway.

The minister mentioned the link to families and carers. It is extremely important that the appropriate services are there for those people. Generally, it is families and carers who have to cope with the effects of mental illness, quite often without the knowledge or awareness of what they are supposed to be coping with. That is where there is a mismatch: the link is not really there yet. The links between working with the patient, prescribing to the patient and providing appropriate therapies to the patient are fine—that is excellent and to be commended—but we must include the families and carers at all times and at all stages if we are to see improvement and success in treatments for mental health issues such as eating disorders.

Yesterday in the chamber, Alex Johnstone led a members' business debate on cyber-bullying. Bullying across the whole spectrum is unforgivable and distasteful, and it needs to be addressed. Bullying itself causes mental health problems, which is something that we need to tackle. In the debate yesterday we tackled work that goes on in the internet and in social media such as Facebook, but we must look at media such as television and how it promotes certain programmes to get viewing figures up. After the debate last night I went home and switched on the TV. On Channel 4 there was a programme called "Supersize vs Superskinny". Versus? It is not a game—it is far from a game. TV producers use headlines and programme titles to get viewing numbers up. I have approached the producers of that programme before to suggest that they need to disengage from that title and portray the issue in another way.

TV does not exist to glamorise mental ill health and mental illness. People are genuinely suffering and looking for solutions, and we need to ensure that the media do not glamorise mental illness as a quick fix to get their numbers up.

The Deputy Presiding Officer: Please draw to a close.

Dennis Robertson: I commend the work that the Government is doing and I think that the strategy is on the right path. I look forward to

further meetings with the minister on tackling eating disorders in a positive manner.

15:27

Mary Fee (West Scotland) (Lab): I welcome the Government's mental health strategy, but I strongly believe that some issues related to mental health and specific sections of the population have been massively overlooked or have gone unrecognised.

The last time I spoke during a debate on mental health I put a particular focus on children. Today I will continue on the subject of children and mental health, but with a greater emphasis on children of prisoners as well as prisoners themselves.

I welcome the recognition of the link between mental health and offending in the strategy, but the focus is primarily on women offenders. I am not complaining that that often-forgotten section of the prison population has been highlighted, thanks to the report of the commission on women offenders, and I was pleased to hear the minister's mention of women offenders. However, the strategy misses the glaring fact that 94.7 per cent of those in prisons are male. Commitments 30 and 31 both target female offenders and commitment 32 looks at community payback orders. That shows either that there is a lack of will to address the mental health of prisoners or that it is not fully acknowledged that if we can tackle the mental health of prisoners we will be on a strong footing to reduce reoffending.

Tackling mental health in prisons is a complex process, which is made all the more complex by an ever-increasing prison population and overcrowded prisons. It is estimated that 90 per cent of prisoners have some form of mental health problem. That figure was estimated by the Office for National Statistics in 1997, based on a review of English and Welsh prisons, but it would be hard to argue that the estimate does not apply to today's prison population.

I recently asked the Scottish Government for the number of self-harm cases in Scottish prisons from 2008 to 2012. The answer showed that reported—I stress reported—self-harm incidents increased by 62 per cent over the four years, and yet the 2012 figure included incidents only from January to November. It is likely, therefore, that the final figure will be higher than the 244 cases reported in the first 11 months of that year. Given the increase in self-harm, the fact that nine in 10 prisoners have mental health issues, and the complexities in tackling mental health in prison, I am disappointed that the strategy barely scratches the surface of the issue of mental health and offending.

There is also a serious issue that the Government does not know how many prisoners in Scotland have mental health problems and what treatment they are currently receiving. The gaps in the information held on prisoners are extremely concerning and do little to improve the mental health problems in Scotland's jails. While the Government lauds its strategy, it has sidestepped a section of the population in which poor mental health is high and disproportionate to the rest of Scotland.

Families of prisoners are often victims as well. That statement is even more significant for children of imprisoned parents. Families Outside reports that 60 per cent of all women in prison have children and that there are two and a half times as many children of prisoners as there are children in care. Even so, little attention has been given to the children of prisoners, who can suffer mental health problems that affect their development or behaviour.

There may be some looked-after children in care as a result of a parent's imprisonment. The 2012 to 2015 strategy targets those children, but it excludes other children of imprisoned parents.

Dennis Robertson: Would the member acknowledge that the getting it right for every child programme might pick up the needs of those children, given that it applies to every child?

Mary Fee: I acknowledge the member's comment. GIRFEC goes a long way to support children but a huge amount of work still has to be done to recognise children with mental health problems, who need help and support.

Evidence shows that children of imprisoned parents are more likely to become offenders themselves later in life. That is attributed to poor mental health as a result of parental imprisonment, leading to developmental and behavioural problems, which further restrict the future social and economic prospects of each child.

The strategy has no mention of children of prisoners and their mental health. The CAMHS targets may include children of imprisoned parents but that group of children is often as isolated as looked-after children, with similar behavioural and developmental issues. Given the Government's focus on early years and reducing reoffending, it is beyond belief that there is no specific action or commitment to improve the mental health of those children.

Children who have a parent or even a relative in prison often experience feelings of worry, shame, anger, fear, depression, grief and burden. Those feelings can contribute to the poor mental health of children in many cases but are more commonplace in children of imprisoned parents.

There is also a serious concern about the stigma attached to those children, so I stress the importance of promoting the wellbeing of prisoners' children. The early years agenda promotes the idea that children must be supported to become successful learners, effective contributors, responsible citizens and confident individuals. On the basis of the three-year strategy, it is clear that we have missed an opportunity to tackle the poor mental health of the prisoners' children.

The Deputy Presiding Officer: I regret that you must close, please.

Mary Fee: Finally, the Royal College of Psychiatrists has welcomed the waiting times target for CAMHS, but I agree with it that no child should be waiting up to six months to access mental health services.

15:34

Christine Grahame (Midlothian South, Tweeddale and Lauderdale) (SNP): I will focus on mental health and the wider criminal justice system and will try not to duplicate the contents of Mary Fee's well-researched contribution.

I acknowledge the expertise and commitment of the minister, who was previously in the justice brief; Dr Richard Simpson, who was also previously in the justice brief; and, of course Mary Scanlon, who we know has been committed to the issue since 1999. It is necessary to repeat that for those who are new to the Parliament.

We have already heard about how many people in the prison system suffer from mental health issues, but we should also look at the broader criminal justice system. We tend to forget that many victims of crime have mental health problems; in fact, it is reckoned that people with mental health problems are 11 times more likely to be a victim of a crime. Of course, sometimes there is hardly a sliver of difference between the victim and the perpetrator; indeed, sometimes they are one and the same person. I remember that in evidence to the committee, someone in the judicial system said that who got the knife out first determined which side of the fence people ended up on. It is very hard and very wrong to put people into strict categories.

Of course, people can come up against the police when they have mental health problems. The police have come a long way when it comes to training officers, but there are still issues around recognising when somebody is not on their medication, why they are aggressive and so on that remain to be addressed.

Then, the person with mental health problems might enter the court system. Again, staff throughout the court system need to be trained to recognise and deal with people with mental health issues, whether they are in the dock, are a witness or are just accompanying somebody. That is another issue.

We have already heard from Mary Fee about prisons. She is quite right—an overwhelming number of people in prisons have mental health problems, which are sometimes drug and alcohol-related: they may have been caused by drugs and alcohol; the mental health problem may have come first; or sometimes it is a bit of both.

The improvement that has taken place with the NHS taking over the delivery of health in the prisons is important. A recent visit to Polmont told me that. There were a few teething problems—with people changing from being employed by the Scottish Prison Service to being employed by the NHS—but I think that it was a good move.

We must also bear in mind the fact—somebody alluded to this—that the majority of prisoners in Scotland are from poor socioeconomic backgrounds, where again there is a higher prevalence of mental health problems and drug and alcohol misuse, so the issue is very complex.

I will deal briefly with Cornton Vale and women's prisons, which have already been mentioned. Real progress is being made, and I do not use the word "progress" lightly. There is real commitment from the prison governor, from the Government, from the chief inspector of prisons and from the prison officers themselves to change what has happened in Cornton Vale.

Of course, we have now had the announcement that the new prison at Inverclyde will be adapted and allocated to be the new prison for women in Scotland—dealing specifically with women, many of whom are victims themselves and who are just coming back into the system because there has not been the proper throughcare.

We know about the throughcare issue—we have known about it for 12 years in this Parliament—and it is utterly depressing. It is getting a bit better, but what happens is that people in prison have a structure: their mental health problems are perhaps dealt with, as are their medical problems and things to do with their families—you name it, prison officers do their very best to deal with such issues. The minute that people come out of prison, that help stops. We could not deal with that, so how can they deal with it? Take a simple thing such as releasing people on a Saturday, when the benefits office is not open—if they are going to get any benefits—and the housing office is not open, so they are left cast out.

