Citizen Participation and Public Petitions Committee

2nd Meeting, 2023 (Session 6), Wednesday 8 February 2023

PE1871: Full review of mental health services

Lodged on	21 June 2021
Petitioner	Karen McKeown on behalf of Shining lights for change
Petition summary	Calling on the Scottish Parliament to urge the Scottish Government to carry out a full review of mental health services in Scotland to include the referral process; crisis support; risk assessments; safe plans; integrated services working together; first response support and the support available to families affected by suicide.
Webpage	https://petitions.parliament.scot/petitions/PE1871

Introduction

1. The Committee last considered this petition at its meeting on 21 December 2022. At that meeting, the Committee took evidence from the Cabinet Secretary for Health and Sport and agreed to consider the evidence heard at a future meeting.

2. The petition summary is included in **Annexe A** and the Official Report of the Committee's last consideration of this petition is at **Annexe B**.

3. Written submissions received prior to the Committee's last consideration can be found on the petition's webpage.

4. Further background information about this petition can be found in the SPICe briefing for this petition.

5. The Scottish Government's initial position on this petition can be found on the petition's webpage.

Action

The Committee is invited to consider what action it wishes to take.

Clerk to the Committee

Annexe A

PE1871: Full review of mental health services

Petitioner

Karen McKeown on behalf of Shining lights for change

Date Lodged

21/06/2021

Petition summary

Calling on the Scottish Parliament to urge the Scottish Government to carry out a full review of mental health services in Scotland to include the referral process; crisis support; risk assessments; safe plans; integrated services working together; first response support and the support available to families affected by suicide.

Previous action

I have contacted my MSP Monica Lennon who raised the issue at first minister questions. I also met with Clare Haughey MSP, then Minister for Mental Health, and raised my concerns.

Background information

My partner Luke Henderson died by suicide in December 2017 after asking for help up to eight times in the week before his death. I feel mental health services and the risk assessment failed Luke in his hour of need.

Luke’s situation is not unique and now families are joining together to push for a fit for purpose mental health service. All these families had someone who tried to access mental health service prior to their deaths and were turned away with no help, resulting in them taking their own life.

With so many people slipping through the crack, we want a fit for purpose mental health service to ensure no other families feel this pain.

The review should also look at the process for people who died by suicide and had been in contact with mental health service within seven day prior to their death and support service for families who lost a loved one to suicide.

Annexe B

Extract from Official Report of last consideration of PE1871 on 21st December 2022

The Convener: Good morning and welcome back to the final meeting of the Citizen Participation and Public Petitions Committee in 2022.

We considered new petitions prior to moving into private session; we now move to agenda item 5, which is consideration of continued petition PE1871, which was lodged by Karen McKeown on behalf of the shining lights for change group. The petition calls on the Scottish Parliament to urge the Scottish Government to carry out a full review of mental health services in Scotland, which should include consideration of the referral process, crisis support, risk assessments, safe plans, how integrated services work together, first response support and the support that is available to families who are affected by suicide.

The committee will recall that we heard very affecting testimony from Karen McKeown about the personal circumstances that led to the petition and the changes that she wishes to see being made to mental health services. We thank her again for lodging the petition and for taking the time to meet us.

We are joined by Humza Yousaf, who is the Cabinet Secretary for Health and Social Care. We are also joined by officials from the Scottish Government. Hugh McAloon is director of mental health, Gavin Gray is deputy director in improving mental health services and Dr Alastair Cook is principal medical officer. Good morning thank you all for joining us to give evidence.

We are also joined by Monica Lennon MSP, who is here in support of the petition. I will invite her to contribute, subsequent to our hearing the cabinet secretary's evidence.

Cabinet secretary, we are happy to move to questions, but I am also happy if there is anything that you would like to say to us before we begin questions.

The Cabinet Secretary for Health and Social Care (Humza Yousaf): I will make a brief statement, if I may, convener.

The Convener: Please do.

Humza Yousaf: I will not take up too much time in my opening remarks. I am keen to hear from members and to allow as much time as possible to take questions.

However, first and foremost, I want to reiterate what you said, convener. I read Karen McKeown's testimony. It was very moving and I offer my sincerest condolences to her for the sad passing of her partner. The passion that she has brought to the issue is a fitting tribute to her late partner, Luke. I am grateful to her for coming to the committee.

