OFFICIAL REPORT
AITHISG OIFIGEIL

Public Audit Committee

Thursday 16 November 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 16 November 2023

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PUBLIC AUDIT COMMITTEE
29th 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:

Mike Burns (Penumbra Mental Health)
Derek Frew (Police Scotland)
Stephen Low (Unison)
Christiana Melam (National Association of Link Workers)
Anne Rowan (Chris's House)
Dr Pavan Srireddy (Royal College of Psychiatrists in Scotland)
Dr Chris Williams (Royal College of General Practitioners Scotland)

CLERK TO THE COMMITTEE

Lynn Russell

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Public Audit Committee

Thursday 16 November 2023

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Richard Leonard): Good morning, everyone, and welcome to the 29th meeting in 2023 of the Public Audit Committee.

The first item for consideration is whether to take agenda item 3 in private. Do we agree to take that item in private?

Members *indicated agreement*.

Section 23 Report: "Adult mental health"

09:00

The Convener: Our main agenda item is further consideration of the report by the Auditor General for Scotland and the Accounts Commission on adult mental health. The meeting will have a round-table format, which is intended to promote discussion among participants, rather than just having questions from committee members and answers from those taking part. I hope that we can have a fairly free-flowing discussion to elicit the evidence that will be useful to us in forming our recommendations and drawing our conclusions.

The people who are joining us remotely are very welcome. If you want to come in at any point, please put RTS—request to speak—in the chat function or indicate there that you want to come in, and we will try to bring you in. Those who are in the committee room with us should indicate to me or to the clerks that they want to come in, and we will do our best to bring them in.

Those who are in the room and those who are joining us remotely should not feel obliged to answer every question; we will bring in the people who want to make a contribution. Those who are joining us remotely should keep their camera and audio switched on at all times, and we will turn the audio on when someone is about to contribute.

I begin by asking the witnesses who are joining us to introduce themselves, beginning with the people in the room.

Dr Chris Williams (Royal College of General Practitioners Scotland): I am a general practitioner. My clinical work is in the Highlands, and I am deputy chair of the Royal College of General Practitioners Scotland.

Derek Frew (Police Scotland): Good morning. I am the chief superintendent in Police Scotland's partnerships, prevention and community wellbeing division, with responsibility for the oversight of mental health.

Stephen Low (Unison): I am a policy officer for Unison Scotland, which is the largest union in the national health service and local government. We are also involved in a lot of other areas, including the third sector, housing and so on.

The Convener: I turn to those who are joining us online.

Mike Burns (Penumbra Mental Health): Morning, folks. I am the chief executive officer of Penumbra.

Anne Rowan (Chris's House): I am the founder of Chris's House, which is based in Wishaw in Lanarkshire, and in Dalkeith.

Christiana Melam (National Association of Link Workers): I am the chief executive of the National Association of Link Workers, which is a professional membership body that provides the collective voice for link workers in the United Kingdom.

Dr Pavan Srireddy (Royal College of Psychiatrists in Scotland): I am a general adult consultant psychiatrist, based in Glasgow, and I am the vice-chair of the Royal College of Psychiatrists in Scotland.

The Convener: I will ask the first question to get us going. One of the striking things that is evident in the report is the impact that the Covid-19 pandemic and the cost of living crisis have had on the overall state of adult mental health. We are particularly interested in your perspective on the differences that you have seen, as a result of those factors, in the demand on the services that you provide. Chris Williams, do you want to kick us off?

Dr Williams: I look back to the difficult and strange times when there was a massive shift in how we interacted as a society. Clear messages were coming from our Government and our health service about how we needed to instantly and rapidly change how we interacted as individuals and organisations. There was fear about a new infection for which we did not have effective treatment or vaccines. Knowledge was being acquired very quickly, but we needed to extrapolate from small amounts of information in order to take emergency measures.

Right from the start of the pandemic, messages were communicated across society, and some immediate changes were needed with regard to access to services that we would previously have always taken for granted. In general practice, for example, people were used to being able to walk up to the reception desk or ask for an appointment without being questioned on what it was about. That was particularly important for mental health, because people do not always feel able to talk to a member of reception staff or somebody with whom they are not yet comfortable about mental health, especially if there is stigma involved. Of course, mental health and physical health do not have clear boundaries.

Therefore, from the start of the pandemic, we saw something build. Those measures had a cumulative effect. It is interesting to hear academics who are versed in dealing with disasters speak about the length of an aftermath—how long the effects last. We have been seeing things building up with regard to people's ability to interact—including even with friends, relatives and other forms of support—and their experiences of using all our public services.

The Convener: Do you discern any impacts of the cost of living crisis on people's mental health and the demand placed on the health service?

