OFFICIAL REPORT
AITHISG OIFIGEIL

Public Audit Committee

Thursday 9 November 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 9 November 2023

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PUBLIC AUDIT COMMITTEE

28th Meeting 2023, Session 6

CONVENER

*Richard Leonard (Central Scotland) (Lab)

DEPUTY CONVENER

*Sharon Dowey (South Scotland) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*Graham Simpson (Central Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jo Anderson (Scottish Association for Mental Health)
Paula Fraser (Voices of Experience Scotland)
Peter Kelly (Poverty Alliance)
Dr Shari McDaid (Mental Health Foundation)
Simon Porter (Royal Edinburgh Hospital Patients Council and Voices of Experience Scotland)
Meriem Timizar (International Women's Group and BEMIS)
Kirsten Urquhart (Young Scot)

CLERK TO THE COMMITTEE

Lynn Russell

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Public Audit Committee

Thursday 9 November 2023

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Richard Leonard): Good morning. I welcome everyone to the 28th meeting in 2023 of the Public Audit Committee. The first item on our agenda is for committee members to decide whether to take item 3 in private. Is the committee content to take that item in private?

Members *indicated agreement.*

Section 23 Report: "Adult mental health"

09:00

The Convener: Our principal agenda item this morning is agenda item 2, which is further consideration of the Auditor General for Scotland and Accounts Commission report "Adult mental health". I welcome everybody to the meeting—we are very pleased to see you. The committee is taking evidence today in a round-table format, which will allow for a more freewheeling session in which we will draw on the experience of the witnesses and the people whom they represent, both in the room—which I will come to shortly—and online.

For those of you who are online—which is the majority of you—if you want to come in at any point, please request to speak via the chat box; that will assist us in making sure that you are brought in when you want. I also ask you to keep your audio and camera on at all times. Your audio will be operated through the Parliament—we will turn on your microphone for live audio when you want to speak.

As is customary for the round-table format, I begin by asking people to introduce themselves and their organisations. We will go round one by one, starting with Jo Anderson, who is with us in the committee room.

Jo Anderson (Scottish Association for Mental Health): Good morning, everyone. I am the director of influence and change at the Scottish Association for Mental Health. SAMH is Scotland's mental health organisation. We deliver services across Scotland, and we are delighted to have been invited today.

The Convener: Thank you very much.

I turn to the people who are joining us remotely.

Meriem Timizar (International Women's Group and BEMIS): Good morning. I am project co-ordinator of the International Women's Group. We are based in Glasgow and we provide counselling services to ethnic minorities.

The Convener: Thank you, Meriem; that is very helpful.

Paula Fraser (Voices of Experience Scotland): I am acting manager of Voices of Experience—VOX—Scotland, which is a member-led mental health collective advocacy organisation.

The Convener: Thank you, Paula.

Peter Kelly (Poverty Alliance): Good morning. I am director of the Poverty Alliance, which is the national anti-poverty network in Scotland. I am very pleased to be here.

The Convener: Thanks, Peter—we are very pleased to have you here.

Dr Shari McDaid (Mental Health Foundation): Good morning, everyone. I am the head of policy and public affairs for the Mental Health Foundation in Scotland. The Mental Health Foundation is a United Kingdom-wide organisation with a dedicated presence in Scotland, and we focus on prevention of mental health problems.

Simon Porter (Royal Edinburgh Hospital Patients Council and Voices of Experience Scotland): I am from the Royal Edinburgh Hospital Patients Council. We are a collective advocacy organisation in Edinburgh, and I am mainly here in support of Paula Fraser and VOX, as we are a VOX member.

The Convener: Thanks very much, Simon.

Last but by no means least, Kirsten, do you want to introduce yourself?

Kirsten Urquhart (Young Scot): Hi, everyone. I am the chief executive of Young Scot. We are a national youth charity, which supports young people aged 11 to 26. We are a generalist youth support organisation, so we do not have a particular specialism in mental health, but we support young people on a wide range of issues. I am delighted to be here today.

The Convener: Thank you very much. We are very pleased that you are here.

We want to cover some of the ground that the joint Auditor General and Accounts Commission report covered. As I mentioned, if you want to come in, it would be helpful if you could type RTS or “request to speak” in the chat box. Do not feel that you are all obliged to answer every question that we put. If you have a particular hankering to come in, we will come to you, but there might be some areas on which you do not have a particularly strong view.

First, I want to ask a fundamental question that is posed in the report, which is about what people’s experiences are and what challenges they face when they try to access mental health services. I will go to Jo Anderson first.

Jo Anderson: We were very welcoming of the report, and we participated in the process on a number of occasions. The report makes strong recommendations that we hope that the Scottish Government will take forward.

Accessing mental health services is a key feature of the report, unsurprisingly. From what we hear when we talk to people—which we do every day—we know that it is very challenging and often quite distressing for people who are seeking help for their mental health. The pathways are confusing and people have to constantly repeat details of a deeply distressing situation because they have to provide that account each time that they meet a new health professional. There are many messages about the length of time that it might take to receive support or, indeed, about the fact that people might be deemed to be not unwell enough to receive support. Therefore, there is a lot going on in terms of the messages that people receive as they try to access mental health services.

The report highlights that people tend to use their general practitioner as the main gateway to access support. We test on that quite often, and the last time that we did so, about 75 per cent of people said that that would be the first place that they would go if they felt mentally unwell. From the work that we did in that survey, we also know that people wait quite a long time even to reach out to their GP, and their mental health is worsening constantly during that time. It takes a long time for people to get to the point of asking for help, and then they experience confusing pathways and long waits for treatment. Even after someone accesses support in some form, that experience can be quite challenging.

When the pandemic hit, we were most concerned about people who were already in receipt of mental health care and support and what that meant for them, particularly during the lockdowns. We conducted research with people and tracked their situation over the course of the pandemic. Six out of 10 participants in that situation reported challenges in seeking support from GPs and specialist services, lack of consistency in who was delivering that support, challenges with remote delivery, and long wait times to get specialist support. There was also a clear preference for face-to-face support among that population, who already had some experience of mental health care and support.

There is a wide set of issues around the difficulties for people, once they have made the decision to seek help, to then access it.

The Convener: Thanks. The expression that the Auditor General used was “slow and complicated.” Do you think that that sums it up quite well?

Jo Anderson: Yes, it does. There are some good examples of where progress is being made. Maybe we will come to those during the discussion.

The Convener: Yes, absolutely.

I think that Graham Simpson wants to come in.

Graham Simpson (Central Scotland) (Con): Yes. By the way, the witnesses who are online can just put up their hands or whatever they need to do online to come in—it does not all have to be Jo Anderson. However, something that Jo said struck me, because I think that it affects everyone and not just people who are suffering with mental health problems. Getting to see your GP is probably more difficult now than it ever has been.

If someone has a mental health issue—as we all know, there is a broad range of mental health issues—their first step is to get past a receptionist, who they might have to phone up to see their GP. If their GP is anything like mine, they will have to describe their condition, but they might not want to tell somebody who is not a GP that they have a mental health issue. Do witnesses think that that is putting people off even seeking help, let alone getting it?

I suppose the follow-up question is whether the GP is the best person to go to, or whether there is anywhere else that people could go.

The Convener: I will ask Jo Anderson to answer that. I will then bring in Peter Kelly on the same general theme and others who might have a response on the GP gateway point that Graham Simpson raised.