I hope that it is clear that the petitioner and the Scottish Government want the same outcomes, although we might not necessarily agree absolutely on how we get to them. I suspect that that is the same for everybody at the table.

We want a mental health system in which, first of all, we can intervene as early as possible before a situation needs crisis intervention, and in which the person does not have to repeatedly tell their story. We heard that clearly from Ms McKeown over and over again. Luke asked for help eight times, I think, before he got the support that he required. We want a responsive system, in which all partners work together at every level of need. That should apply to signposting to help and advice, access to support in our communities, provision of the right support to people who are in distress and, importantly, delivery of specialist mental health support and services where that are necessary and critical.

Our forthcoming mental health and wellbeing strategy will be key in setting out not only those aspirations but how we will achieve them. We will publish that strategy in spring 2023. It will set out what every member of the public is rightly entitled to expect when they ask for help in relation to their mental health. I want our strategy to act as a blueprint for a high-functioning mental health system in respect of how we respond to all levels of need. We expect the system to act responsibly. Nobody—I emphasise that—should have to struggle in the way that Luke had to struggle, or to fight for the help that they need. The earlier that we can get people the right support, the better will be our chances of having better outcomes and stopping issues from escalating.

At the heart of the work, especially on our new strategy, must be a focus on reducing stigma, on prevention—including suicide prevention—and on involving the voices of lived experience at every level. That came over strongly from the petitioner and it resonates with many people.

I will get into the finer detail of that, convener, but I am happy to leave it there for now and to end where I started, which is to acknowledge Karen McKeown's passion, drive and bravery, and to commend her for a petition that is of fundamental importance.

The Convener: Thank you very much, cabinet secretary, and thank you for your sympathy for, and the comments that you have expressed to, the petitioner. The petition was difficult to read. It was equally difficult to hear the real-time experience of the petitioner, and I know that the sentiments that you have expressed are shared by us all.

Perhaps you could, as we proceed, indicate when you would like to include your colleagues in responses to questions. I will leave that to your discretion. If they wish to intervene at any point, I ask them to do so. We try to keep proceedings relatively informal in order to have as productive a discussion as possible.

I have an introductory question. I am intrigued to know what factors you think were responsible for the fall in the number of suicides that we saw during the pandemic?

Humza Yousaf: I will perhaps hand that question over to clinical colleagues and others. We have certainly had that discussion. It is very difficult to say and, given that we are still not quite out of the pandemic, it is challenging to do so.

In relation to mental health, one of the key concerns that I and, I think, every member at table had was about access, or lack of access, to services during the pandemic. We have put a lot of work into suicide prevention. Even at the most difficult times during the pandemic, when we were under significant legal restrictions, we still tried to ensure that vital services—in which I include suicide prevention and mental health services—were as accessible as possible.

Of course, suicide prevention has been a mission of this Government for many years, and we see some positive signs that things are going in the right direction, if we look at recent trends, but we are nowhere near where we want to be, which is why we have the suicide prevention strategy that was co-designed with the Convention of Scottish Local Authorities. Alastair Cook might want to come in on that.

Dr Alastair Cook (Scottish Government): We have an academic group that supports the work of the national suicide prevention leadership group. Initially, there was a little bit of surprise from the academics about the direction in which things were going. Given the difficulties of lockdown and some of the figures that we were seeing around increased suicidal thoughts and so on within the population, the expectation was that we might see a rise. However, internationally there appears to have been a decrease.

At this stage, we are theorising about, rather than understanding, why that would be the case. Certainly, with historical patterns of suicide rates, you tend to see increases in suicide at times of greater disparity within populations, so perhaps the sense of coming together that there was during the pandemic had an impact on some people. However, again, that is theory rather than something that is based on research or on work in academia.

Humza Yousaf: One of the other theories—Alastair Cook is right to describe them as theories at this stage—was that in the early days of the pandemic and throughout the really difficult periods, we saw a real groundswell of local activity in terms of third sector support and help. I think that we could all testify to that, and it still exists to an extent. I certainly remember that, at the beginning of the pandemic, it just sprung up organically. Therefore, people might have had access to services in ways that now, as people get on with the jobs that they would normally have done, do not exist as much. Again, that is one of the discussions that we have had.