Dr Williams: If you are someone who can rely on money coming in and going out and on your basic needs being met, life is a lot more comfortable and coping with everyday challenges is more straightforward. When the numbers in front of you are changing and you have no control, that must have a massive impact on a huge number of individuals and families.

The Convener: Pavan Srireddy, do you have a perspective on that from a psychiatrist's point of view? I was going to say "from the psychiatrist's chair", but I probably should not say that.

Dr Srireddy: I agree with a lot of what Dr Williams said. We have seen a consistent increase in the demand for mental health services over the past three years, since the onset of the pandemic and, subsequently, as a result of the cost of living crisis. There has been a specific increase in certain conditions, such as neurodivergent disorders—autism and attention deficit hyperactivity disorder. In some cases, there has been an increase in the number of referrals of between 700 per cent and 1,000 per cent.

However, probably the greatest impact of the pandemic, the lockdowns and the cost of living crisis has been felt by people with pre-existing mental health conditions. Sometimes, that is lost in figures for referral rates and demand. People with significant to severe enduring mental health problems were greatly affected by the loss of social support and family networks, the reduction in service provision over that period and the shift to remote working, which had a disproportionate effect on many of those people. Those effects have spiralled out and had an impact on access to medical services, with people having poorer physical health at premorbid level.

In addition, the cost of living crisis has hit people with mental health conditions harder than it has hit most other people. People with long-term severe mental health conditions are among the most vulnerable people in our society. They already struggle from a financial perspective, so, as I said, the cost of living crisis has had a huge impact.

What that leads to on the ground is an increased need for support for people with pre-existing mental health conditions or severe mental health disorders, alongside an increase in the use of services. The rate of detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 is now, as per the Mental Welfare Commission data, higher than it has been at any other point.

That reflects the disproportionate effect that these crises have had.

The Convener: That is helpful. We got evidence on that—very distinctive evidence on the final point—last week.

Christiana Melam wants to come in with a link worker's point of view.

Christiana Melam: Our members are having to hold people for longer—the more statutory services are stretched, the longer our members are having to hold people. Some cases are becoming a bit more complex, in terms of mental health, than we would expect our members to take on. In addition, as a result of the pandemic, rather than just the usual suspects, people who were previously a bit resourceful and were able to cope are now coming forward and needing support, too.

We have not quite managed to rebuild communities, so some of the community supports that were available to people before the pandemic are no longer there. During the pandemic, the elderly and those with long-term conditions were asked to shield, and some of the support groups for those people have not managed to start up again. There is a need to rebuild communities.

We are also finding, in relation to Maslow's hierarchy of needs, that most people are in survival mode because of the cost of living crisis. Before we can even start to build their resilience or help them to cope with their situation, we need to deal, at the basic level, with the fact that they need to feel safe and have money. That must happen before we can move on to anything to do with managing their resilience in terms of mental health.

The Convener: Thank you very much indeed.

I invite Anne Rowan or Mike Burns to come in. I do not know whether you have a perspective on that, from the point of view of community-based or charity-based intervention. What has happened to the demand on your services?

Mike Burns, what has happened over the past four years to the services that Penumbra Mental Health provides?

Mike Burns: Without a doubt, the cumulative effect of Covid and the cost of living crisis is having a major impact on people's mental health and wellbeing. We have only to look at the considerable increase in the number of people with whom we, as an organisation, work and engage. Last year, for instance, 12,649 people required mental health interventions.

We can look at the impact of suicide ideation or suicide itself and how that impacts disproportionately on our most deprived areas across Scotland, and at the impact of poverty on people's mental health. If we put those things together, the anecdotal evidence that comes from people who walk through our doors is that, yes, that is having a big impact on their mental wellbeing.

The Convener: Thank you. Anne Rowan, do you want to add anything to that?

Anne Rowan: Yes. I agree with what everyone is saying. There is more than a financial impact; for example, there is the social anxiety and shame that people feel because of the financial impact and the difficulties that they face in that regard. I do not know what the answer is; I think that everyone is doing their best to find the answers.

We are seeing many more people with very high levels of anxiety leading to depression and suicidal ideation. That is a result of the hopelessness that the pandemic has left. Dr Pavan Srireddy mentioned autism in relation to isolation as a result of the pandemic and its aftermath, and there is the issue with access to GPs and everything else.

09:15

People are feeling less and less valued and more and more worthless. I do not know whether that is relevant, but that is what I see from the people coming into Chris's House and that is what I think. We are passing round a hot potato. People should be working together on the holistic side of things, but they are not. I read that in the report.