When members visited 218 in Glasgow, the provision for women trying to be rehabilitated from

Cornton Vale, we were told a very simple thing: they have somebody at the prison gate to meet a woman on release, take her somewhere and ensure that she has her benefits and that she has not lost her tenancy because she has been in prison for six months. The woman has somewhere to go and someone to help her—that is very basic.

We cannot do that for every prisoner.

Roderick Campbell (North East Fife) (SNP): Does the member accept that we heard evidence at the Justice Committee that a byproduct of the NHS taking over medical care in prisons was that it gave the potential for an improved throughcare system?

Christine Grahame: I will come to that. I will say that with 15,000 prisoners being released every year, we cannot have someone meeting all of them at the gates. However, we found out a simple thing on a visit to Polmont, and I am sure that Richard Simpson and others will recognise this: many people leaving prison simply do not have a GP, so their medical records and information on their mental health, their physical well-being and all the good work that has been done in prison is lost to the winds. They come out and there is nothing to meet them. We cannot impose GPs on people, but surely to goodness we can find a system where prisoners on release have somewhere to go and somebody to help them to go there to ensure that their medical treatment—physical and mental—continues once they are released.

15:39

Linda Fabiani (East Kilbride) (SNP): Successive Scottish Administrations and this Parliament have made mental health a priority. We have made much progress, and that progress continues with the strategy, which is to be very much welcomed.

I want to focus on two areas, which are inextricably linked: stigma and self-esteem.

Let us look at stigma and what goes along with it—bullying and humiliation. Whether we are talking about depression, bipolar disorder, psychosis or schizophrenia, and whether it is a one-off, periodic or on-going condition, the effects on the individual concerned are marginalisation and isolation. Those effects do terrible things to people.

If something presents in childhood or adolescence, we can imagine the legacy that the person has to carry into adulthood having suffered stigma and its associated problems for so many years. That is why the work of the see me campaign is so very important. That campaign does tremendous work, and I do not think that any member of this Parliament has not at some point taken part in an event through the see me campaign and been very impressed by the work that it does.

I also believe that if we can alleviate the stigma along the way towards eradicating it, there will be a direct effect on wellbeing and self-esteem. I do not think that we should ever underestimate the value of self-esteem and wellbeing. That fact was brought home to me a few years ago by the work of the East Kilbride dementia carers group. I remember watching the joy of dementia sufferers who, even for a short time each day, took part in something that made them laugh or smile and made them feel good. It may have been that, later that evening, those people could not remember or tell their partner, daughter or son what they had been doing, but at the time they felt good—and that is important.

What helps to promote wellbeing and self-esteem? Two things are participation and creativity—in the arts, drama, song, dance or culture. That is not to deny necessary medication and treatments but to enhance and maintain wellbeing and, in some cases, to prevent progression.

The work of Theatre Nemo is well cited in relation to the use of drama and the arts in the health and justice services. Nemo began its life in East Kilbride but has expanded through its work and recognition awards, and it is now Glasgow based.

We heard Mary Fee and Christine Grahame talking about the justice system and prison. In an article in *The Herald* last summer, the governor of Barlinnie prison, Derek McGill, claimed, in giving a snapshot from that time, that

"Of a prisoner population at Barlinnie of around 1100, as many as 260 could be classed as having mental health problems."

He also said:

"there are people routinely here who are mentally ill, but not so ill they should be in a hospital. If we can stabilise them, get them taking medication and improve their self esteem, there is less chance they will reoffend when they go back into the community."

One of the Theatre Nemo participants talked about

"Working as a team, knowing you can contribute to society and create something positive, can see yourself in a new light as someone with strengths and skills."

The group has done a lot of good work in Leverndale, Rowanbank, Stobhill, the Southern general, Gartnavel and Carstairs.

Over the years, I have attended many Theatre Nemo events. The first time one sees someone, they are perhaps standing on the sidelines, slightly

away from the crowd, watching what is happening with a bit of disdain or shyness, and it has been an absolute privilege to see the difference three or four years later. In fact, that happened recently: there was such a person at the front of the choir, singing at East Kilbride arts centre. That is wonderful—the self-esteem that such experiences bring is absolutely tremendous.

There has been a long history of the creative arts helping people to adapt to or recover from mental disorder, and there have been many academic studies on the subject. Back in 2003 to 2005, there was the arts, creativity and mental health initiative. It evaluated four arts therapies trial services across sites in Scotland. In a summary of the project, Dr Andrew McCulloch, chief executive of the Mental Health Foundation, said:

"the art therapies have a valid therapeutic role and ... arts in health projects can improve the resilience of individuals and communities."

The findings showed that, overall, participants experienced significant improvement in their mental health and social functioning. In particular, they highlighted improved self-esteem, communication skills and social interaction.

That further emphasises the need actively to reduce the stigma that is associated with mental ill health. Society has overcome other deeply ingrained prejudices, and we must keep working on that one.

For academic and practical reasons, I am pleased that our mental health strategy has commitments. Commitment 4 concerns working with the see me campaign and commitment 15 concerns increasing local knowledge of social prescribing opportunities. We need more of that. Both those commitments work towards the prevention agenda and joined-up policy implementation. I look forward to that implementation.

15:45

Mary Scanlon (Highlands and Islands) (Con): I thank Nanette Milne and Christine Grahame for their kind words. I have had an interest in mental health since being elected to the Parliament in 1999, when I was deputy convener to Adam Ingram on the cross-party group on mental health. In the first two sessions of the Parliament, we worked well together on the topic.

I welcome the mental health strategy. It is progress and a step in the right direction. I also welcome the review of progress in 2015, following the introduction of an 18-week waiting time target in 2014.

Like other members, I put on record the tremendous work done by many in the voluntary sector to support people with mental health issues and to address stigma. In particular, I highlight SAMH, the Depression Alliance and the Samaritans. The Samaritans website is wonderful; it even tells us how to approach people with depression, which I think many people are nervous about.

Like other members, I welcome the 34 per cent increase in the CAMHS workforce and the waiting time target of 26 weeks for CAMHS that is to be introduced this year.

I hope that the minister will now consider increasing the psychology workforce in preparation for the December 2014 target. Although I note that waiting times are down, it is only three years since people in Easter Ross were waiting four years and seven months to see a psychologist.

I also welcome the progress on improving dementia diagnosis. However, I would also like to see improvements in treating dementia. The Scottish intercollegiate guidelines network—SIGN—guideline for dementia is now seven years old despite SIGN reviews generally being done every three years.

The Mental Welfare Commission for Scotland confirmed to the Health and Sport Committee—Christine Grahame, Richard Simpson and, indeed, the minister have been on the committee—that 75 per cent of people in care homes were being given psychoactive medications for sedation and behaviour control when the SIGN guideline states:

"In patients who are stable antipsychotic withdrawal should be considered."

I find that figure—75 per cent—very serious. It has not been mentioned, but I trust that the minister will mention it again.

As the Health and Sport Committee did, I ask for a more consistent review of medication for older people. Not only could that save money, but it could improve health. The committee recommended that pharmacists and GPs should visit care homes more regularly to review the medication of elderly people.

I recently became aware of a woman in her late 80s who, as her daughter told me, was on eight different types of medication. She was taking them at all different times of the day. She was on hormone replacement therapy for menopausal problems—the woman is 87—and on antidepressants. Her daughter said to her, "I didn't know you were depressed, mum." She replied, "Oh I was feeling a wee bit down when your brother was born." The brother is over 60. It is not

unreasonable to comment on that. I think that we might find such situations throughout Scotland.

As 43 per cent of people on benefits in Scotland have a mental health issue, it is right that we give more time to mental health. Also, 79 per cent of people with a long-term mental health problem are not in work, and Siobhan McMahon and Aileen McLeod commented on that. As far as Siobhan McMahon's point about the work capability assessment is concerned, I am not sure which period she was referring to, but I know that Professor Harrington has looked at fluctuating conditions such as ME and mental health and has ensured that they are taken into account as part of the assessment process. I welcome the Welfare Reform Act 2012, because I feel that many people with long-term mental health conditions need the two years of support that is offered to get them back into work.

The strategy also talks about

"Treating depression in those with long term conditions such as diabetes".

It is my understanding—perhaps the minister could confirm this—that support should be given for treating depression among sufferers of many, if not all, long-term conditions, but the treatment of depression is rarely addressed or, indeed, mentioned in SIGN guidelines.