The Convener: Certainly, the initial questioning in Parliament included issues such as domestic abuse and suicide. People were concerned that the prolonged lockdown might have—in some cases, it did have—a negative impact. As you said, we are only theorising at the moment, but perhaps the fact that people's experiences were not so different or isolating, in the sense that they were part of an experience that everybody else was sharing, made some things easier to bear or to deal with.

Paul Sweeney: I note the comments that have been made so far about trying to understand the reasoning and the causal factors behind the figures. Nonetheless,

“Scotland’s Suicide Prevention Action Plan: Every Life Matters” from 2018 set a target of a 20 per cent reduction by this year. Although we do not have the figures for this year, the trend broadly suggests that the target is unlikely to be met. Why will it not be met?

Humza Yousaf: You are right to suggest that we need to wait for the figures, and I do not disagree with your assumptions around the issue. We will always set ambitious targets to stretch ourselves in order to ensure that we are going as far as we can.

I commend to you the most recent strategy that has been developed in conjunction with COSLA. I am certain that Paul Sweeney will, if nothing else, have seen and skimmed through it. “Creating Hope Together—Scotland’s Suicide Prevention Action Plan 2022-2025”, which is the long-term suicide prevention strategy and action plan, looks at the trends over past years and asks how we can improve. We have a goal in the plan to reduce the number of suicide deaths in Scotland while, importantly, we tackle the inequalities that, as Dr Cook mentioned, contribute to suicide rates. That is why we were so keen to produce the strategy alongside COSLA.

We have not managed to go as far as we wanted on reducing suicide deaths, but there has been positive progress. The new strategy takes into account the good that we were doing, and says where we need to go further, how we can work with local partners and, importantly, how we can further reduce inequalities, because we know that disparities and inequalities are, beyond a shadow of a doubt, disproportionate contributing factors in respect of deaths by suicide.

Paul Sweeney: I accept that not everything to preserve life in all circumstances is within the gift of the Government. That is obvious, but the Government can, nonetheless, have a positive influence in terms of trying to ameliorate the effects in some areas and moving towards that target. To that end, what assessment against performance has there been of workstreams or activities in the plan? Which areas are showing promise and which are showing difficulty? I am interested to get more insight into where you see the plan achieving the greatest impact and which areas are harder to deliver in.

Humza Yousaf: That is a really good question. There are a few areas to mention. As you will see from the most recent strategy, which was, as I said, co-designed with COSLA, there is a significant focus on tackling the social determinants of suicide.

Literature upon literature and academic research after academic research makes the link between social determinants such as the inequality that exists and the unfortunate completion of suicide. We are working exceptionally hard on the issue, but we can do more in that workstream.

You will also see in the strategy that a lot of work is being done on pre-crisis intervention—getting to people before their situations escalate to becoming specialist mental health challenges.

Regarding my assessment, it might be better to take that off the table and to get an answer to you in writing with more detail on each workstream and the assessments that have been made. The most recent published strategy, “Creating Hope

Together", gives a good indication of what we think has worked and of where we need to go further collaboratively with local partners. I hope that you get the chance to look through the strategy in detail.

Does Hugh McAloon or anyone else want to come in to add to what I have said? I know how involved you were in the strategy with COSLA.

Hugh McAloon (Scottish Government): The thinking on targets in that area has moved on since the previous strategy: you will see that there is not a specific target. There are a few reasons for that. We were led by stakeholders, who were heavily involved in the development of the new strategy. Their view was that the complexity of suicide is such that looking only at headline numbers can be a crude measure. All in all, setting a target might indicate to some people who lose loved ones through suicide that if we are below that target the problem matters less but, of course, it does not.

At the local level, population sizes vary so much that there will be variation in the numbers, so there are technical reasons, but there are also important matters that relate to the people who are left behind and how that feels. The view of the group was very much that we should continue to monitor the overall headline figures, among a range of other outcomes. That is the direction that the group took.

As the cabinet secretary said, we can get back to the committee on evaluation against the workstreams from the previous strategy, if the committee would find that helpful.