The quicker we can get people into holistic therapies, the better. You have been to Chris's House, convener, so you know how we work. People can walk in our door. That is imperative and it gives people hope immediately. I totally agree that there is more behind why we are seeing mental illness figures rising. It is not just the "usual suspects", as Christiana Melam called them; people who have never been affected before are now affected by poor mental health, social anxiety, shame and desperation. God help them; God love them. Everyone is doing their best. That is all I want to say.

The Convener: Thank you. We will bring you in during the course of the morning, because it is really valuable for us to hear about that direct, front-line experience.

I have a very particular question that I will ask Pavan Srireddy and Chris Williams to respond to, although it is fine if anyone else wants to chip in. One of the things that struck us in the report is that, despite the huge increase in demand, the number of psychiatry appointments appears to have decreased. Can you shed any light on the reasons for that? If you do not want to come in, that is fine, but I will start with Pavan Srireddy.

Dr Sriredddy: The simplest explanation is that that is a reflection of the workforce crisis that we face. We just do not have the staff to provide the basic services that we need to provide, let alone the high-quality services that we want to provide. There is a finite number of consultations and appointments and a finite amount of work that each individual clinician can undertake. There has been a reduction in the number of psychiatrists in the past five to 10 years, rather than an increase to match the increase in demand.

That is not true only of psychiatrists. Mental health nursing vacancies are at the highest level that they have ever been, and that spirals out across almost every component of the mental health system. The reality is that we just do not have enough staff, and the reduction in the total number of appointments simply reflects the contraction of the workforce when what we need is an increase.

That is one of our biggest concerns. The Royal College of Psychiatrists in Scotland has just published its "State of the nation report: The psychiatric workforce in Scotland", which highlights the needs of the workforce and some of the challenges, as well as proposing solutions across all areas of the psychiatry and medical workforce that we represent. One issue relates to consultant psychiatrists, with vacancy rates in general adult psychiatry at almost 30 per cent. That is more than three times the official figure of 9 per cent, which is an underrepresentation because a lot of posts are being filled by locums who will not necessarily have the relevant qualifications. If there is a vacancy rate of 30 per cent, with one in three posts empty, you can get a sense of how that translates to the capacity of services.

The Convener: That is very helpful. Workforce planning is a recurring theme that the committee has to address.

Chris, I will bring you in.

Dr Williams: I am very keen to illustrate some of the changes in how our services operate across primary and secondary care. When we went into the pandemic, we had a viable technological solution in the form of Near Me. Video consulting was coming to NHS Scotland and it had been proven to be something that clinicians and patients alike could use. It turned out that that is not so beneficial in some sectors and that face-to-face consultations are more beneficial for mental health conditions and services. We also see that in general practice.

The number of consultations is one metric, but that does not fully reflect need. Services are limited in their capacity to deliver consultations, but there are still referrals and there is still need, so there are other forms of activity: waiting lists increase and referrals are bounced back or rejected. Our psychiatry specialist services are under so much strain that the people who are asked to triage and look at those referrals sometimes find reasons to try to hold the dam and knock things back to general practice. A lot of referrals are not progressed. That is a reflection of the limited workforce capacity in that specialist service.

I also flag that we in general practice still count our workforce by head count rather than whole-time equivalents. That is a hidden problem.

The Convener: We have tried to tease that out with the Scottish Government when it has sat in front of us.

I was going to bring this up later, but I will bring it up now, because it seems to relate to what you said. We have been struck by exhibit 3 in the report, which is a graph that shows huge variation among health boards in the number of face-to-face appointments versus telephone or video appointments. It is not just about remote communities being more reliant on video and telephone appointments. There are stark contrasts. For example, in NHS Ayrshire and Arran, 86 per cent of psychological therapy appointments are face to face, with just 14 per cent being by telephone or video, whereas in NHS Lanarkshire—which I guess has a similar population demographic—just 32 per cent are face to face and more than two thirds are by video or telephone. Can you explain that variation?

Dr Williams: I cannot fully explain it, but I can offer some insight. Many primary care practices are in very limited premises that cannot house all the members of staff, especially where we have been trying to transform primary care and bring in an expanded multidisciplinary team.

There are also differences in preference. It would be interesting to map that activity to patient preference and experience, as well as to clinician preference. Even with our current information technologies, we are not doing a good job in mapping who has a preference for taking an appointment as a phone call or video call. Videoconferencing works really well for some people because they can interact with services without missing large amounts of their time in employment or giving up some of their caring responsibilities. However, the variation needs to be understood and looked into.

The Convener: I will move on shortly to Graham Simpson, who has a question about the role of the police, but first I will bring in Christiana Melam, who wants to comment on this area before we move off it.