I think that I understood Jim Hume's point very well. Early diagnosis and treatment of depression are essential. As Richard Simpson said, cognitive behavioural therapy has been a wonderful success, particularly in the Western Isles and the Highlands, but in its review of CBT, NHS 24 said that it was effective only for those people who received an early diagnosis; it had no effect at all on those who had severe, chronic and enduring depression. I think that Jim Hume's point was that there is a place for antidepressants, but there are also times when people should be referred on to specialists and when talking therapies should be considered.

Audit Scotland's 2009 report, "Overview of mental health services", said that 75 per cent of people with a drug addiction had an underlying mental health problem and that 50 per cent of people with an alcohol addiction might have a mental health issue. There is no point in treating the addiction unless we treat the underlying mental health problem.

I accept what the minister said about borderline personality disorders. I ask him to continue to inform the Parliament on the issue, because I am aware of what some families go through in order to get a diagnosis and to get the very complex treatment that is required.

15:52

Fiona McLeod (Strathkelvin and Bearsden) (SNP): I want to confine my remarks to mental health problems in older people. Dementia is very much the headline mental health problem for older people. The dementia strategy was welcome and was well received but, as Richard Simpson explained, more older people experience mental health problems such as depression and anxiety than suffer from dementia; I add that I am in no way playing down the worries about dementia.

I have a huge number of statistics to provide, but given the time pressure I will go with the statistics and figures that Dr Simpson gave. Instead, I will turn to some of the remarks that Mary Scanlon made. If someone who is in their 80s needs antidepressants and has needed them for 60 years, they need them; it is not a laughing matter.

Mary Scanlon: I apologise if I gave the wrong impression. The point that the lady's daughter made was that her prescription had not been reviewed in 60 years. She suffered from depression only after having a child who is now 60 years old.

Fiona McLeod: Given that we are very short of time and that I have already cut my speech, I hope that the minister will be able to respond to some of that, which was nonsense.

I would like to talk about why more older people are suffering from mental ill health. There are a number of reasons for that. We talk about multiple morbidity. It is a fact that many of us are living longer, but we are living longer with ill health, which can often be mental ill health. Many people are living in loneliness and isolation, and many are living with financial worries. Mental ill health is a serious problem among the elderly.

I cannot read out all the facts and figures that I wanted to read out, but I will mention one statistic, which relates to something that Dr Simpson said. The highest incidence of suicide is in men aged over 75. Indeed, the incidence of suicide is 11 per cent higher in that age group than it is in young men—and we know that we have a problem with suicide among young men. It is a startling fact, which we should bear in mind when we talk about mental ill health in older people and its consequences.

I thank Dr Gillian McLean, a consultant in old age psychiatry, who gave a powerful and informed presentation to the cross-party group on mental health last week.

What can we do about mental ill health in the elderly? One of the first things that we must consider is the diagnosis of ill health in the elderly. I refer to our success in diagnosing dementia in

Scotland—we are world leading in that regard. We need to build on that success in diagnosing other forms of mental ill health in the elderly.

We need to raise awareness of mental ill health as a problem in the elderly. As we grow old, there are many neurobiological changes, which can affect our mental health. We should not regard anxiety and depression as just a fact of old age—we must move beyond that attitude.

People take multiple medications nowadays, so we must train our medical workforce and carers to be aware of that. A person needs to be trained to watch out for signs of an impact on their mother's or father's mental health each time their prescription is changed or added to.

Many conditions mask mental ill health in the elderly. For example, urinary tract infections can cause confusion. However, when an older person is confused and forgetful, we must not always say that it must be a UTI or dementia; we should explore the person's mental health and not regard the issue as just the effect of natural ageing and cognitive decline.

We should also alleviate external factors that can lead to depression and anxiety in the elderly. I mentioned that loneliness and isolation can be a contributory factor. That is a good argument for continuing to offer concessionary bus fares to the elderly, which is one way of alleviating isolation. There are also genuine financial fears. Old folk have always worried about the pennies, but we need to realise the effect on people of the coming welfare reforms and cuts and Labour's talk of a cuts commission and a something-for-nothing society. We need to move away from using such language.

I would have liked to have had time to talk about social prescribing and the physical activity that SAMH promotes through its get active programme.

I will finish with a message that emerged from the cross-party group's meeting last week: clinical mental health services should be delivered not on the basis of someone's age but on the basis of their mental health needs. I hope that the mental health strategy will enable us to live long and happy lives.

15:58

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): When I read the strategy, the first thing that I noticed was the amazing contrast between the completed strategy and the draft that was issued a few months ago. I do not say that in a spirit of criticism, because it probably means that the Government was listening, which is not always the case when consultation documents are issued.

On key change area 1, the draft contained little about the Scottish Government's wider work on the early years and the focus was almost exclusively on the CAMHS specialist area. Almost the opposite is the case in the published strategy, to the extent that key CAMHS issues are ignored. One such issue is the need for an adolescent intensive psychiatric care unit, which the Royal College of Psychiatrists highlighted in its paper for members for this debate. I was more struck by the complete absence of reference to integrated care pathways for child and adolescent mental health, because the issue was mentioned in the draft and when I talked to a child psychiatrist, she said, "This is crucial; you must say that implementation support is essential for integrated care pathways." However, integrated care pathways are not mentioned at all.

I do not say that in a carping way, because I very much welcome the wider early years agenda that is highlighted and given prominent place in the strategy, in key change area 1. A preventative, population-based approach to mental health is particularly crucial in the early years, and I have to give credit to the Government more generally for having recognised that. The minister highlighted that, of course, in pointing to the importance of attachment and in his references to programmes such as triple P and incredible years, which are evidence-based parenting programmes that the Government is quite right to roll out.

There are therefore many quite interesting and exciting things going on in the early years, the latest of which, of course, is today's first meeting of the early years collaborative. I have seen such things in action in health and know that they can work. I believe that the early years collaborative will work, and I hope that Sir Harry Burns was right when he said today that it may have the butterfly effect. He is usually right, and I hope that he is right about that.

Finally, on children and adolescents, I want to pick up on what Richard Simpson said. Let us not just do the early years to the age of three or five. Work in schools is important. I have seen the Place2Be initiative in Forthview primary school in my constituency, so I certainly support what Richard Simpson said about that.

On key change area 2, I like the focus on common mental health problems such as anxiety and depression, including in older people, and I welcome the fact that there is now a separate section for older people. I do not think that that was in the draft document. For those commonplace, or more commonplace, problems, people can of course benefit not only from access to psychological therapies, but from physical activity, as Aileen McLeod emphasised, and from social integration.

I highlight the excellent community connecting project in Edinburgh, which has been run by Health in Mind, although it will be run in my area by the Pilmeny development project. Basically, it focuses on certain older people who have isolation and possibly depression issues and other mental health problems that are connected with that. The project pairs them up with a volunteer for four months, I think. The evidence is certainly that it has had a remarkable effect on quite a few older people in Edinburgh. That is a really good example of the wider mental health agenda for older people working. Richard Simpson said that I would say more about that, of course, but he said most of it. The matter was highlighted last week in the cross-party group in the Scottish Parliament on mental health.

I will give one statistic that really surprised me—I think that I have got it right, as I checked it. Dr Gillian McLean, who is a consultant in the minister's health board area, said that, in secondary care, 1 per cent of older people with depression are referred to a psychiatrist, whereas 50 per cent of adults—that seems to be a high figure, but I think that Dr Gillian McLean said that—would be referred to a psychiatrist. That is certainly an amazing gap. Many older people who should be referred are not. One issue that she highlighted, perhaps not with psychiatry, is that there is a lack of clinical psychologists who specialise in the care of older people. Therefore, there are some issues, but I give credit to the Government for having recognised that and for having a section in the document about it.

Key change area 2 also deals with trauma and distress. Today and on Tuesday, Dennis Robertson highlighted the importance of eating disorders. We know that he can speak more from experience about that than anyone can, so I will not say more about it.

On trauma, I recently visited the Edinburgh women's rape and sexual abuse centre, which does really important work on counselling for women who have suffered the trauma of rape. I highlighted the funding problems there in a previous debate. We have to look at the wider support services for people who have gone through trauma.

I have only one minute left to deal with key change areas 3 and 4, so I will start to talk a bit faster.

Crisis services are really important. SAMH has said that they need to be rolled out across Scotland. I can certainly vouch for the fact that crisis services have been really important in Edinburgh. The crisis centre there is based in Leith. Users of mental health services campaigned for it for a long time, and it is a great model that we want to see more of.

Prisons are covered in key change area 4. Mary Fee has dealt with them, but an issue that relates to prisons is the lack of advocacy. I am still concerned that I can find nothing in the document about advocacy. I think that I asked Nicola Sturgeon a question about that when the draft strategy came out, and my memory seems to tell me that advocacy would be included, but I cannot see it. It was, of course, an issue from the McManus review, so it is supposed to be carried forward from that.