Dr Cook: One of the areas in which we are making real progress is the response to suicidal ideas and people coming in when they are in crisis. The work on that is headlined "Time, Space and Compassion" and that new approach chimes with what we have heard from stakeholders and people with lived experience. The approach is also hugely welcomed by the clinical community because it is trying to be less binary than the approach that was taken in the past might have been, when the question was, "Are you ill and in need of a secondary mental health service?" The "Time, Space and Compassion" approach acknowledges that people are there because they are in distress, and that we need to have a range of responses. The new suicide prevention strategy and the mental health strategy will take us in that direction.

Paul Sweeney: It is quite promising if there are signs that the crisis element can be practically addressed in a holistic way. From experience of dealing with veterans, for example, I know that people were just getting passed around and no one seemed to be taking ownership of the situation, which led people into despair and suicide.

The approach sounds promising, although I accept that something like the increase in interest rates and the consequent financial pressures, for example, could increase suicide figures, but that is not necessarily within the gift of a Government policy.

Hugh McAloon: Some of that aligns with the general direction of our mental health policy. There will always be people who experience mental illness; they deserve a high-quality clinical response.

We are seeing more and more people for a number of reasons, including what we have been through in the past few years and what people are going through now in the cost of living crisis. A wide range of factors can ramp up emotional distress. From a clinical point of view, we might think that someone does not have a particular mental illness, but they are probably at risk of suicide or suicidal ideas because they are distressed by factors that impact on their wellbeing at a point in time, which can come and go.

A lot of our focus has therefore been on what we can do to respond when people experience emotional distress. We are talking about things such as distress brief interventions, which have been in development for a number of years, and access to the NHS 24 mental health hub. Those are things that people can access, but sometimes people cannot wait for an appointment and sometimes the key point of their distress takes place within a very contained period of time.

We see that in the petition: a person was experiencing serious distress over the course of a week. It might not have been based on anything clinical but, tragically, it shows where such distress can lead. We need a balance. That is true of a wider range of issues than the risk of suicide, but when distress is heightened at that stage, we want a range of interventions to help people to manage it better.

Paul Sweeney: Convener, may I ask a brief supplementary question?

The Convener: You may, Mr Sweeney.

Paul Sweeney: How do the strategies interact with the national mission on drugs? From personal experience, I have discovered that a suicide completion might not be intentional but, in some instances, there is indifference to being alive. The person might be ambivalent to it, and that is characterised by their indifference and reckless behaviour. When there is a request for treatment or support, it is often not forthcoming or their referral to a mental health service might be weeks away. Is there any interaction between the strategies and the national mission on drugs?

Humza Yousaf: Absolutely. Angela Constance and I meet and talk regularly about this.

I should have said from the outset that I am grateful to Paul Sweeney for speaking about his own mental health issues. I know that other members have also done so in the past, and I think that it is important for us to do that. It is not incumbent on us—we do not have to do it and we do not necessarily owe it to people—but, given the platforms that we have, the more that we can talk about such things, the more that we can, I hope, reduce the stigma around mental health issues. I am grateful to all members who have done that.

Medication-assisted treatment standard 9 is key. MAT standard 9 is the expectation that all people with co-occurring drug use and mental health difficulties will receive mental health care at the point of the MAT delivery. As always, some local authorities are doing better than others, but we have asked all local authorities to submit their implementation plan to the Scottish Government, setting out how they will embed all 10 standards across the piece in their area.

As you can imagine, we are monitoring that very regularly. I am doing it monthly, where necessary, or quarterly. Local authorities that are doing well in that regard will have less monitoring and supervision. As you can imagine, where we see issues with regard to that MAT standard—all MAT standards, but MAT standard 9, in particular, is relevant to your question—we are monitoring those local authorities very regularly and having conversations about that. Obviously, that is also backed by a commitment to multiyear funding.

David Torrance: Good morning, cabinet secretary. In evidence to the committee, the petitioner stressed that measuring and evaluating the performance of plans and strategies is crucial. When will the outcomes framework for a new suicide prevention action plan be published? Can you tell the committee more about the work that is taking place to develop the outcomes of the framework and how it will be used?

Humza Yousaf: I will address the general issue and come back to the specific question.