Jo Anderson: Graham Simpson is absolutely right. I mentioned the number of times that people have to describe their situation, and the receptionist is the first place that they have to do so.

People quite often told us—particularly during and after the pandemic—that it is difficult to even get to sit in front of a GP. Often, they feel that there are others with more prominent health problems and that they do not want to put a burden on an already overstretched system. People are reluctant—that might be psychological—if they feel that their situation is not as important as that of others, so they de-escalate based on that.

On whether GPs are the only gateway to getting mental health support, they should not be. We think that community-based direct-referral supports should be widely available, and we have been calling for supports of that kind for some time.

Peter Kelly: I want to pick up on some of the points that Jo Anderson made. In preparation for this session, we did a snapshot survey with Poverty Alliance members on general issues around accessing adult mental health services, and we got around 60 responses.

One thing that struck us from those responses was the increase in more focused approached from community-based third sector organisations. We asked what the change in the representation of mental health issues for those organisations had been since before the pandemic. We found that, before the pandemic, about 15 per cent of those organisations were always dealing with mental health issues. That meant that, when individuals presented, there was always a component of mental health in the reason for their presentation. Now, 40 per cent of the organisations said that they see people presenting with mental health issues every time.

The organisations that we work with have seen a significant increase in the representation of mental issues. Some of them are specialist organisations that work on mental health specifically, but many of them are not; many of them are food banks and advice organisations, and they are having to skill up to deal with the change in nature of the issues that people present with.

I will mention challenges that people face in accessing services that are similar to those that Jo Anderson mentioned. Almost all the respondents talked about the importance of GPs as the initial gateway into receiving help. There are very well-known problems with accessing GP services, and there is an issue about what happens to onward referrals to specialist services, in that people do not always receive a service once a referral is made. That was one issue that was mentioned.

An additional question relates to some of the practical dimensions of accessing services. For a number of organisations that are based in rural parts of Scotland, there are real problems with people finding accessible transport to allow them to engage with services. That acts as a barrier to people receiving the help that they need.

I can say much more on the role of the third sector, but I know that we will pick that up later, so I will leave it there just now.

09:15

The Convener: Thanks, Peter—we will. We will also focus on the unequal impact of health issues. I come to Dr McDaid.

Dr McDaid: The Mental Health Foundation is happy to be partnering with the Poverty Alliance on a programme to build the capacity of the alliance's member organisations to support people's mental health. That programme is in its early stages and is funded by the Scottish Government, so I wanted to acknowledge that.

Peter Kelly's comments link with what we hear about where the gaps are in support. I will highlight two at-risk groups that have not been mentioned so far, although I appreciate that others might come in on these perspectives as well.

I will draw on concerns around black and minoritised ethnic communities that were raised at a round table that we held with organisations that represent those communities when we prepared our submission on the mental health strategy. I will also draw on our experience of hearing from the diverse experiences advisory panel, which has been set up to inform the Scottish Government on its mental health policy and for which the Mental Health Foundation provides the secretariat. From both groups, we heard that there are concerns about individuals in minority ethnic communities knowing how to access services.

There are significant problems with people from minority ethnic communities knowing where to go for help and how to navigate the system. However, we also heard that, when those people come into contact with the system, they are often met with a very white ethnocentric service that does not properly recognise the way that their community talks about and understands mental health and the appropriate way to respond within that community. Although that is mentioned in the mental health strategy and although the delivery plan that was published earlier this week mentions culturally sensitive services, we cannot see any specific action in the delivery plan to deliver culturally sensitive mental health services. That is a significant concern.

Another group that we are working with is lone parents, who are a high-risk group for a number of reasons. Not only do they experience isolation just from the process of being a lone parent but they are much more likely to live in poverty—they are at higher risk of having low income. I connected with my colleague who runs our small talk programme, which works with lone parent organisations. We have heard that, although there is a perinatal mental health service, it is a specialist mental health service and is orientated towards providing a crisis service for individuals or a service for lone parents who have severe mental health problems. However, we do not have provision for new lone parents with mild and moderate mental health problems. That is a huge gap and needs urgent attention.

The Convener: That is helpful.

I will bring in Meriem Timizar next, because I am sure that she will pick up some of those themes.

Meriem Timizar: Dr McDaid mentioned ethnic minorities, and I work with ethnic minority women. The Scottish Government has acknowledged the existence of mental health inequality among ethnic minorities. That disparity primarily comes from an attitude that leads to a lack of culturally appropriate services.

Ethnic minorities experience a language barrier when accessing mental health services. The International Women's Group has provided a counselling service to ethnic minority women since 2014, but we are not able to provide the service to them all.

We face a big challenge on waiting lists because of that. During the pandemic, we started to provide that service in Arabic and English through video contact on WhatsApp. That culturally sensitive multilingual service should be provided within the NHS. That would reduce waiting lists, which make the situation worse for women from ethnic minorities.

The Convener: Are you saying that multilingual information is available or that there is a gap there?

Meriem Timizar: There is a gap. It does not exist. Multilingual information is not provided, so we had to take that action and start providing the service to ethnic minorities. The NHS provides interpreters, but we found that the women were not comfortable with speaking to people such as interpreters and counsellors. They prefer to use their language when speaking face to face to a counsellor.

The Convener: One theme that the report highlights is the alarming rise in mental health issues for young people, which is why we were particularly keen to get Young Scot to give evidence this morning. I ask Kirsten Urquhart to give us her perspective and the perspective of young people on accessing the service and the challenges that young people face in relation to that.

Kirsten Urquhart: Towards the end of last year, we, together with other youth organisations, carried out research with young people around mental health and emotional wellbeing. More than 1,000 young people from the ages of eight to 25 participated. We did survey insight with the older demographic of 12 to 25-year-olds, of which around 35 per cent were over 18, and almost half of those reported that they did not feel good about their mental health and wellbeing. As you said, it is an issue that young people deal with.

It is interesting that some of the insight echoes what Jo Anderson said about access to services. Young people tend to automatically think of their GP as a first port of call, but there are wider issues there. Young people talk about privacy, trust and confidentiality in relation to how they might access services. Peter Kelly picked up issues and barriers around physically being able to access services, transport, affordability and timing of when services are available for young people to access. All those issues come up for young people.

A big part of that is young people's confidence in knowing where and how to access services. More than half of the young people who participated in the survey said that they felt that they could find information about mental health should they need it, but they felt less confident that they would be given the correct information that they need.

Issues around accessing support in school and educational settings also came up. Some young people are concerned about the stigma that could be raised in a school environment in relation to what they are seeking support for—for example, if you want to engage with a counsellor, you might miss a lesson. There is a wide range of issues.

As Jo Anderson was saying, face-to-face appointments continue to be young people's preference in terms of access and support. Digital is an important tool but they look for the same characteristics in online digital support: trust, privacy, the feeling of not being judged and the feeling of safety are a big part of that.

Also, we may come on to talk about digital services but there is a big misconception that, because young people spend a bit more of their time online, they are able to use these digital spaces to access appropriate support. However, going on TikTok is not the same as knowing where to find and how to use a mental health support tool.

There are some big misconceptions in particular of young people's ability to navigate digital tools. It seems like a bit of a catch-all solution for supporting young people but we are hearing that young people want to access support through face-to-face appointments with trusted individuals—trusted adults—in a familiar setting and space. However, we are hearing that, at the moment, they possibly do not feel that confident about accessing those services, so we are hearing very similar themes from children and young people to those that are being reflected in the adult space as well.