Perhaps, in winding up, the minister can tell us what will happen about the new further legislation on mental health.

I have had six minutes, so this is a good point at which to end.

16:04

Kevin Stewart (Aberdeen Central) (SNP): We have heard many tributes to the Parliament's mental health champions, who not only take part in debates in the chamber but continue the good work beyond it. I want to pay tribute to my former Aberdeen City Council colleague, Councillor Jim Kiddie, who served on the Millan commission on mental health and who tries to create mental health champions out of almost everyone whom he meets. People like Jim Kiddie have led us to the place where we are today, where—although I recognise that we still face challenges—we have a mental health strategy, which I think is pretty good. When Malcolm Chisholm referred to differences between the draft and final strategies, I thought that Jim Kiddie was probably one of the folks who had been in communication to say that he was not entirely happy about certain aspects of the draft.

I also pay tribute to the many groups and volunteers throughout Scotland who work to help folks with mental health difficulties. On Monday, I had the pleasure of having tea with a friends group in Aberdeen, which is entirely voluntarily run but makes a huge difference to people's lives. Organisations like that, which often operate on a shoestring budget, are to be praised for the efforts that they make.

On health inequalities, it does no harm to reflect on the Audit Scotland report on that from December 2012. Audit Scotland notes:

"People in deprived areas have lower overall mental well-being and more GP consultations for depression and anxiety ... (62 consultations per 1,000 patients compared to 28 per 1,000 patients in the least deprived areas).

Suicide rates are three times higher among men than women and over three times higher in the most deprived areas. Between 2007 and 2011, the suicide rate in Scotland was 26.4 per 100,000 in the most deprived areas compared to 7.1 in the least deprived areas."

Many people say to me that I come from a very rich city, but in Aberdeen we have poverty amidst plenty. We need to ensure that tackling health inequalities is a priority, so I am pleased that the minister in his opening speech mentioned that as the Government's ambition.

My great fear about the current situation is that welfare reform will have a massive impact on some of the most vulnerable people in our country.

Dennis Robertson: As the member is probably aware, welfare reform will result in many people going through appeals, in which they are subjected to rigorous questioning. The people involved often have an identified mental health problem, but that does not seem to be taken into cognisance during the appeals process.

Kevin Stewart: I agree with Mr Robertson on that point. In evidence to the Welfare Reform Committee just this week, a representative of the Scottish Independent Advocacy Alliance said that her staff are having to do much more work to help folk through those processes. She gave an example of a client in East Ayrshire who had to attend an appeal tribunal in Ayr, which basically required the advocate to be with the client for the entire day. We need to ensure that those folks who perform the work capability assessments and appeals recognise that some folks have real mental health difficulties. Unfortunately, such difficulties do not always seem to be taken cognisance of.

Having gone with committee colleagues Alex Johnstone and Michael McMahon to see Atos undertake a work capability assessment—a very good actress stood in for the client, but it gave us a feel for the process—I think that the assessment process would be pretty scary for many people but it can only add an additional strain for people with mental health problems and learning disabilities.

I have a great fear that we may see deterioration in people's health as a result of the processes that are in place. Mary Scanlon talked about the Harrington review: although that has made things slightly better, there is massive room for improvement. I hope that that will be looked at more carefully.

16:10

Mark McDonald (North East Scotland) (SNP): I associate myself with my colleague Kevin Stewart's remarks about our former council colleague, Jim Kiddie. Having spent five years in the Aberdeen council chamber, we know that anybody who ever listened to Councillor Kiddie speak on mental health—and, indeed, on his personal experiences, about which he is extremely candid—could not have helped but have the hairs on the back of their neck raised. Councillor Kiddie emphasised to me early on—it has stayed with me since—that mental illness can affect anybody at any stage of their life, irrespective of their status or, indeed, their general health and wellbeing.

I want to cover a number of different areas. I have a lot to get through, so I hope that I can manage that within the six minutes. The first of those areas is parental mental health, which I raised in a couple of interventions. That extremely important issue needs to recognised. I pulled up Nanette Milne on the use of the phrase "poor parenting", and she accepted that that was poor phraseology. However, at the same time, there is a perception that child mental health or behavioural issues stem from poor parenting. Sometimes that is the case, but often they are a consequence of attachment issues that develop as a result of parental mental health issues, including, but not exclusively, post-natal depression.

Post-natal depression affects around 10 to 15 per cent of women. It is estimated that, for every 1,000 live births, 100 to 150 women will suffer a depressive illness. Studies have estimated that around 10 per cent of fathers can develop and suffer from symptoms and effects of post-natal depression; that should be borne in mind.

I noted a 2008 report, "The Effectiveness of Interventions to Address Health Inequalities in the Early Years: A Review of Relevant Literature", which suggested further

"exploration of interventions that reduce risk for postnatal depression".

That is because it is recognised that that has an impact on the mental health and wellbeing of children in the early years. I would welcome comments from the minister on how the Government sees post-natal depression fitting into the mental health strategy, particularly with regard to the application of the Edinburgh scale for post-natal depression.

I understand that the expectation is that all women should receive the Edinburgh scale. However, I have anecdotal evidence that some women, who have later been diagnosed with post-natal depression, were not given the Edinburgh scale to complete. That might not be widely prevalent, but perhaps the need to take cognisance of the Edinburgh scale needs to be re-emphasised to either health visitors or GPs—or, indeed, to both—when it comes to looking at women and women's health postpartum.

I want to look at environmental factors, and a number of colleagues have spoken about welfare reform and the wider recession. The March 2012 report "GPs at the Deep End: GP experience of the impact of austerity on patients and general practices in very deprived areas" makes for sombre reading:

"A central concern of the Deep End practices is the number of patients with deteriorating mental health."

Two ends of the spectrum were looked at. At one end, there are

"those who are in work, and previously well"

who found themselves under increasing stress in their jobs due to potential cutbacks and job security fears, and under the stress of taking on extra work or jobs, with the

"resultant impact on family and relationships".

At the other end of the spectrum, there are

"those with chronic mental health issues and established physical problems who are 'deemed fit to work' and have their benefits cut.

Those people are

"struggling to make ends meet ... increasing contact with GPs and psychiatry ... increasing antidepressant/antipsychotic use ... self-medicating with drugs and alcohol".

A number of testimonies were borne out in the report. One GP said:

"I observe this again and again that I cannot address medical issues as I have to deal with the patient's agenda first, which is getting money to feed and heat."

Another said:

"In my surgery I am hearing from patients who for 2-3 days a week cannot afford to heat their houses (many use metered cards which are more expensive than direct debit payments)."

Then there was a kind of gallows-humour comment:

"For obvious reasons, the patients in X ... area ... call Corunna House [where the Work Capability Assessments are done] 'Lourdes' because all the sick come out cured!"

That emphasises that the work capability assessments do not necessarily take cognisance of some of the very real issues.

The Royal College of Psychiatrists states that

"recessions have been shown to be accompanied by an increase in the suicide rates. The people most at risk of suicide at this time are those who are experiencing financial problems."

Evidence from the Centre for Welfare Reform showed that 45 per cent of people in debt have mental health problems, but that only 14 per cent of those who are not in debt have such problems. The centre's hypothesis is that poor mental health is linked to real poverty, which I think has been borne out by some of the evidence.

There is also an issue about the pressure that is experienced on the front line. When I was a member of the Finance Committee, I asked questions of Dr Margaret Somerville, from NHS Highland. She said:

"I have not talked much about mental health issues, but we expect an early impact on mental health services and particularly on primary care services. Again, we need community resilience and support. Uncertainties and unknowns produce stress in people, which leads to depression and anxiety. That will have an impact on primary care and on our mental health services."—[*Official Report, Finance Committee*, 12 June 2012; c 1388.]

That shows clearly that welfare reform will have an impact on services.

Stigma about mental illness still exists in many ways, which makes people more reluctant to come forward about their illness. Depending on the walk of life in which people operate and work, they might not come forward because they consider that to do so will impact on their job security. We must do all that we can to tackle stigma. I think that the mental health strategy will play a strong part in that, and I very much welcome it.

16:16

David Stewart (Highlands and Islands) (Lab): In the early 1980s, when I was a fresh-faced social work student, hard as that may be to imagine now, I was in a Stirling GP surgery waiting room. On the wall was a striking poster by the Health Education Council that pictured a young woman with a bright smile and perfect complexion who radiated good health. The caption read:

"Six months after Mary had a nervous breakdown, her friends are still recovering."