It has been my view since I came into post that, although we have a suite of quality standards for measuring and monitoring outcomes for child and adolescent mental health services, we do not have similar for adult mental health services, so there is a gap. A range of work is on-going to develop that suite of quality standards to improve the quality and safety of mental health care and support, which definitely includes adult secondary mental health service standards and the delivery of psychological therapies, interventions, eating disorder standards and so on.

Hugh McAloon might have the specifics with regard to the dates and our intentions in relation to the outcomes framework. Because we have co-designed the strategy with COSLA, we are trying to ensure that anything that we do in that space is done collaboratively with COSLA and local authorities.

Hugh McAloon: I do not have a specific date, but we can come back to you with more specific information. As we develop and roll out the delivery plan alongside the strategy, there will be regular evaluation, monitoring and review against those outcomes. There is a programme of work and we can provide more detail, but—I am sorry—I do not have specific dates.

David Torrance: The final report of the Scottish Mental Health Law Review was published in September 2022 and made more than 200 recommendations. Can the cabinet secretary provide an update on when we can expect the Government's response to that report?

Hugh McAloon: As you are aware, it is a wide-ranging, extensive and very detailed report that runs to about 1,000 pages. We are starting work with a range of stakeholders to assess that to establish the order in which we might do things, the further work that we might have to do in some areas and the priority that we will attach to various steps in what will be a long-term programme of work to align mental health law with equality and human rights law. Our intention is to produce our initial response probably before the summer recess. As I said, we are working with a range of stakeholders, some of whom were involved in the review. In part, that is in order to fully understand how they saw the work being taken forward and the various aspects

linking together. It is very complex, but we are looking to come forward with something on that before the summer recess.

Alexander Stewart: I will touch on the issue of access. The Scottish Government set the standard of 90 per cent of individuals being referred within 18 weeks. That is not being achieved—the most recent statistics, from September 2022, showed a figure of 80.7 per cent. When does the Scottish Government see the opportunity to reach that standard of 90 per cent, and what is it doing to support that aspiration?

Humza Yousaf: Obviously, we have publicly said that we are attempting to reach that target by March 2023, which will be challenging—it is an ambitious target, to go back to my previous point. We will set ourselves those ambitious targets in order to push the entire system to help us to meet them.

It is a common theme, I know, but, although I am confident that some health boards will meet that target, there are other health boards—including one of the health boards that the member has cited regularly to me—that are very unlikely to achieve that target, so we are giving them more intense support and getting improvement plans from them. We are not accepting the fact that they will not meet the target by March 2023, but we are saying, “How can we help you to get there or as close to there as possible?” There are a myriad of challenges. As the member knows, although we have done well on workforce recruitment, that will be different in rural areas, urban areas, island communities and so on. That target for spring next year will be challenging, but I am committed to doing everything that we can to get us there.

Alexander Stewart: You have touched on population issues. We know that NHS boards with larger populations have mental health assessment units that are available 24/7. That is really useful for larger populations, but the issue is in trying to evaluate these services, cabinet secretary. Is the Scottish Government looking to make it much more of a national service? You have touched on the issue of rural areas, where, as you have identified, it is a much bigger challenge for you to make that happen. There is a disparity between what happens in urban areas and what happens in rural areas, which do not have the same support and opportunities, and patients might fall through the gap.

Humza Yousaf: Alexander Stewart understands that urban areas and large population centres have their own challenges. Urban areas often have areas of higher deprivation in large concentration. We have talked about those social determinants that can have negative outcomes for people’s physical and mental health. Urban areas have their own challenges—as do remote, rural and island communities—which are usually centred around access to services, as he rightly says, but also the workforce, which is not unrelated to that point, and the recruitment and retention of the workforce.

I should say that NHS 24 has a mental health hub—as, I am sure, the committee is aware. There were some challenges when it first started, but we saw improvements across all the metrics in 2021. The demand for the NHS 24 mental health hub has remained consistently high—I spoke to the chief executive a couple of weeks ago—and the service has not seen much of a dip since July 2020. There have been peaks

and troughs, as you would imagine, but demand has been consistently high at more than 2,500 calls per week, and thus far it has responded to more than 200,000 calls.