The Convener: Thanks, Kirsten. That is very helpful and it is good to dispel some of the mythology about where digital exclusion lies. We have a whole load of other areas to cover so I will turn now to Sharon Dowey, who is the deputy convener, to put some questions about where the demand is and what response there is from the services to that demand.

Sharon Dowey (South Scotland) (Con): Good morning. I want to ask a bit more about the current demand for mental health services. Where is that demand being felt the most among service providers, and how is unmet need being measured?

The Convener: Paula, do you want to come in on that question? I apologise, I know that you wanted to come in on the previous passage of discussion that we had, so please reflect on that first.

Paula Fraser: Okay, I will start with the previous bit first. I echo what Jo Anderson was saying. VOX members took part in Audit Scotland's audit and we also endorse the recommendations in that report. Unsurprisingly, a lot of the themes that came up from that are about access to services. The top priority of our members for a number of years, unfortunately, is around the difficulty that they have in accessing services. Part of that is to do with the long waiting list, but it is also about the communication around how long a wait will be and when or how they will get an appointment. People may be contacted via a phone call and, if they miss that phone call, that is them off the waiting list. People are saying that they are absolutely terrified that, when they finally get an appointment, if it is a phone appointment rather than a face-to-face one and they miss that phone call, they will then not have any access to that service any more. That is what the experience of our members has been, and they have reported that it has got worse since Covid.

Jo Anderson mentioned the issue of eligibility and the idea of capacity. A lot of our members report being told that they do not qualify and they are not eligible to have any support or access the service that they want access to because they are "too well"—they are coping too well, they are too able, they are able to do this or they are able to do that, they are not crying or they are not too upset, and so on, so they are told that they do not need access to the service.

The other thing that can happen is that they have a few appointments with a community psychiatric nurse, for example, and then, after those few appointments they are told, "You are doing fine now—you don't need this support." Our members report that they understand that this is probably to do with a lack of resource and a lack of sufficient workforce to be able to meet the increasing demand. However, for the person involved, that means that they are back to square 1—they do not have the support that they need and they feel that there is nothing to help them maintain wellness. They then end up in a crisis situation again and that just repeats and repeats and costs a lot more money than having those three-monthly appointments with their CPN or whoever it happens to be. That is one of the main things that our members continue to report.

09:30

On face-to-face appointments, our members talk all the time about the lack of choice in that regard. Their appointment sheet or whatever might say that they have the choice of face-to-face or virtual appointments and, of course, some members might prefer virtual appointments as that might help them, but a lot would prefer face-to-face, and they might not be getting that choice. People do not feel that they have agency and choice in the treatment that they are receiving.

As Kirsten Urquhart mentioned, face-to-face appointments are important for building up trust, especially when people are talking about a mental health issue, which is very difficult to do online. It is also difficult for the clinician to pick up well on what is going on with the person and to help them in that way. That was another thing that came across as being really important.

On transport and accessing services, a lot of our members in rural areas report that it is extremely difficult to get an appointment with psychiatry, a community psychiatric nurse or a psychologist, because there are no staff in their area to give them one. People are willing to travel, but it is difficult for them to afford that, and transport arrangements are not in place for them to attend appointments that they would like to attend elsewhere.

On the question about GPs that was asked earlier, a lot of our members are reporting a situation in which it feels like the receptionist is the gatekeeper, and you have to get past them and prove why you need an appointment. Of course, it is very difficult and a bit humiliating to have to talk about that with a receptionist. We hear about that a lot as well.

On the question of unmet need, obviously, our members are in a variety of situations and are reporting not being able to access services. We hear about people having to wait in accident and emergency and people who do not have an in-patient mental health bed to go to. That is one of the situations where there is demand on services. We also hear from our members that there is a two-year waiting list, for example, for them to see a psychologist if they want psychological therapy, and that, particularly in rural areas but also in other areas, there are waits for people to see a psychiatrist.

As I said, there is the on-going situation where people feel that they need a community psychiatric nurse but there is no facility for that to continue. People maybe have only a few sessions and are then told that they are well enough to cope without a CPN, unless they have an extremely serious mental health problem and need depot medication, in which case they may have continuing access to a CPN.

I hope that that answers the question—sorry for going on.

Sharon Dowey: That is great—thank you. I ask Jo Anderson to come in.

Jo Anderson: I have three things to say on demand. There is quite a lot of data that tells us that demand is rising, and the indicators all show that. Obviously, the Audit Scotland report highlighted some of those. Calls to the NHS 24 mental health hub have increased dramatically over the recent period, and the same applies to our mental health information service. We expect to speak to around 7,000 people this year, which is almost double what we were doing before the pandemic. People are reaching out to get information, support and signposting, and the numbers are there.

During the pandemic, the Centre for Mental Health produced a report that suggested that the NHS will need two to three times its current capacity to adequately meet and treat the expected increase in mental health problems resulting from the pandemic. That was a report for England and Wales, but one can expect something similar for Scotland.

All the indicators on the dashboard are flashing and demand is increasing. You can see that in the numbers of people being referred to psychological therapies, for example. Of course, the pandemic brought mental health and wellbeing into sharp focus for all of us—I was talking to the gentlemen outside the room about that before we came in. People are thinking about the issue more, and they are thinking about their wellness, or not. Therefore, one can imagine that that will increase help seeking over time. Frankly, people should be able to just ask once and get help fast—it is as simple as that.

Demand is on the increase. We know that there are some groups that we should be concerned about. The mental health tracker that was run in Scotland during Covid told us that, and colleagues who are participating remotely have described some of the groups whose mental health and wellbeing particularly suffered during the pandemic. Kirsten Urquhart mentioned young people, and others mentioned women and people with pre-existing mental health problems. We should have concern for, and should target support to, all those groups.

Because people are not able to get support through traditional routes, unmet need will be displaced to other places such as workplaces, schools, community groups, sports groups and all the other places where we live our lives. Therefore, we expect that workplaces and other places will need to do a lot more on mental health and wellbeing because people are not able to access support through health services.

Sharon Dowey: To go back to your previous comments, you mentioned confusing pathways and GPs being the main gateway, and in your response there you mentioned asking once and getting help fast. Do we have a robust enough system so that people know which pathways they can follow?

There is various funding available for groups. Once a group gets funding to help with mental health, are GPs made aware of it? Are GPs made aware of all the help that is funded by the Scottish Government so that they can offer those pathways?

Meriem Timizar is the co-ordinator for the International Women's Group. If a doctor was struggling to get a translator for somebody from an ethnic minority, would they know to go to that group for help?

Jo Anderson: I suspect that the answer is no. Many years ago, there was an attempt to gather up all that intelligence. I cannot remember the name of the system, but it was populated with lots of those programmes, supports and interventions and made available to GPs so that they would be more knowledgeable about what was going on in their area. However, sadly, the system got very tired very quickly because funding cycles mean that things go as quickly as they are set up, so that is a real challenge.

We talked earlier about primary care and gatekeeping. The introduction of community-linked workers in primary care has been particularly positive. We have a SAMH worker in every GP practice in Aberdeen city. We are there as a support system for individuals when mental health is a component of why they are sat in their GP surgery, although there may be other reasons, so the GP can send them down the corridor to us, and we have the time to listen to them, work out what would be the best supports for that individual and help them to reach those community assets.