I think that Mary had a lot in common with Winston Churchill, Florence Nightingale and Gandhi, who all suffered from episodic mental illness. In Roy Jenkins's seminal work on Churchill, Sir Winston described his depression as the "black dog", which was perhaps not helped by his legendary drinking.

I will focus on the stigma surrounding mental illness, which Mark McDonald referred to. I will illustrate it by a couple of examples from my experience as a mental health officer, looking at social and economic implications and touching on best employment practice.

Before I move on to that, though, I want to say that the Scottish Government document on the mental health strategy for Scotland is well researched and well argued. I certainly support the three quality ambitions of being person centred, safe and effective, and the seven themes, particularly the anti-stigma work and the Scottish Human Rights Commission's work on promoting rights for those who suffer from mental illness. I support of course the 2016 standard to have 18 weeks between referral and commencement of treatment.

Previous speakers have rightly pointed out that mental health problems cause considerable poor health in Scotland. The World Health

Organization, to which previous speakers have referred, estimates that one in four people will have a mental health problem at some time in their lives. The Audit Scotland overview of mental health services reported that depression and anxiety combined is the most common mental health problem. The Scottish Government's information service estimates that 300,000 Scots take antidepressants regularly and Audit Scotland has highlighted that socially excluded people are at greater risk of developing mental health problems. To paraphrase Nelson Mandela's famous line: while social exclusion persists, there is no true freedom.

I think that Kevin Stewart got it right when he said that there are higher levels of mental health problems in deprived areas. For example, the suicide rate for people living in deprived areas is four times that of people living in the most advantaged areas. The Office of National Statistics reported in 2004 that nearly half of all councils' looked-after children have mental health problems.

In 2003, as Mary Scanlon correctly said, the Scottish Executive stated that three quarters of drug users and half of those with alcohol problems may have mental health problems. Many members have mentioned the Scottish Association for Mental Health study that showed that the social and economic cost of mental ill health has reached £10.2 billion a year, which represents an increase of 25 per cent since 2004-05.

What is the solution? I highlight the groundbreaking work by BT, whose mental wellbeing strategy has led to a 30 per cent fall in mental health related sickness absence and more people returning to work after absence.

What about a personal view of mental illness? Lynsey Pattie gave evidence to my Public Petitions Committee in November. She has a mental health problem. She said in evidence:

"we need to address the stigma of mental ill health. From a young age, children are taught social education, starting with relationships in primary school and going right through to drugs and alcohol in secondary school. I feel that mental health should feature more heavily in such education, with the correct facts being given. I find it amazing and saddening that so many people have the wrong facts about mental health ... Words such as "psycho" are used daily in newspapers for no other reason than to describe a footballer making a bad tackle. Just yesterday, I heard a news reporter calling a news story "bonkers" and someone else being called a "loony" because they had a different opinion. When there is a murder, people automatically assume that the person is mentally ill."—[*Official Report, Public Petitions Committee*, 13 November 2012; c 868.]

My experience as a mental health officer in the mid-1980s was that services were hospital-centric and, in the spectrum of overall healthcare, mental health was the Cinderella service. I still remember working in the locked ward at Craig Dunain hospital in Inverness, which was a Victorian institution, and watching electroconvulsive therapy being given to an elderly patient. I had nightmares for weeks afterwards.

Of course, there has been a major shift to community-based and person-centred care. I highlight in particular the excellent work that is carried out by the choose life team. Before joining the Parliament, I worked closely with the Highland team leader and saw at first hand the excellent training that is carried out with nursing, police and local authority staff in the field of suicide prevention.

We know from the Royal College of Psychiatrists briefing—and we heard earlier—that economic cycles give a clear indication of suicide trends. I was struck by the comment that more older people experience illnesses such as depression and anxiety.

Dr Simpson: On the choose life programme, the percentage of NHS staff who have been trained has improved, but it is still only 52 per cent. Does the member agree that we need to push on with further training for staff in the public sector?

The Deputy Presiding Officer (Elaine Smith): You must close, Mr Stewart.

David Stewart: I strongly agree with the point that Richard Simpson makes.

In conclusion, I welcome the Scottish Government's mental health strategy for Scotland. To campaign for improvements to mental health services is to lead a crusade for social justice and inclusion and to champion the fight against the tyranny of the stigma of mental illness.

16:22

Roderick Campbell (North East Fife) (SNP): I am pleased to have the opportunity to speak in this debate and to follow so many thoughtful contributions.

Mental health is affected by an extremely broad range of factors, many of which are interconnected. The reasons behind the mental health problems that we face as a nation are many and varied. That is why it is clearly right that the Scottish Government launched the consultation to update the strategy. I was pleased to hear from the minister about the strong response to the consultation.

I recognise that in the past decade progress has been made on preventing suicide, but we should also bear in mind the academic evidence from the University of Edinburgh and the University of Manchester. Last year, they published research that identified something called the Scottish

effect—that is, the phenomenon that causes suicide rates in Scotland to be higher than those elsewhere in the UK. One of the authors of the report suggested that a more prevalent tendency in Scotland to treat symptoms of mental health problems with psychotropic drugs, rather than getting to the root of patients' anxiety or depression, could be partly to blame, although it was not clear to the researchers whether that tendency was caused in the seeking of treatment or in its delivery.

There is good evidence, anecdotal and otherwise, that the use of psychotropic drugs can have seriously unwanted side effects. I am pleased that prescription of antipsychotic drugs for the elderly, particularly those with dementia, is now being actively discouraged.

The paper also suggests that alcohol and deprivation play a significant role in the Scottish effect, being responsible for 33 per cent and 24 per cent respectively of the excess suicides—"excess" meaning above the UK average. Sadly, the paper also identifies men as being at a greatly elevated risk. Indeed, the Scottish suicide information database published a report in December 2012 that showed that, according to the latest figures, three quarters of suicides involve men and that 56 per cent of those who committed suicide in 2010 had received mental health prescriptions in the year leading up to their death. The link between increased suicide risk and poor mental health is beyond question. We know that. David Stewart and others have referred to the choose life initiative, and I think that such initiatives are helpful in our attempts to make inroads against the Scottish effect, but we need to keep working at this.

Several speakers have referred to the impact of welfare reform and the recession. Clearly, we need to acknowledge the scale of the recession's impact on mental health. A recent research paper that was published in the *British Medical Journal* is one of several in recent years whose conclusions suggest an increase in the prevalence of mental health problems, which seem to align with the onset and development of the recession. In fact, several papers that have been published in the past two years appear to indicate a growing problem, and some academics are investigating why it is that men appear to suffer more negative mental health effects than women as a result of the financial crisis and recession. Of course, we all know that women are suffering from the UK coalition's policies in plenty of other ways.

The paper says that further research is needed—no doubt that is the case. We need to explain the effects on men. However, it is also increasingly clear in modern medicine and psychology that issues around gender, age, employment status, physical health and many other variables, demand a mental health strategy that is centred on patient needs.

I am pleased that the Government's strategy contains measures that will help to deliver a more patient-centred approach to treatment. I certainly strongly support efforts in that respect.

In our debate in September 2011, I touched on the value of peer groups as a form of independent advocacy. I am pleased that, in commitment 3 of the strategy, the Scottish Government commits itself to a review of peer support. I acknowledge that that is a step in the right direction. I hope that peer support will become much more important in the future.

Many speakers have referred to stigma. I welcome the Scottish Government's commitment to the development of the see me campaign. However, we should bear it in mind that a survey that was conducted by see me last year suggested that 56 per cent of people still would not want anyone to know if they were suffering from a mental illness. Research shows that sufferers are often reluctant to talk about it with others, whether that is because they are worried about people's perception of them changing for the worse, or because they are embarrassed or do not want to become a burden on family, friends or colleagues.

Mental illness has been described as the last great taboo, and we must do all that we can to destigmatise it. There are signs that progress is being made, and we can be encouraged by the international reaction to some of our efforts. The see me campaign has been lauded as an example of best practice internationally, and statistics show that Scotland has progressed a great deal in the past few years when it comes to tackling stigma.

As others have said, the perception that depression is a sign of weakness can impede a sufferer's career progression or make life difficult in a number of ways. It is depressing to note that see me's survey says that only 35 per cent of people think that it would be suitable for someone to be a primary school teacher if they experienced depression from time to time.

Those and other forms of discrimination must continue to be tackled. I think that we are heading in the right direction to change attitudes for the better, but we have a long way to go.

On older people, I was also at the recent meeting of the cross-party group on mental health and I can confirm that Malcolm Chisholm is correct in saying that we heard evidence that only 1 per cent—in fact, I think that it was fewer than 1 per cent—of older people with depression were being referred to psychiatrists. We also heard evidence that there were not enough clinical psychologists dealing with non-drug treatments, but that is an

issue that goes wider than the issue of older people. We also learned of the frustration that is felt by some elderly folk that mental health services for the elderly concentrate on dementia, without recognising the range of mental illnesses that elderly folk encounter. I am glad that the strategy takes that on board.