We will continue to invest in local services. In remote and rural areas and island communities, in addition to ensuring that people have access to the important statutory services, I am particularly keen that we work closely with the third sector, which has an important role to play. It plays that role across the country, but, in remote and rural areas of Scotland, we can utilise the third sector to help us with some of the challenges around access. That is not to say that statutory services should not do what we need them to do, but there is an ability to use and invest in the third sector more than we currently do.

Alexander Stewart: You mentioned suicide bereavement services. There are pilot schemes in Ayrshire and Arran and in the Highland health board region, and there is the potential for a more widespread or national service across Scotland. Are there plans for that, and can you outline what other forms of support are available to families who are affected by suicide? What further developments are planned to try, once again, to bridge the gap?

Humza Yousaf: Hugh McAloon will come in on some of the specifics. We will, of course, evaluate the projects that Alexander Stewart rightly cites and look to see how we can upscale them.

I am the first person to say that, far too often within Government, we suffer from pilotitis—the inability to go from a pilot to upscaling. We have to be better at that, and I think that we are getting better at that. If the pandemic taught us anything, it is about the need to have a slightly bigger risk appetite in relation to upscaling things. Not everything will work when you upscale it, but the desire for perfection should not get in the way of progress. There may well be faults and glitches that we will have to work through, but, generally speaking, we should be able to upscale far more quickly than we currently do when things are going well.

On the other matters that you raise, a lot of that is within the strategy that we referenced. Can you remind me of your very last question?

Alexander Stewart: It was about the further developments that are planned and about how families who are affected by suicide are supported.

Humza Yousaf: Obviously, we want to prevent as many suicides as we possibly can. That is a core part of the strategy. A lot of work is going on with the third sector in relation to the support that we can offer to families that have suffered—and not just families, as we understand that suicides have an impact on entire communities. In my Glasgow Pollok constituency, throughout the course of the pandemic, there were a number of tragic cases of young men and women completing suicide, and entire communities were rocked by that.

We will be working on the bereavement support, but a lot of the work is on the preventative side and, because the statistics tell us that a disproportionate number of young males are completing suicide, a lot of focus is going into that space. Hugh McAloon can say a bit more on the pilots.

Hugh McAloon: As you are probably aware, the evaluation of the first year of the pilots has been published and we have moved into the second year of funding those pilots. We are working with the national suicide prevention leadership group to implement what we have learned from the first year in the second year. That work will be guided particularly by the lived experience panel and the youth advisory group. There is work going on to further enhance what we are getting from those pilots, and we will then look at what we can do to extend those further.

Humza Yousaf: It is very important to come back to what the petitioner said. I do not want there to be any illusion that we do not think that bereavement support can be improved, because the petitioner made it very clear that they do not feel that such support was there for them or their family. Although there is support—we can give details of that—I do not want there to be any misunderstanding that we do not think that that support can be improved.

The Convener: You referred to the petitioner's courage and obviously we very much felt that courage in the evidence that she gave. We explored with Karen the aspect of what happens in an acute situation—if somebody has a heart attack or if somebody is having elective surgery, it is clear what to do, but in the hierarchy of mental health services, what do you do? Karen said that when, in a crisis, "you phone NHS 24 to get help for mental health or speak to an out-of-hours doctor or anything like that, you are told either to contact the police if you feel that you cannot keep yourself or someone else safe, or to attend accident and emergency"

I think that she very much felt that attending accident and emergency with people who were attending for physical health reasons, not mental health reasons, was not the appropriate place to be in those circumstances at all. What are your reflections on that point?

Humza Yousaf: You will know, convener, that I was Cabinet Secretary for Justice before I was in this role. It is a real failure—I do not use that word lightly—in our approach to have police officers attending somebody who is in distress and be with them for five hours. That is not good for the individual who is suffering that distress, because the police officer—who will do an excellent job, given the circumstances—would be the first to say that they are not the best person to help with mental health needs. It is not the best use of the police officer's time, and it is not the best approach for the individual involved. It is not good for the system as a whole in relation to the response that we are giving to people. In itself, it is a failure of approach and lays bare some of the failings that the petitioner spoke about when she gave evidence on Luke's case. I know—I do not suspect—that Luke's case is not an isolated one.