It is a great programme, but we are very concerned about its future, because the emergency budget cut £38 million from the mental health budget. As a result of that, there was a delay to mental health and wellbeing primary care services progression, which is of deep concern.

Sharon Dowey: I would ask you more on that issue but there will be questions later on funding, so we will come back to that.

Simon Porter: Our members see a mismatch between supply and demand, and that you are spending money on the old paradigm, not the new Convention on the Rights of Persons with Disabilities paradigm. Our members might think that you spend too much on the biomedical model and the psychological stuff, and not enough on the social side of what works in mental health. The Mental Health Foundation would perhaps call that task shifting.

We hear that people do not necessarily think that mental health is a problem for them, but they think that it has a wider significance and that it might be worth spending more money on stuff that supports families and communities. Peter Kelly mentioned community-based solutions.

We might be empowering professional groups very well—psychiatry and psychology are very well empowered—but I do not know whether we are empowering people to get into mutual aid and to support their own mental health. A paradigm shift towards much more social funding might be what our members would like to see.

Sharon Dowey: What impact are the Covid-19 pandemic and the cost of living crisis having on demand for mental health services, and how does that affect service delivery?

Shari McDaid: First, I just want to follow up on what Simon Porter said about what we call task sharing.

We run a project in Dundee that brings a variety of agencies and community supports that work with children together with the NHS child and adolescent mental health services to schools to try to get faster support for children who are on waiting lists for CAMHS. We are trying to get them more support in general, and also more appropriate support, because many of the children may not need CAMHS. It might be—just as Simon Porter said—that a lot of other circumstances in a family's situation are giving rise to children having a behavioural issue that needs some support.

I am supportive of the idea of taking a better look at the resources in communities, how we can invest in communities and also how we can bring those resources together.

I also agree with Simon Porter that people often tell us that peer support is what helps them in their mental health journey. That means spending time with others and being given opportunities to connect with other people who are in a similar situation.

We are working on that through our project about bringing lone parents together, which is called small talk. Often, the people who take part in that are young long parents who said that they do not feel comfortable going into the usual new mother groups that might not have as many young mothers in them. We also support that kind of work with the ALLIANCE, offering advice on how people with long-term health conditions can be brought together to support each other.

Peer support is not meant to be a replacement for important clinical services that people need. However, a vast quantity of mental distress cases involve people with mild to moderate mental health difficulties, and, for situations of that kind, it is possible that peer support can play an important role.

With regard to your question about the pandemic and the cost of living crisis, our pandemic study showed a rise in levels of distress during the pandemic. I will not be able to quote exact statistics from that off the top of my head—apologies for that—but I can get further information to you. Towards the end of the pandemic, we saw that those levels of distress had not come down to pre-pandemic levels. That is probably reflected in the statistics that SAMH reported on levels of demand for services.

We also did a bit of polling of the population on the cost of living crisis, and, when we asked people about that, they reported that the increasing cost of living is negatively affecting their mental health. That does not surprise us, because financial stress is a clear risk factor for poor mental health.

I will say one thing in relation to young people. In our huge sample studies of young people in universities and colleges, there was a clear link between lower levels of mental wellbeing among the students and food insecurity. We do not often think about that, or maybe it is not spoken of enough in relation to young people. Lots of things in young people's lives might negatively affect their mental health, but we often forget the reality that many young people today struggle to have enough money in order to eat and have adequate shelter. That financial stress further exacerbates young people's mental health issues.

09:45

Sharon Dowey: Thank you for that—there are lots of points to consider.

Peter Kelly: It is well understood that poverty is both a cause and a consequence of mental health problems. Since the start of the pandemic, we have been through a time of acute financial crisis. During the pandemic, people who were already on low incomes suffered most, and then we moved into the cost of living crisis, which we are still very much in. We should not be surprised that that translates into increased demand across a range of services that are related to mental health.

I will make a couple of points in that context. With the Scottish Women's Budget Group, we did some research into women's experience of the cost of living crisis. One of the very clear messages that came out of the report was that managing poverty has mental health impacts for women in particular, because they are often responsible for care within the family and they are trying to juggle those responsibilities at a time of acute financial crisis.

The other related issue is debt—we have seen increasing levels of debt. In response to our survey, one of the Poverty Alliance members—a debt advice agency—noted that, in the period between 2018 and now, a third of its clients reported suicidal ideation when they presented. Now, half of the clients are reporting suicidal ideation. That one statistic from that one organisation is really compelling information about the impact of the current context on individuals' mental health.

The other part of Ms Dowey's question was around what happens to that demand. As Simon Porter and Shari McDaid have said, voluntary sector community organisations are really important for providing alternatives to primary care, in order to address mental health issues early. I know that we will talk about funding later. Those services are very much under stress. Our members told us that, in response to the current context, they have done various things. Almost 70 per cent had increased training around mental health to staff and volunteers. Very often, that was around mental health first aid. As I said earlier, they are looking to skill up their staff and volunteers to be better able to support the people they are working with. Around a fifth had recruited specialist staff to provide specialist services to enable them to better respond to those areas.

However, that is the tip of the iceberg, and organisations are undoubtedly struggling to respond to the demand that is there. As I said, I know that we will go on to talk about funding issues later.

The Convener: I thank Peter Kelly and the other contributors for those answers. Unfortunately, due to time limitations, we will not be able to take everybody who wants to come in on every question. I shall exercise egalitarian principles and make sure that everybody gets a reasonably equal amount of time. I apologise to those who wanted to come in on that question, but I will move things along and invite Colin Beattie to put some questions to the witnesses.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I have one or two questions on initiatives to increase in-person and remote access to support. There have been a number of such initiatives across Scotland, with the NHS 24 111 mental health hub and the distress brief intervention programme perhaps two of the main ones. However, there seems to be a wide variability in primary care mental health services, third sector services and peer support services, and perhaps the joining up of those services is not as we would want to see it. It could be better.

I would be interested in hearing the witnesses' views on that. Maybe we can start with Jo Anderson, as she is here.

Jo Anderson: Okay. I do have a few things to say about that.

It is true that there are some great interventions and supports out there and that the system does not necessarily connect up so that people know how to get to them or how to refer on to them. If we could make those connections in the system, that would be a welcome improvement and help a lot of people.

However, it also comes down to the present funding cycles, which I am sure we will talk about later. Supports are on annual funding cycles, which makes it very difficult, particularly in the third sector, to plan over time and set up something robust enough to exist beyond the end of a year. That is a real challenge for us.

As for the DBI programme, which you mentioned, it has, in our view, been quite a success story in Scotland, and it has been particularly effective in de-escalating distress for many thousands of people since its inception. As one of the delivery partners, we deliver the programme across multiple locations in Scotland, and it has also been expanded to include young people, in recognition of the fact that the service can bring real benefits to lots of people.

However, we know that the dedicated funding for the programme will be going and that it will be down to local commissioning and procurement processes to determine future provision. Thankfully, the national pathway will remain in receipt of dedicated funding until March 2026, which is good news, as it means that anybody who comes through the 111 number will still be able to get into the DBI service.

That said, we have concerns about what might happen with the local commissioning of such services. We absolutely believe that we should retain the core elements of the service as it was set up. Our slight fear is that we end up with DBI-lite versions or the service being drawn in with others and jointly commissioned. That should be a concern for all of us.