16:28

Jim Hume: We have had a good and fruitful debate. Of course, there are still challenges. Dennis Robertson rightly highlighted that one in four adults in Scotland will experience mental ill health at some point in their life, with the resulting social, economic and personal cost of mental health problems estimated to be in the region of £10.7 billion annually. Mental ill health is now the dominant health problem of people of working age, and the cost to employers is now in excess of £2 billion a year. Of course, the emotional cost to families is even greater. Perhaps all of us have been touched in some way by mental health issues in our families. That is why I welcome the publication of the strategy and its important commitments.

When Kevin Stewart referred to the many mental health champions in Scotland, he should perhaps also have mentioned Tommy Whitelaw. For many years he cared for his mother, who had dementia, and witnessed her writing her name and date of birth on her arm to hide the fact that she was suffering from the condition. He is now taking his tommyontour campaign around Scotland to spread his good word.

In my opening speech, I highlighted the issue of equal access to psychologists. Proportionally, the number of clinical and other applied psychologists available to treat a patient in Kincardine is twice that available to treat someone three miles away in Clackmannan. That kind of inequity is worrying and I would like the minister in his summing-up to make a commitment not only to meeting the HEAT target by December next year but to addressing that disparity.

As has been stated, there are no statistics on waiting times for access to psychology therapies because of delays and changes in personnel at Information Services Division Scotland. I accept that the infrastructure for collecting the relevant data needs to be in place, but also note that as waiting times for psychological therapies were approved as a HEAT target more than two years ago, we should by now have some idea of where we are. Again, I would appreciate it if the minister addressed that point either when he sums up or later.

In my opening speech, I highlighted the increase in the use of antidepressants. Although I acknowledge the minister's comments and Dennis Robertson's remarks and experience, I think that Mary Scanlon made clear the point that I was trying to make that GPs have no formal process to support any review of patients with common mental health problems. I firmly believe that the Scottish Government should work with health boards to roll out nationwide successful pilots such as that undertaken by NHS Greater Glasgow and Clyde, in which patients on antidepressants for more than two years in 78 participating practice areas had their cases reviewed. As a result of the review, changes were made in the therapy of 28 per cent of patients, ranging from changes in dosage, the use of alternative drugs or treatment being stopped altogether. All of that led to a 9.5 per cent reduction in prescribed daily doses and, more important, better patient treatment.

One of my overriding concerns, which I know is shared by others, is that the use of antidepressants has increased because GPs lack alternatives. For example, exercise referral schemes are too inflexible or are not available during working hours and the perception is that waiting lists are too long and inaccessible. There also needs to be access to the kinds of alternative therapies that Linda Fabiani so eloquently described. I completely understand that antidepressants need to be used to treat conditions other than depression, but it is a sobering thought that one in 10 Scots are being medicated with them.

Many members have mentioned SAMH and its good work in highlighting physical activity to address stigma and improve mental health. Its see me campaign, which just about everyone has mentioned, has through its agreement with the Professional Footballers Association Scotland done great work in challenging the stigma associated with mental health in the likes of the football community. In 2011, the campaign produced five excellent short films to coincide with Scottish mental health week and I recommend that well produced video to members.

As I said, Linda Fabiani referred to creative alternative therapies. The minister knows that I have an interest in this issue through PND Borders and I appreciate and am grateful that he agreed to meet the group just a couple of months ago.

I am disappointed by the real-terms cut in the budget for physical activity. I believe that such activity is a good example of preventative spend that the Government could take up and I ask the minister to address that issue in his closing speech.

Many have mentioned suicide rates. Given the facts and figures that Roderick Campbell cited, I do not think that we should be complacent or get too excited by the claim in the strategy that the

figures are going down. This is still a major concern.

The Deputy Presiding Officer: I would be grateful if you could begin to conclude, Mr Hume.

Jim Hume: The Liberal Democrat amendment in my name expresses concern at the steep increase in the use of antidepressants; outlines ways in which the Government could address the issue, including, for example, the use of "talking therapies"; notes the UK Government's huge investment in improving access to psychological therapies; and recognises that mental health is at the core of Scotland's "ability to flourish". I therefore welcome support from across the chamber to show Scotland that we take the issue seriously and believe it to be above party politics.

16:34

Jackson Carlaw (West Scotland) (Con): I begin, as Richard Simpson did, by welcoming the minister's sober and candid assessment and his tone in his introduction to the debate. We know that a strategy is in place and that advances have been made; all that is widely welcomed and has enjoyed cross-party support. The recognition that progress needs to be made in a range of other fields has facilitated the debate, which has been punctuated throughout by specialised and informed contributions on specific areas.

Richard Simpson referred to the challenge of an ageing population in all its forms. It is sometimes easy for us to pass over and simplify that issue. He also talked about the incidence of adolescents in adult wards, but he was perhaps a bit optimistic in hoping that an alternative trend is being established. There was a spike in the figure, and we have got it back to where it was, but for me to be confident that a new trend has been established, I want the figure to start to drop a little below that. I know that a plan is in place, although I take Richard Simpson's point that there are not as many beds as was hoped. We know that the situation is not ideal, and the minister recognises that we want to see progress on that in the future.

I suppose that the major stushie of the afternoon centred on the introduction to the debate of the issue of antidepressants, as characterised by Jim Hume's speech. I kind of understood where he was coming from. It is perfectly true that, as the minister said, the defined daily dose has gone up—from 88.4 to 120.9—but the number of items dispensed has also gone from 3.5 million to 5 million. I do not want to simplify the argument, but there is a concern somewhere in there, and the response has to go beyond Fiona McLeod shaking her head and saying that anyone who addresses it is talking nonsense.

We do not want antidepressants to become the method that we rely on to treat people. They have their part to play, and it would be reckless and foolish to suggest that they do not. That might even require an increasing incidence of their being prescribed. However, we want to know that there is something parallel and in addition to that. That is the point that members were trying to articulate.

Nanette Milne and the minister touched on the fact that the suicide rate is falling. That contradicted Mark McDonald's point that, in a recession, it is inevitable that the suicide rate will increase. Actually, that is not the experience. However, we should not forget or ignore SAMH's two too many campaign. If we stop and think about it, that means that, daily, two people are losing their lives by their own hand. That ought to chill us when we consider the individual, the effect on the families concerned and those around them, and the loss of potential.

Siobhan McMahon's speech was in two halves. She had a rather personalised contribution that was addressed to an empty chair, although I hope that what she had to say was nonetheless taken account of. She, Aileen McLeod and Kevin Stewart—in the second half of his speech—touched on welfare reform. The debate is not about welfare reform, but I want to try to respond in two ways to the points that were made. I hope that they balance, taken as a piece. Some of the assessments that we are talking about were introduced by the previous Labour Government. Nicola Sturgeon, at the beginning of this session of Parliament, told the Health and Sport Committee that she supported the principles of welfare reform. There is a paint-your-bandwagon approach—members can hitch their caravan to the end of any bandwagon and start complaining about the consequences.

There is an acceptance that this country needs to face up to and address welfare reform, but that is not the equivalent of my being comfortable as an individual and as a Conservative with the consequences of the assessment process on the lives of some individuals. Therefore, I accept some of the comments and criticisms on that. The Harrington review has made progress, although it is not enough, and I hope that more lessons can be learned.

However, in itself, that is not an argument that welfare reform has no place. If we do not support specific welfare reform proposals, we have to provide alternatives. However, I accept that not everything that is happening is something that I can stand up and applaud and support, or say is an acceptable process or outcome.

Mary Scanlon and Malcolm Chisholm have long perspectives and understandings of the topic and they illustrated, through whistle-stop tours of the

issues, that we can welcome the progress that has been made, and still throw some grit into the porridge and ensure that we are still prepared to probe the things that are being proposed without that necessarily becoming a confrontational or polemical exercise. We should be mature enough to accept that there will always be areas in which progress is not being made, even while it is being made in others. That is not a failure of party politics; it is a failure of our ability to make progress simultaneously on all fronts.

Kevin Stewart made an uncharacteristically understated contribution that I very much enjoyed. Nanette Milne, who is sitting beside me, said that she thought that Councillor Kiddie's contribution had been immense, so I am happy to endorse that view.

Later in the debate, the issue of stigma was touched on by Linda Fabiani and others.

The Deputy Presiding Officer: I must ask you to come to a conclusion.

Jackson Carlaw: The debate has been constructive and has been punctuated with some very well-informed contributions. The people who are concerned about the issue can be satisfied in the knowledge that experience and interest is widespread across the chamber.