We often talk about mental health being on a par with physical health and, from the Government's perspective, that is true in terms of priority, but I do not think that we see the evidence of that cascading through the entire system. The example that you give is good, which is why we have in recent years set up the NHS 24 mental health hub, so that people have access nationally to clinical specialists for the mental health distress that they face.

I go back to the common theme of pilots. A number of pilots that we have run across the country—some of which have now been evaluated—have shown us a much

better model. I think back to the one in Govan in the south of Glasgow, where, if a call came into the police because somebody was worried about the possibility of another person seriously harming themselves, the police officer would go with a specialist community psychiatric nurse to attend the incident. I will not quote exact figures, but if I remember correctly, the amount of officer time that was then spent on such a situation reduced by more than half.

Perhaps I would be better passing to Dr Cook, who will be able to answer your question from a clinical perspective.

Dr Cook: We have been doing a lot of work around unscheduled care pathways for mental health, and the NHS 24 hub has been referred to as the starting point for many people, but many also attend accident and emergency or emergency departments.

Over the past year, we have ensured that in every health board area in Scotland there is a senior clinical decision maker—we use that term because the role is filled by different people in different places; in many places it is a nurse and in some places it might be a doctor—so that NHS 24 can make that contact.

The rationale for that is that, for some people, attendance at hospital and assessment by specialist mental health services may be exactly what they need, but, for others, there may be a requirement for other services, such as distress brief intervention, which we have described before. We want to ensure that there is a clear pathway that can avoid the need for people to come into the emergency department as the first port of call, while acknowledging that some people do that anyway and can therefore be picked up from there.

The Convener: The petitioner was not able to give the latest figure for people presenting at A and E, but it was quite a high number of incidents. I think that she had figures that showed that around 600 people had done so.

Obviously, Karen’s experience very much influences the view that she has of everything that Luke experienced. I do not want to be superficial or to react to an individual circumstance, but she felt that there was an impression or a suggestion that the risk assessments that had been done had partly been coloured by a desire to play down the likely seriousness of the issue rather than to escalate it, and that there was a drift to try and achieve that. She is not pointing to Luke’s case in isolation, but she feels that that meant that his higher risk status was not recognised at a point when something could have been done. It is very easy to generalise or not to really know, but what is your sense of that?

Dr Cook: Risk assessment is not an exact science. The risk assessment tools that have been introduced to support mental health decision making are inexact. They can be helpful in bringing people towards a decision but, ultimately, clinical judgment needs to come into it.

The sense of downplaying can be misinterpreted to some extent. As a clinician, I would always try to find a way to get somebody the help and support that they need without the situation escalating into hospital admission or, ultimately, detention under the mental health legislation. You would always look to use the least restrictive

option. From a clinical perspective, the aim would always be to try to manage the situation with the least restriction and the least intervention but, clearly, if a risk assessment indicated a high level of risk and a lack of immediate safety, you would look to find a safe option and the only one might be admission to hospital.

The Convener: Monica Lennon is not here to take evidence from the witnesses, so I ask her whether there is anything that she wants to say to the committee that the cabinet secretary can hear and that might he want to touch upon in any final remarks that he wants to make.

Monica Lennon: Thank you, convener. I am grateful to have the opportunity to be here in support of Karen McKeown, the petitioner. As everyone knows, Karen's partner, Luke Henderson, died by suicide in December 2017, so this is a difficult time for her, her children and the wider family.

We meet at a time that can be difficult for many of our constituents. Many of us welcomed the opportunity to take part in a debate in Parliament on male suicide. That debate will now have to wait until the new year but the issues are of concern to all of us.

I am grateful to the committee because the session with the cabinet secretary and his officials has been great in the sense that he is not trying to put any spin on the matter. I know that he is sincere about the challenges. It was reassuring that, at the beginning, he said that, although there might be a different outlook about the process for getting there, he, the Government and Karen McKeown want the same thing.

To be frank, one suicide is one too many. We can examine the numbers and data, which is important—targets have a role to play because we have to monitor progress—but we are all here because we want to save lives.

Committee members have asked pertinent questions, including about the wider impact on families and communities. I have been scribbling some notes. We are rightly focused on what happens within the NHS—primary care, access to general practitioners, NHS 24, mental health harms and so on—but there is a wider piece of work to do. Therefore, it is good that the committee has kept the petition open.