Colin Beattie: I suppose that, when we talk about variability, we are talking about the availability and quality of services. Some of that goes back to funding.

Paula Fraser: Most of our members have severe and enduring mental illnesses, and they have reported that phoning the NHS 111 number, for example, is not helpful to them in getting the help that they need. It seems to be more of a talking-through and signposting service, but with people being signposted on to something that is not available or which they cannot access.

We hear about variability a lot. The value of peer support, community link workers and wellbeing hubs has been mentioned, but people's access to such things and their ability to attend, say, a local wellbeing hub or get peer support seems to vary from place to place across the country. It is what our members continually ask for and want. Indeed, as committee members will have seen, access to wellbeing hubs and peer support was one of the recommendations of the Scott review.

It is an issue. As the Audit Scotland report has mentioned, although specialist clinical support will be needed for people at times, it is not necessarily always about somebody having a high level of specialist training; sometimes, it is about a person's attitude and the time that they take with somebody—it is about being empathetic and the ability to listen. Some of our members have reported that they have a brilliant GP who still takes the time to talk to them, and that their regular appointments with them keep them well. Alternatively, the person might be a community link worker or a peer support worker. It is not necessarily always about seeing a psychiatrist or psychologist; it is about being able to connect with a trusted person who maintains an empathetic attitude, and that sort of thing is not available to everyone across the country when they need it.

People say that although crisis support is something that is really needed at the weekends and during the night, they cannot access it when they need it. Our members report that continually, and the situation seems to have got worse during the Covid pandemic and afterwards.

Colin Beattie: I will bring in Kirsten Urquhart.

Kirsten Urquhart: I do not have a huge amount of insight to bring, particularly from young people, in relation to crisis support. However, I will add to the points that Paula Fraser made about timing of access to services.

In the survey work that we have done, young people have flagged up to us that such services are sometimes available only during business hours, when they are at school or in employment. When it comes to accessing digital support, younger people quite often do not have access to devices. If they are living with a parent or carer, their access might be restricted at certain times of the day when they need it most. There is a whole range of issues that might impact on young people's ability to access services.

We have also mentioned transport and accessibility. You will be aware of the initiative on free bus travel for the under-22s, with which we work in partnership. Transport is always a barrier to accessing services, and young people in particular have issues with accessing transport. We look to work in partnership with such initiatives, because it is not just about a particular mental health challenge; it is about looking at the bigger picture, the young person's world and the things that make accessing services and support possible.

Going back to earlier points, I would say that the issue is not always access to acute crisis support. With the post-Covid cost of living crisis, we have been hearing from young people about secondary mental health issues. They are witnessing their parents and carers going through really challenging times, and that is having an impact. A survey that we did in December found that more than 70 per cent of young people are concerned about the financial pressures on their parents or carers and the associated stress and impact on their own mental and physical health. Young people talk about that triggering aspect; we have 16-year-olds saying that they are worried, because they are embarrassed about not having enough money for lunch and about their parents not being able to put food on the table. Young people are saying that they do not want to continue their studies, because they want to work and contribute towards the household. That secondary impact on young people is heavily felt.

During Covid, lots of services closed for young people. With the cost of living crisis, access to swimming pools, leisure centres and so on is being decimated in communities across Scotland. Those are the things that should support young people in living their lives, having fun and doing the things that they should be able to do for their emotional and physical wellbeing and mental health. We must pay attention to the preventative measures that we are putting in place to support young people's—and everybody else's—wellbeing. We need a whole-system approach to supporting young people's mental health.

Colin Beattie: On a slightly different aspect, what are the advantages and disadvantages of in-person support versus remote access? To what extent do people have a choice in the type of support that they receive?

10:00

Simon Porter: I want to quickly say something about intersectoral partnership working. The advocacy view is that there is a power dynamic between the NHS, integration joint boards and local authorities. Sitting on the sidelines, we see a pecking order when it comes to partnership working between the third sector and the public sector. There is an assumption that the NHS is professional and does the serious stuff—the good stuff—whereas the people in social care are keen amateurs. In other words, we are well intentioned, but we do not really know what we are doing. We therefore think that there is an epistemic injustice in the undervaluing of social care in the funding that is provided, and we wonder whether the national care service could help to equalise that. In a way, the NHS is disproportionately powerful; it exerts a gravitational pull on resource and attention that I do not think patients think that it warrants.

In response to your question whether people have a choice, no, they do not—there is coercion. Our end of the mental health system relies on coercion, which is a human rights violation. By definition, many people in the psychiatric hospitals have not chosen to be there and do not have a choice about the treatment that they receive. Their voice is basically irrelevant. What they want does not really matter at all. There is no choice in the system for many of its most disabled users.

Colin Beattie: Thank you. Meriem Timizar, can you comment on the advantages and disadvantages of in-person and remote access?

Meriem Timizar: There are disadvantages that people face in accessing services. As I have mentioned, the language barrier is an issue for ethnic minorities women; as they have no information about whom to approach, the only person they can think to contact is their GP. They do not have more information about who to contact about a mental health issue. In addition, as I mentioned earlier, they do not feel comfortable using interpreters; they prefer to speak directly about their issues to the counsellor.

We also face disadvantages as a community group, in that we do not have enough resources to meet all the women's needs. We are very limited in resources. We can provide just a few hours, and we have quite a big waiting list to see all the women who need a service. Those are some of the disadvantages.

However, the IWG provides other activities for women to ease their isolation; for example, we provide yoga and Zumba exercise classes as a way of reducing mental health issues. Those are some of the advantages of the services that we are able to provide with our limited resources. We also provide English classes for women who are waiting for college places. As they are from ethnic minorities, their language is not English, and we must take that into consideration. We provide English classes, so that they can learn English. That way, we can address some of the language barriers. We also provide a drop-in service so that women can come in, meet others and talk.

In addition, we were able to secure some funds to reduce mental health issues. To help with the cost of living, we provided some vouchers to women and families to reduce the mental health problems that arise from thinking a lot about their financial situation. I hope that I have answered the question.

Colin Beattie: Finally, I want to ask Dr McDaid the same question.

Dr McDaid: Simon Porter raised a very important point about personal choice. Although the evidence that I am aware of about the effectiveness of online versus in-person support, which comes from a few years ago, usually shows that they are about equivalent, we have seen that the effectiveness of online support is not less than that of in-person support. As Paula Fraser has pointed out, it very much depends on the quality of the relationship that is built up between the therapist and the individual seeking help. All the evidence is that the quality of that relationship is key to whether you get any therapeutic benefit.

It is important that the digital option is the person's choice. On the other hand, I have seen evidence that such a choice has led to people who have never asked for mental health support coming forward for it. I have heard that, for parents of young children, the ability to get support at home instead of having to organise their infant in order to get out the door for it might be the difference between their getting help and not getting help. Moreover, for communities and people who still have a high sense of stigma around seeking help—indeed, men and older people still feel some stigma around seeking help for mental health—we think that the digital option could be important in enabling those people to access support that they might otherwise not go near.

Colin Beattie: I turn to my final question. We talked a bit about the NHS 24 111 mental health hub and the distress brief intervention programme, and we heard feedback on that. What is the impact on those programmes of the withdrawal of dedicated funding?

Peter Kelly: We have not sought information from our members on that area, so I would not be confident giving you a response on those particular funding streams. There may be others on the call who are better able to say what that impact would be.

The Convener: Jo Anderson mentioned it earlier.