16:41

Jackie Baillie (Dumbarton) (Lab): I agree with Jackson Carlaw that the debate has been absolutely interesting and largely constructive. With all due respect to my front-bench colleagues, I have to say that the debate has been owned by the back benches. I do not want to pick people out, but there have been incredibly impressive and informative speeches from Mary Scanlon, Mary Fee, Linda Fabiani and Dennis Robertson. Kevin Stewart and Mark McDonald will both be quite surprised that I mention them, too, because we do not often agree, but on this issue I thought that their speeches were very impressive.

We acknowledge the achievements of, and the progress that has been made by, the Government, the NHS and all the partners, but it is always the case that we can and should do more, although my comments are set in the context of that broad support. I echo the minister's praise for all those who work in mental health—the health service staff and people in the voluntary sector who provide care and support daily for people who have mental health problems.

I will start where Richard Simpson started. Irrespective of political colour, we are good at producing strategies. Our shelves are littered with them. The mental health strategy rightly commands support from across the chamber, but we need to make sure that it is implemented so that it makes a difference on the ground. That is a challenge not just for the Government, but for all of us.

The minister told us about a new dementia strategy and a refreshed suicide and self-harm strategy, which are both welcome, but we need to be sure of their implementation. I ask the minister seriously to consider setting up an implementation group that has a clear action plan, a monitoring framework and a timetable for key milestones so that we can measure progress. Let us make sure that the strategy is not destined for the shelf but leads to change.

Nanette Milne rightly reminded us that one in four of us is likely to suffer from mental health problems at some point. Mental health services used to be regarded as a Cinderella service, but I think that the collective efforts of Parliament and successive Governments have changed that. However, I am concerned that, in a time of austerity, the clock will be turned back.

In many communities across Scotland there have been cuts to social care services and in others charges have been introduced for the first time. I know of constituents who face losing a service or paying £50 a week for the first time in order to retain provision that is essential for their mental health and wellbeing.

At local level, parts of my constituency in Helensburgh do not have access crisis services after 8 pm, due to lack of resources. Malcolm Chisholm rightly drew our attention to the value and importance of crisis services in his constituency. We need to be vigilant. We recognise the value of community-based services, which are often much to be preferred to inpatient care because they support people to continue with their everyday lives. Let us ensure that they are adequately resourced.

Jim Hume raised the question of statistics when he discussed child and mental health services. I welcome the Government's HEAT target of referral to treatment within 18 weeks and the progress that the minister outlined. However, children are being admitted to adult mental health wards; I am sure that across the chamber we agree that that is inappropriate. We need action to tackle that. I press the minister to ensure that sufficient CAMHS beds are available. I know that he is committed to making progress on that.

Jim Hume also made a point about the lack of statistics, although I note that the minister was able to give us some and said that 89 per cent are being seen within the CAMHS target. However, when we asked SPICe for the statistics, it told us that there are none. We were therefore unable to measure progress. This is a critical area of policy,

so will the minister advise when the data will be available? Does he agree with SAMH's call for an audit? If we establish our baseline position, we can effectively measure progress. That would be a useful tool for us all, including the Government.

I turn to Mary Fee's authoritative contribution on the justice system and the impacts on families of offenders, which was very much complemented by Christine Grahame's contribution. Mary Fee was right to point out the serious omission in the mental health strategy, which is that there is no mention of the very real challenge for and impact on children of having a parent who is an offender. In the past—in a previous life in Government—we used supplementary reports to pick up on areas that needed further development. I invite the minister to do just that and to ensure that mental health support for the children of offenders is part and parcel of the mental health strategy in the future.

Many members spoke about early intervention for children. Mark McDonald raised the issue of support for parents, and post-natal depression, which has an impact predominantly on women, but also impacts on men and children. We support the many positive things that are being done by the Government, such as the triple P programme, the incredible years programme and, as children move on to primary school, the Place2Be programme. We welcome continuing investment in those initiatives.

Linda Fabiani, Roderick Campbell and many other members talked about the importance of tackling stigma and the extremely positive work of the see me campaign and SAMH in challenging stigma. Again, we commend their work to Parliament.

I turn to NHS 24 and its CBT service, which was mentioned by Mary Scanlon. When I visited the project at the Golden Jubilee hospital, I was struck not just by how flexible the project is, but by how it is making a huge difference to people predominantly in rural areas, where individual telephone support is essential to their improved mental health and wellbeing. The statistics that we are starting to see are extremely positive. I wonder whether we could roll that out beyond rural areas, where there is a need to do so.

David Stewart rightly reminded us of something that had thus far been missing from the debate: the importance of occupational health services and the importance of challenging employers' attitudes. The majority of people who experience episodic mental ill health still need to hold down employment, and may struggle to cope with that.

I close by talking about the wider challenges of mental wellbeing. Kevin Stewart spoke very well about welfare reform; there was much in his speech with which I agreed. Although I hope that mental health organisations have contributed to the Harrington review, there is a real need to provide support and advice to people who are faced with having to reapply for their benefits. I am concerned about the preparedness of the NHS to cope with the impact.

Mark McDonald rightly referred to the deep-end group of GPs and its report about the challenges that those GPs face in providing adequate support for their patients. In my view, that will get worse with austerity.

The strategy needs to be set in the context of the likelihood of increasing levels of child poverty in Scotland; the challenge of youth unemployment and unemployment more generally, which is increasing; and the challenge of a reduced standard of living, with rising levels of in-work poverty, which leads people to have to use food banks and payday loans.

People in our communities are increasingly struggling to cope with everyday life. The need for the strategy is self-evident: the pressure on our mental health is increasing. The minister will have our support if he puts in place a robust implementation plan and monitoring framework so that this strategy really makes a difference on the ground.

16:49

Michael Matheson: Like other members who have given closing speeches, I think that this has been a very good debate, with some excellent speeches in which members have raised significant issues that they wish to see addressed.

Members will recognise that, in taking forward the strategy, we had a debate in Parliament before the consultation started. I asked all members to feel free to engage in that process and to make their views known because, as I am sure all members will recognise, the Government does not always have the answers when it comes to dealing with all the issues and challenges that the mental health system faces. We need to prioritise areas in which we believe that we can make good and sustained progress.

Since the publication of the strategy, the general feedback that I have had from the sector is that the strategy is moving in the right direction and allows us to build on the progress that has been made in previous years—not just by this Government but by previous ones. That progress is a tremendous credit to the Scottish Parliament and to the way in which NHS Scotland has taken forward the reform of our mental health services over the past 12 to 13 years, if not longer.

One of the most important areas in the mental health field that we need to focus on much more is the early years. To date, work on the early years has largely been associated with dealing with health inequalities, but mental health issues do not necessarily register among the health inequalities that we face in our society.

One aspect of the strategy is that it seeks to work with other areas of Government policy to ensure that we have a greater focus on the early years interventions that can make a difference—not only in improving people's future health and wellbeing but in reducing the potential for them to drift into the criminal justice system or anything else that may arise from a poor experience in their early years.

As Malcolm Chisholm pointed out, today is the launch of the early years collaborative. That provides an exciting opportunity to ensure that we have much greater collaboration among agencies so that we can make a real difference in the early years where it is appropriate.

I accept Richard Simpson's point that we should not look at the early years as purely being the pre-school years. His suggestions for work that could be taken forward in schools, particularly in primary education, are worth further consideration to see whether we can take that forward as a preventative approach as well.

Richard Simpson also raised the issue of the ministerial task force. The evidence base that is now emerging in a whole range of areas to do with physical or mental health issues shows that tackling health inequalities is not just about physical health; it is also about mental health. It is about social justice and, if we are to get to the root causes of it, we have to tackle the issues of social injustice much more effectively than has happened over many years.

A number of members referred to CAMHS and the changes that have happened to those services. Richard Simpson and Christine Grahame will recall their Health and Sport Committee inquiry into the provision of CAMHS in the previous parliamentary session. Mary Scanlon was a member of that committee as well—I apologise if I have forgotten anyone else who was a member of the committee who is in the chamber. All those members identified the need to improve access to CAMHS and the need for much earlier intervention when issues arise. I think that all members recognise that the additional resource that has been provided over the past four years has made a marked difference in improving access to services earlier. That ensures that we can intervene at the earliest opportunity to support a young person who is exhibiting mental health issues.

That brings me to the issue of improving access to psychological therapies. Although it is difficult to give exact figures at present, because the data is incomplete and not to a level that allows us to be fully confident about the scale of it, some of the data indicates that a significant number of people are making use of different psychological therapies in NHS Scotland. I hope to be in a position, when the data is of a higher quality, to publish it later this year—it is an issue of data quality rather than anything else. I have no doubt that, once that data is published, it will help to give focus to ensuring that we maintain improvement in this area and it will demonstrate the scale to which patients are benefiting from psychological therapies.