I have made notes about employers and education because we all have to become more literate about mental health. To be frank, I struggle to signpost constituents to the right place as a regional MSP working across two different health boards and three different local authorities. Pilot schemes are welcome, but it can be difficult to know what the pathway is. All the MSPs sitting in this committee room might have different systems and procedures to which to point people.

Karen's partner Luke had a history of mental illness. She has highlighted the point that she and Luke knew how to ask for help, so they did the right things. They reached out many times and still could not get the help that they needed. I welcome the work that is in the pipeline for next year and do not doubt the good intentions of the cabinet secretary and the Government but we have serious problems with resourcing and workforce, of which the committee is well aware.

I want to pay tribute to the workforce because what I am seeing increasingly is a workforce that is struggling, and that is having an impact on their mental health and wellbeing. We have to be honest about that.

The cabinet secretary is absolutely right and it is good to hear that he can take a wider view because of his background in justice and so on. Karen McKeown and I met the former Minister for Mental Health, Sport and Wellbeing after I raised this tragic case with the First Minister a number of years ago, and we talked about some of the issues that Paul Sweeney has gone into today, such as drug disorders and alcohol. We have not talked about alcohol but it is a big issue. Clare Haughey, who was the minister at the time and had been a mental health professional, told us that the strand of work was for her public health colleague and she was the mental health minister. We must get away from that siloed thinking, and we are seeing some progress on that.

The petition is so important because the constructive challenge needs to continue, and I am sure that the cabinet secretary would welcome that. We do not yet have answers about resourcing and how we are going to deliver on the good intentions. That is what Karen McKeown talks about in the petition. Without going into detail about individual constituents and others in different parts of Scotland, I know people who, this week, phoned their general practitioner to try to get an appointment to discuss their mental health and the fact that they are struggling dozens of times, even over a hundred times, in two days. Colleagues have previously raised that issue with the cabinet secretary in the chamber and it is the reality. How do we close the gap between what we want people to think is on offer for them to have hope and know that they are not alone and the reality of the waiting times that some people experience? I have lots of statistics here about people in Lanarkshire, for example, who are waiting for several months, if not years, for psychological therapy. We need to go into granular detail about how we are going to do that.

Again, like everyone else, I pay tribute to Karen McKeown. I know that she is listening today because I am looking at my phone and I see that she has been messaging me. This is a difficult time for families with lived experience, but I hope that they know that we, as a Parliament, are taking the issue seriously.

The Convener: I would like to comment on the sincerity and sensitivity with which everybody has addressed the issues this morning. It has been a constructive discussion. Would like to say anything in conclusion, cabinet secretary?

Humza Yousaf: Convener, we will go through you to give the committee some of the information that members—David Torrance in particular—have asked for, and it can be cascaded to other committee members.

I started my opening contribution by thanking Karen McKeown for her bravery. I have not met her, but I would be happy to speak to her directly if Monica Lennon wishes to get in touch with my office about it.

I want to give the committee and, I hope, Karen an assurance that nobody in Government, certainly not me as the Cabinet Secretary for Health and Social Care, comes to the issue with defensive walls up and saying, “This is all the great stuff that we are doing.” That said, a lot of good work is being done by the workforce. For

example, child and adolescent mental health services is seeing more people than it has ever seen before, but the demand is huge.

Nobody is coming up with defensive walls and saying that we have got it all right, that it is fine, and that people are only being failed here and there as a result of the odd exception. We are saying that there are some serious systemic issues, some of which were there before the pandemic and have been exacerbated by the pandemic, and joint work is being done across the Government to address some of those issues. It will take time but I do not want anybody to have the experience that Luke did, and we will do everything that we can through the implementation of our suicide prevention strategy to make sure that we reduce the number of suicides in Scotland in the years to come.

As I said, convener, I am happy to follow up in writing some of the issues that have been raised that we have not been able to give additional detail on today.

The Convener: Cabinet secretary, thank you to you and your colleagues for joining us this morning. I very much appreciate it.

Colleagues, are we content to consider the evidence at a subsequent meeting?

Members *indicated agreement.*