Colin Beattie: I was just about to go to Jo.

Jo Anderson: Our concern is that the moment you remove dedicated funding, you open up the opportunity for 32 different versions of what is, in essence, already proven to be a very effective programme of supporting somebody who is in a distressed situation. Our concern is how to retain the effectiveness of the programme that has been piloted over the last period when you do a national roll-out. Removing the dedicated funding suggests that it might then be open to interpretation.

That has happened to other programmes such as individual placement and support, which is an employability programme that supports people with severe and enduring mental health problems into sustained work. It is the single most effective programme to do that, which has been proved time and again. However, the minute it gets into the procurement system, it becomes a lite version of itself and it loses its fidelity.

Colin Beattie: Paula Fraser, do you have a comment on that?

Paula Fraser: I do not know whether I know about the impact of the reduced funding; I just know from what members have reported that it has become more difficult for them to access services. Even those who might have depended on phoning, say, NHS 24 during the night if they cannot access other crisis services have reported not being able to get through to somebody or not really getting the help that they need when they need it. However, I do not know whether that is a direct impact of reduced funding.

As for distress brief intervention, that would not necessarily be appropriate for most of our members, given their severe and enduring mental health conditions, but I totally understand that it is helpful for other people, and I see Jo Anderson's point about how to keep things consistent if there is no dedicated funding.

Colin Beattie: Finally, Shari, do you have any views on this?

Dr McDaid: I wanted to add one more comment about digital mental health, which is that, according to the evidence of its effectiveness, such an approach is better when guided by a professional. It is important to bear that in mind when we hear the view expressed that it is possible to replace clinical support or the support of a mental health professional with the digital approach, when what has actually proved to be effective is the involvement of a therapist. It might enable therapists to see more people than if everything were face to face, but having a therapist involved online is really the best approach.

Colin Beattie: Thank you.

The Convener: Jo Anderson, I think that you mentioned the Aberdeen example as something that is under threat because of funding issues. If you or any of the other panellists have other examples of such initiatives being at risk, it will be really helpful if you can give us a note in writing about them.

I am going to have move things along, and I invite Willie Coffey to put some questions.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): Hello, everybody.

I wonder whether I can take us back to the earlier discussion of how we reduce mental health inequalities. The Auditor General's report, which I am sure that you have read, points to certain groups in society, and it is obvious that inequalities in this respect basically reflect the inequalities that we see in society. I am thinking of, for example, people living in deprivation as well as the issues affecting young people, LGBT people, people with learning disabilities and, as we have been hearing today, ethnic minorities.

The funding allocated to the mental health directorate in recent years has gone up significantly. In 2020, it was £130 million a year, and now it is nearly £300 million a year. Where is the money going? Is it not being spent or targeted correctly and appropriately in your opinion? What more do we need to do in that respect?

I would like to start with Dr McDaid, but I would appreciate hearing a brief perspective on the matter from each of our panellists, if that is possible.

Dr McDaid: I will be as brief as I can be.

With regard to reducing mental health inequalities, which is something that the foundation feels is a very big priority, the reality is that many of the reasons for such inequalities lie outside mental health services. As a result, until we have a whole-of-Government and whole-society approach to addressing mental health, we will see them persisting. One of the foundation's concerns is that the mental health strategy delivery plan, which has just been published, is still relatively vague on how Government departments beyond the mental health directorate and beyond NHS mental health services will be involved in taking action on mental health.

One of the best ways of reducing mental health inequalities would be to require every Government decision to be assessed on its impact on mental health. In other words, any decision on, say, social security, transport, housing, investment in community spaces and so on that was taken by the Government would be assessed on its mental health impact. If that was happening, we would find that the circumstances in which people are trying to have good mental health would change and become more balanced so that individuals who are at higher risk have a better chance.

Willie Coffey: Jo Anderson, can you offer a perspective on that? The funding has been increasing, but are we targeting it correctly?

Jo Anderson: I whole-heartedly agree with everything that Shari McDaid just said about the cross-Government opportunity. The delivery plan that was published earlier this week is vague on that. Something like 80 national policies are listed at the back of that delivery plan, but there is no sense of how we are going to make that a reality. Therefore, we urge that great attention be paid to how we implement that over the course of the delivery plan.

On funds, you talked about the communities mental health and wellbeing fund as a particular example of a recent innovation in mental health directorate spending. However, as much as that is welcome, it is annual funding, which limits its effectiveness. However, we also know very little about the outcomes for the recipients of that—in fact, we know nothing. I am not saying that there was no benefit to those individuals, but we do not know what it was. We might know how many people have received support in some way, but we do not know what the outcomes were for those people. That is the kind of transparent data that we need in order to assess mental health spending.

Willie Coffey: My colleague Graham Simpson will touch on outcomes in a wee while.

Meriem Timizar, you said that, in a number of circumstances, there is not even multilingual information to direct people from minority ethnic communities to those services. Is that the case? I mean, I am astounded, convener, if we do not even provide the information that people need to access a pathway to support services. Could you tell us more about that, please, Meriem?

Meriem Timizar: Yes. As I said, in our experience of working with ethnic minorities women, they do not have that information. The only way they know to access services is to contact the GP to refer them. No bilingual services were provided for them, so we tried to provide a service to help them, such as a counsellor who speaks both Arabic and English. We found a high demand for that service.

As I said, when we started, we had only two hours a week to provide the service, but we have now secured it for six hours a week. We found that the women prefer to speak to the same person who speaks both languages. Unfortunately, we were able to provide that service to English and Arabic speakers only. We did not have the funding for counsellors who speak more languages.

We are also facing the challenge that we do not have more funds to continue that project. We have only two years' funding, because we were funded by the National Lottery Community Fund mental health and wellbeing project, but it is not providing that kind of project any more. We do not know what will happen.

As I said, we were able to provide counsellors who spoke Arabic and English only, but we hope that, in the future, the NHS can provide that kind of support or give more support to community groups to provide those kinds of services.

Willie Coffey: Thanks very much, Meriem. The committee will be keen to follow that up.

Kirsten Urquhart, I know that you have to leave at about half 10, but can you give us a little perspective on these issues and why these inequalities exist, particularly for young people? We saw in the report that young people often report much higher levels of anxiety, stress and mental health-related issues, and you described a few circumstances. However, can you give us a flavour of what we need to do more to effectively target spend where it is needed in order to reduce the inequalities that we are talking about?

Kirsten Urquhart: I absolutely appreciate that the spend on mental health services has gone up. Mental health is such an all-encompassing issue that it can be a challenge to consider where such funding should be diverted to at the moment. We must also take into consideration the intersectionality of the many other issues that we have identified. The challenge is then how we can provide effective support to all people, but particularly young people.

I fully agree with Dr McDaid's view on having a whole-system approach to a young person's situation. Quite often, poor mental health is a result of their circumstances, such as their living situation, relationships and life experiences. As I mentioned earlier, much of the focus is, rightly, on fixing the problem. However, that is what we might call a sticking-plaster approach. Instead, we should ask what could do further upstream on early and effective intervention, in particular for young people. The world that we currently live in can feel like a heavy place for everyone, but particularly for them. They had their education disrupted during the Covid pandemic. For many of them, key milestones in their lives were missed, along with social interaction and all the other things that make people people.