The issue of psychological therapies also sits alongside some of the issues and some of the discussion around antidepressants. Too often, there can be the simplistic read-across that the level of antidepressant prescribing means that we do not have enough psychological therapies. That is not necessarily the case. A combination of approaches may be appropriate and, in some cases, antidepressants may be the best course of action rather than some form of psychological therapy. We should not make an automatic link between the level of antidepressant prescribing and the availability of psychological therapies. I hope that members are reassured that we will try to publish the data this year once we have addressed some of the issues with its quality.

Several speakers, including Malcolm Chisholm and Richard Simpson, referred to older people and mental health issues. With people in my constituency such as Eddie Kelly, who works with Falkirk & District Association for Mental Health and is a passionate advocate of the need to improve services for older people with mental health problems, there is no way that a strategy for which I am responsible would not recognise that issue.

A number of members mentioned dementia. If we improve services for older people with mental health problems, people with dementia will be able to benefit from the improved access to psychological therapies, because those therapies are not simply for younger people or any particular age group. However, it is necessary that we recognise the number of older people who experience mental health problems. There is still some work to do to achieve that.

Dennis Robertson made a good observation about the opportunity that arises from the integration of health and social care to ensure that our local authorities and health services deliver services for older people in a much more co-ordinated, and the most effective, way.

One of the important points about improving access to psychological therapies is that the

therapist does not always have to be a psychologist. Sometimes, it is about improving access to social prescribing, which the strategy also sets out, or increasing physical activity. All of those have an important contribution to make to improving older people's mental health.

John Pentland: Will the minister give way?

Michael Matheson: I am trying to cover a lot from the debate, if John Pentland does not mind.

Dennis Robertson also mentioned eating disorders. I met him yesterday to discuss the progress that we are making on that and the further work that is necessary. I will continue to work with him to ensure that we do what we can to improve the delivery of services for those who experience an eating disorder.

Some members also referred to crisis services. We must get much better at delivering such services in Scotland.

I had the pleasure of opening the crisis centre in Leith to which Malcolm Chisholm referred. There is real benefit in giving people an opportunity to go to a venue that is not necessarily a health facility but gives them the time out and support that are necessary to enable them to address the issues that they find difficult.

In NHS Tayside, we are also doing pilot work to determine how we can become much better at identifying individuals who present in distress or crisis and ensure that agencies are better at tracking them when they present to services. We know from research on suicide that many such individuals, far from not having presented to services, have presented to services time in, time out but have not been picked up effectively. We must get much better at picking up such individuals. I refer not only to health services but to local authority social work departments. The criminal justice system must also be much more effective at that.

To touch briefly on the criminal justice system, I accept the points that Mary Fee and Christine Grahame raised. We need to make more progress on that. The fact that the mental health services in our prisons are now part of NHS Scotland gives us a greater opportunity to address some of the challenges.

One of the most important areas that have been highlighted is the continuing work on reducing the stigma that is associated with mental ill health in Scotland. David Stewart made a very good speech on that. We need to ensure that we maintain momentum on that to remove the stigma that can often be associated with mental health problems, but we should also take that work further.

We must tackle not only stigma but the discrimination that prevents those who have a mental health issue from engaging in services in the way in which they should or receiving the services that they deserve to receive. The work that I wish to be taken forward as part of the strategy involves a focus on the discrimination that many people with a mental health problem experience.

Malcolm Chisholm said that he noticed the difference between the draft strategy and the final strategy. I hope that members will be reassured that we have genuinely listened to all those stakeholders who have an interest in mental health services in Scotland with a view to ensuring that we have a mental health strategy that is fit for the 21st century and which will deliver real change and build on the improvements that we have made over recent years.

Point of Order

17:00

The Deputy Presiding Officer (Elaine Smith): There is a point of order from Jim Hume.

Jim Hume (South Scotland) (LD): Presiding Officer, this morning the Cabinet Secretary for Health and Wellbeing announced an emergency care action plan in response to the well-reported difficulties that are being experienced at accident and emergency units across the country. That announcement comes after repeated assurances from him that those were isolated incidents and that no action would be taken. Unfortunately, the announcement was made in a press release and not, as it clearly should have been, to the chamber, which would have allowed members to scrutinise the plan in detail.

The announcement comes two weeks after I was told, at topical question time, not to paint the picture that I was trying to paint, and 24 hours after the cabinet secretary accused the BBC of dishonesty and of broadcasting factual inaccuracies. A complete policy reversal has occurred in the past 24 hours and members of the Parliament will not have the opportunity to question the cabinet secretary in detail.

The Deputy Presiding Officer: Mr Hume, could you tell me your point of order, please?

Jim Hume: Do you agree with me that, in the first instance, such important announcements must be made to the chamber? Can you confirm whether time exists in next week's business programme for a ministerial statement on the matter?

The Deputy Presiding Officer: I thank the member for indicating to me his intention to raise a point of order. Decisions on when and how to make announcements are judgments for the Scottish Government. There are, of course, a number of ways in which the Government can keep Parliament informed.

The member asked about the business programme. The Parliament's business programme and, indeed, requests for ministerial statements are matters for the business managers in the first instance, so I suggest that Mr Hume raises the issue with his representative on the Parliamentary Bureau. As we have often said, the Presiding Officers cannot require the Scottish ministers to make statements to the chamber.

Decision Time

17:02

The Deputy Presiding Officer (Elaine Smith): There are three questions to be put as a result of today's business. The first question is, that amendment S4M-05444.2, in the name of Richard Simpson, which seeks to amend motion S4M-05444, in the name of Michael Matheson, on Scotland's mental health strategy, be agreed to. Are we agreed?

Members: No.

The Deputy 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)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
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)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Milne, Nanette (North East Scotland) (Con)
Murray, Elaine (Dumfriesshire) (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)
Scott, Tavish (Shetland Islands) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

Smith, Drew (Glasgow) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, David (Highlands and Islands) (Lab)

Against

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)
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)
Ewing, Fergus (Inverness and Nairn) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
Finnie, John (Highlands and Islands) (Ind)
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)
Lochhead, Richard (Moray) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk East) (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)
Neil, Alex (Airdrie and Shotts) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)
Robison, Shona (Dundee City East) (SNP)
Russell, Michael (Argyll and Bute) (SNP)
Salmond, Alex (Aberdeenshire East) (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)
Urquhart, Jean (Highlands and Islands) (Ind)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Wilson, John (Central Scotland) (SNP)

The Deputy Presiding Officer: The result of the division is: For 53, Against 60, Abstentions 0.

Amendment disagreed to.

The Deputy Presiding Officer: The second question is, that amendment S4M-05444.1, in the name of Jim Hume, which seeks to amend motion S4M-05444, in the name of Michael Matheson, on Scotland's mental health strategy, be agreed to. Are we agreed?

Members: No.

The Deputy 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)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
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)
Henry, Hugh (Renfrewshire South) (Lab)
Hume, Jim (South Scotland) (LD)
Johnstone, Alex (North East Scotland) (Con)
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)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Milne, Nanette (North East Scotland) (Con)
Murray, Elaine (Dumfriesshire) (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)
Scott, Tavish (Shetland Islands) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, David (Highlands and Islands) (Lab)

Against

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)
Ewing, Fergus (Inverness and Nairn) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
Finnie, John (Highlands and Islands) (Ind)
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)
Lochhead, Richard (Moray) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk East) (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)
Neil, Alex (Airdrie and Shotts) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)
Robison, Shona (Dundee City East) (SNP)
Russell, Michael (Argyll and Bute) (SNP)
Salmond, Alex (Aberdeenshire East) (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)
Urquhart, Jean (Highlands and Islands) (Ind)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Wilson, John (Central Scotland) (SNP)

Abstentions

Harvie, Patrick (Glasgow) (Green)
Johnstone, Alison (Lothian) (Green)

The Deputy Presiding Officer: The result of the division is: For 51, Against 62, Abstentions 2.

Amendment disagreed to.

The Deputy Presiding Officer: The third question is, that motion S4M-05444, in the name of Michael Matheson, on Scotland's mental health strategy, be agreed to.

Motion agreed to,

That the Parliament welcomes the publication of Scotland's Mental Health Strategy; recognises the challenges that Scotland, in common with other western nations, faces in tackling mental ill-health; notes the significant progress that has been made in mental health improvement, improving mental health services and reducing suicide, and believes that the priorities identified in the strategy will build on and increase the pace of change in mental health in Scotland.

Meeting closed at 17:05.

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