Quite often, when young people talk about needing face-to-face support, they perhaps mean not physically but through experiencing the human connection that they miss because of social isolation and loneliness. We only have to turn on the news to see the stark reality for many young people at the moment. It is not only that. We often look to young people to come up with solutions to issues such as climate change anxiety, but they are the ones who bear the brunt of thinking that they will have to deal with such issues in the future. When we put all that together, we are not painting a very optimistic future for young people. The Carnegie report that came out this week mentioned the wellbeing index. The difference in the figures for people over 55 and those for young people is a stark reminder for us all that our young people are challenged in the current environment.

I agree that more resource needs to be allocated to mental health provision, but we should have a whole-system approach to young people's lives, the provision that they can access, the opportunities that they can take up and the type of education that they can have. The issue is wider than the provision of mental health support services; all the infrastructure that sits around a young person needs attention.

Turning to Jo Anderson's point, I think that the annual funding cycle presents a huge problem. The year-to-year cycle makes it challenging for us, as a third sector organisation that provides mental health information for young people, to do any long-term planning.

I always say that it is important that we keep having conversations with young people. We must involve them so that we are not making decisions on their behalf and they are at the table when we discuss possible solutions for the future.

Willie Coffey: Thanks so much for that, Kirsten.

Convener, does anyone else online want to contribute?

The Convener: Both Simon Porter and Peter Kelly indicated that they want to come in on that question. We will go to Simon next.

Simon Porter: There is quite a big Polish community in Edinburgh, so we have a lot of Polish members. Their reasons for not accessing NHS services are interesting. They will often pay to fly to Poland for treatment that they could get free in Scotland, but they do not want to do so. When we ask, “Well, why don't you?” it seems that they have trust issues with the NHS. I guess that we were all brought up to worship and adore the NHS, but other communities do not necessarily have that ingrained in them. They do not trust it and, in particular, they do not trust its approach to data sharing and where their data goes. They are concerned about health and the Government sharing information, but they also have issues with quality. That is hard to hear, because morale in the NHS is low and people do not want to hear the negatives. Polish people tell us, “Our health service is better than yours. Okay, we have to pay, but we wouldn't put up with what you get.” I appreciate that people do not want to hear that, but that is what Polish people say to us.

As for where we should spend money, I am not sure that it is correct to assume that giving more and more to the NHS will bring in BME communities.

Willie Coffey: Thanks, Simon.

The Convener: I invite Peter Kelly to come in.

Peter Kelly: I will try to be brief. I echo much of what Shari McDaid said. The answers to how we reduce mental health inequalities largely lie outside the mental health system.

We must ensure that there is alignment between Scottish Government policies and other parts of the policy-making framework in Scotland. Is there alignment in our efforts to reduce child poverty? We have a well-developed strategy to reduce child poverty, with regular delivery plans, but are those plans closely aligned to efforts to reduce mental health inequalities? Do they take enough cognisance of mental health issues? There is still some way to go in that regard.

One of our priorities is to develop a wellbeing economy. Addressing mental health inequalities is fundamental to that, so issues relating to how our labour market operates, the security of contracts, the stability of work and the number of hours that people have all contribute to whether we are effective in reducing mental health inequalities. Taking that into account when we develop our approaches in those areas will help to reduce those inequalities.

Another really important area is housing. Edinburgh has just declared a housing emergency. We know the impact that insecure accommodation has on people by way of stress, so if we are to address mental health inequalities and the stress that results from homelessness, we need to prioritise that area.

Willie Coffey: Thank you.

The Convener: In the time remaining, I will invite Graham Simpson to lead a discussion on an area that the committee is keen to get your views on.

Before I do so, I should say that we would very much welcome any written submissions that you want to provide the committee if you feel as though we have not covered some of the ground that you wanted us to cover. We have been really up against the clock this morning. We have been presented with a lot of rich evidence, which we will be keen to look at in more detail and reach some conclusions on, but we would really appreciate it if you could provide a written submission on anything that we have not covered.

Graham Simpson: While Kirsten Urquhart is still with us—I know that you have to shoot off—I want to come back to your comment that the world feels like a “heavy place for everyone”. Is there a danger of giving the impression that we have a nation of stressed-out young people who are struggling with life? That is not the case for every young person, is it? Some young people struggle, but not everyone is in that place, and we do not want to give that impression, do we?

Kirsten Urquhart: No—absolutely not. I apologise if that is how what I said came across; that was absolutely not my intention.

I work for an organisation that supports young people to do amazing things, to participate and to share their views, so I know that we have a generation of young people who are very socially aware and socially active, and who are very kind, considerate and caring of others. We have a brilliant generation of young people in Scotland.

However, we have to pay attention to the fact that, although what we have said is not true of everybody, it is true of some young people, who are being exposed to a wide range of things in the changing environment in which they live. That young people are motivated to seek support for their mental health and emotional wellbeing, and that they are thinking about the types of services that they can access, can be seen only as a positive.

We have a fantastic generation of young people who have lots of good opportunities and prospects, and they are active in shaping those. Everything that I have said today has come from young people telling us their views and how they would like things to change so that they are better for them and for future generations.

I absolutely agree with you. I am all about positivity and opportunities for young people but, for those who need support, we should have an adequate system that supports them. I apologise if I gave a bit of a doom and gloom view of the world of young people.

10:30

Graham Simpson: I am glad that you have injected some positivity. I know that you have to shoot off, so I will let you go, but thanks for that—I appreciate it.

I will put my next question just to Jo Anderson, because we are up against the clock. You mentioned outcomes, and the report states:

> “The Scottish Government does not measure the quality of services or outcomes for people receiving mental healthcare.”

That seems to me to be a huge oversight. If you accept that the situation should be rectified, how should it be rectified, and what kind of things should we measure?

Jo Anderson: We have been saying for a long time, along with many other organisations that are represented on the panel, that, for us to understand the effective use of the mental health budget, we need to know what works for people. That is crucial, and it can be done, because it is being done in England right now. That programme used to be called improving access to psychological therapies—IAPT—and it is now called NHS England's talking therapies for anxiety and depression programme. We have studied that and written quite a lot about it. Individual outcomes data is routinely published and readily available. That includes data on recovery and lots of other things.

That is a good example of what can be done. I am not saying that it is the only example, but it demonstrates that it is possible to do that. The fact that we only measure things by waiting time targets on a quarterly basis is just not good enough. We absolutely must get to a position where we understand the effectiveness of an intervention for an individual. We do that in our organisations, because we have other funders who expect that of us, so it can be done.

Graham Simpson: There are examples in Scotland of various organisations doing their own thing but, as you say, we do not have a nationwide approach.

Jo Anderson: There is no national standard.

Graham Simpson: I am seeing somebody else nodding. Who is that? It is Paula Fraser, I think.

Paula Fraser: Yes, I was nodding in agreement. It seems ridiculous that we do not collect that information and data or have that evidence about how things are working and where they are working for people. It would be welcome if we were able to do that.

Graham Simpson: I go back to Jo Anderson. You mentioned the model in NHS England. Why are we not doing something similar? Why is NHS Scotland not doing it? Has anyone asked it to do that?

Jo Anderson: I do not know. SAMH has said a number of times in submissions to consultations that the example in England is a good one and is worth looking at. I know that people from the IAPT programme have been in Scotland to talk about it. It is entirely possible to do it.

Graham Simpson: That is possibly a question for the Scottish Government, and we will have it in at some point.

I have a separate question about something that arises in the report. This is not necessarily a question for Jo Anderson—I am just looking at you because you are in the room, but it could be for anyone. The report says that spending on medicines to deal with mental health has gone down, because the cost of drugs has gone down, but that the number of items being dispensed has gone up. Does anyone have a view on whether it is appropriate that we are prescribing more and more drugs? Are there better ways of dealing with mental health issues? Is it too easy to prescribe drugs?

I see someone nodding, and I think that it is Simon Porter, so he might want to come in on that.

Simon Porter: Yes, there definitely is too much emphasis on medication. There is an unchallenged assumption that just keeping taking the tablets works. It is as simple as that. It is assumed that people should either get professional help or just keep taking the tablets. Those are very old-fashioned ideas, but we still hold to them.

On the lack of evidence, it is very interesting that, in such an evidence-led discipline—all medicine is meant to be evidence led—evidence cannot be provided for that. Why can people not provide evidence for that? I suppose that one possibility is that people know that the evidence would not support the claim that the approach is effective.

I remember Colin McKay from the Mental Welfare Commission for Scotland saying that there is no evidence that hospital in-patient detention and coercion work. However, we do that. Everyone assumes that we must do that and that that is the answer for mental health at the severe end.

The question is interesting. Why can people not provide evidence that the approach is efficacious?

Graham Simpson: Yes. If people are going to do something, whatever it is, they need to know that it is working and why it works—or why it does not work. You are billed here as the voice of experience, so tell us about your experience.

Simon Porter: People say that coercion and detention are necessary evils, but the people whom I represent simply say that coercion and detention are evil and not necessary. Scotland is a civilised society, but we cannot come up with better solutions.

A lot of the mental health system is backed up by an element of coercion. Patients argue that that creates stigma. If we lock somebody up for something, that tends to mean that they will get stigmatised. The solution is to take out the coercive element. That is what the United Nations Convention on the Rights of Persons with Disabilities says that we should do.

On data that you could monitor, the Scott review recommended that we should at least try to work to reduce coercion. Could there be costed things so that people do not get money unless they are reducing coercion? History teaches us that what tends to happen with every new mental health act is that the use of coercion ratchets up year after year and detentions go up year after year. People start by saying, “Let's be least restrictive,” but they end up saying, “Let's keep locking people up and institutionalising them.” Could a mechanism be created in which people get money if they reduce coercion but, if coercion keeps going up, it is said, “Sorry, but we’re not going to pay for that any more.”?

Graham Simpson: Obviously, coercion is a big deal for you—you have mentioned it quite a few times. Does anyone else want to come in? I am going to look at a screen with lots of faces on it and—

The Convener: Paula Fraser and Dr McDaid are interested in coming in.

Graham Simpson: Right. Paula Fraser was mentioned first.

Paula Fraser: I totally understand a lot of what Simon Porter has said. We hear that from our members and, obviously, we are keen to see a reduction in coercion, as recommended by the Scott review.

On medication, there is a varied wealth of experience among our members. Many members will talk about how much the medication that they are on has really helped them alongside having regular community psychiatric nurse appointments with people whom they trust, for example. That is important. Medication might work alongside something else that helps people. However, there have, of course, been lots of very bad experiences. People have felt that all that they have been offered has been medication or a higher dose of medication, particularly for things such as depression, with nothing else alongside that that helps them.

I know that, with regard to a lot of the increase in the use of medication, you hear reports about the increase in the prescription of antidepressants. I assume that that is to do with the lack of resource or workforce to be able to give other therapies, treatments or help, and GPs having to resort to medication because there is not that other help.

There is a balance, because it is really important for some of our members that they have access to the medication that helps to keep them well, but other support is also needed and where the money is spent is important.

From what we hear, a lot of money—and I mean a lot of money—is being spent on, for example, locum psychiatrists that could otherwise be spent a lot more wisely. I hope that the workforce plan will do something to help with that, so that psychiatrists or community psychiatric nurses can be recruited in the areas in which they are needed rather than locums being used, and that the money that is left can be used elsewhere to help. For example, as I mentioned, it could be used for community resources and community wellbeing hubs to keep people well.

Dr McDaid: I was requesting to speak in relation to Graham Simpson’s question about young people and whether we are overstating the extent of the distress. I want to use this opportunity to comment on that, if you do not mind.

We did two thriving learners studies. One was of 17,000 university students in Scotland and the other was of 2,000 college students in Scotland. We found that two thirds of university students had low mental wellbeing and that more than half reported symptoms of moderate to severe depression. When we gathered that information for college students, nearly three quarters reported low wellbeing and about one third reported moderate to severe or severe symptoms of depression.

Graham Simpson: Can I come in there?

Dr McDaid: Yes.

Graham Simpson: What questions did you ask? If you ask, “Do you get stressed about things?”, most people will say yes. It depends on what you ask and how you phrase a question.

Dr McDaid: I can get you the detail of the questions, but I can say that the questions that we asked were quite standard ones that are used to measure wellbeing and symptoms of depression. We were not just asking students whether they feel stressed; we were using standardised questions that are considered reliable for gathering that information.

We have to acknowledge that there are levels of distress in young people. However, the levels of resilience are impressive. Three quarters of college students are not seeking mental health support, so some are managing to cope without seeking it. However, it behoves us to recognise the extent of the difficulty. That is the best way for us to move forwards in responding, particularly for young people, who have their whole lives ahead of them. If we respond early, at that point in their lives, there is a much better chance of better outcomes in the remainder of their life.

The Convener: I got a note to say that Peter Kelly wants to come in a final time. We have a couple of minutes left, Peter, if you want to come in. You probably want to speak to some of the broader issues that were raised during that last part of the meeting.

Peter Kelly: It was really just to come back on the question of the increasing use of medication. I am not going to comment on that, specifically, but it is very clear from grass-roots community organisations that responded to our call for evidence that social isolation is one the big factors that drives problems in mental health. The stigma that is associated with the experience of poverty and with the experience of mental health issues are also key drivers.

Community-based responses are in a very good position to support people with that relatively low level of mental distress. We have seen members of ours—for example, the Scottish Professional Football League Trust—working with grass-roots community football clubs and trusts that are associated with football clubs. They have been a real driving force in tackling social isolation, particularly—but not only—for men, and in addressing mental ill health through that means.

Finally, if we are thinking about alternatives, the fact is that we need to support our community and voluntary sector more effectively. Questions have been raised again and again in this session about the duration and stability of funding, and I would just repeat the need for longer, more sustained funding for third sector organisations.

The Convener: On that very clear note, Peter, thank you very much.

I thank all our witnesses this morning for what has been a very fruitful session. As I said earlier, the evidence that we have taken from all of you has been very rich in quality, and I want to thank Kirsten Urquhart—who is no longer here—Simon Porter, Shari McDaid, Peter Kelly, Paula Fraser and Meriem Timizar for joining us online and for their contributions this morning. I also very much thank Jo Anderson for joining us in the committee room and for the evidence that she has given us.

At future sessions, we will speak to some of the agencies and organisations that are on the front line, providing the services, and we will also speak to those who have some responsibility for the oversight of the implementation and delivery of services. We then expect to have a session with the accountable officer and the Scottish Government on the state of adult mental health services.

Again, thank you very much indeed for helping to inform our work. I also hope that you have been able to get some important messages out to a wider audience.

I now draw the public part of this morning's meeting to a close.

10:46

Meeting continued in private until 11:01.

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