Christiana Melam: It is important to us that life issues are not overmedicalised. We need the right numbers to meet the needs but, again, it is about how many needs there are. Mental health issues that are caused by social determinants need a different approach. I think that the people in this meeting agree that we all have mental health as well as physical and emotional health. What we are talking about is the state that people are in. For some people, that health is poor, but they do not yet have a mental illness. The focus should be on reflecting the need, then deciding what sort of workforce we need, as opposed to the numbers. If we get it right, we will not expect lots of people to develop mental illness in the first place, because things can be prevented from deteriorating to that stage.

The Convener: That is very helpful. I now ask Graham Simpson to kick off his areas of questioning.

Graham Simpson (Central Scotland) (Con): Before I speak about the police—I will speak to Derek Frew about that, obviously—I want to go back to something that Dr Williams said. I raised the difficulty that people face in getting to see a GP in our evidence session last week. It has become much more difficult. You almost have to get past the receptionist, whereas before, you could phone up, ask for an appointment and be given one. Now people have to explain what is wrong with them to somebody who is not a GP. I do not know whether you agree with me, but that must put people off, particularly people with mental health issues. They may not want to discuss it, so people will be put off and we will miss people. What do you think about that?

Dr Williams: It does not put a lot of people off, but it drives frustration and negative experience. At the moment, general practice and our GP workforce face a difficult time. Other parts of the system have long waiting lists, as I mentioned. People keep returning to us with problems that we have already referred on, such as the need for knee replacements that they cannot have yet, and we have to deal with their needing pain-killing medicines and the other problems that rack up.

We have a limited GP workforce, and some of the changes that have been introduced in recent times have involved bringing in other types of staff such as pharmacists and physiotherapists, who can deal with specific issues. There is a combination of our GPs needing to train more students, supervise more GP trainees and offer input to those rapidly expanding teams. Our GPs are very stretched. We have constant demand, much of which is driven by genuine need. It is very difficult to be a GP in that position.

You can see from the number of contacts that we have on a daily basis that we need what we describe as triage systems because we have to try to understand who, out of the huge volume of people who contact a practice, needs to be at the top of the list. It is not always those who shout the loudest.

Among all that reactive work, there is a very clear danger for some of the planned care and proactive work—mental health especially falls into that area—whereby we would in previous times seek out patients who are vulnerable and who we have not seen in a while. We would be wary if they dropped off our radar.

It comes back to the issues that Christiana Melam raised. Some people out there might ordinarily rely on coping in their normal role in society, but there have been such pressures over the past while that many people are turning to general practice. We know that many people prefer to speak to their GP and would like to not have to explain themselves about it, but it is an operational issue that we do not have GP capacity to meet that demand.

09:30

Graham Simpson: We could spend ages on that subject, but I will move on.

I want to chat to Derek Frew about the police's involvement in mental health cases, because that has been a big concern of mine for a while now, having spoken to police in my patch. Both the convener and I represent Central Scotland, which includes Lanarkshire. When I speak to the police there—I think that, nationwide, other police say the same—they tell me that the amount of time that officers spend dealing with mental health cases can be very great. The figure that I was given locally was that 80 per cent of cases involve mental health issues, which I found astonishing.

I have also heard locally that there have been incidents where entire shifts of officers have had to sit with people in accident and emergency and so have been unable to deal with other cases. That seems to me to be a ludicrous situation and not a good use of resources. I ask you to comment on that initially, then we will move on.

Derek Frew: I, too, have heard those anecdotal stories—they are not unique. His Majesty's Inspectorate of Constabulary in Scotland, which recently carried out a review, was provided with similar evidence.

As for police officers having to go to hospitals and so on, when we look at our stats—we are getting better at understanding demand through our demand productivity unit—we can see that the 80 per cent figure covers a wider number of incidents, including investigating concerns for people and cases of missing persons, and

assisting members of the public. A wide range of descriptors would be included in getting to that 80 per cent figure. However, there is no doubt that a huge element of it relates to individuals who suffer from mental health problems. It is true that we often go to hospital with them. There is high demand for NHS services, so it is not the staff's fault that they have capacity issues when we take individuals there. People might say that the police are being risk averse, but our view is that we are investing in the safety and protection of vulnerable individuals.

That goes back to when we became Police Scotland and the unique point made in the Police and Fire Reform (Scotland) Act 2012, which states that our purpose is to

"improve the safety and wellbeing"

of individuals. That was probably not stated in our purpose before we became Police Scotland—although, regardless of that, as a police service, we have always supported people with vulnerabilities. What does "wellbeing" mean, though? We are probably still wrestling a wee bit with how we should define that in our service provision. If we do that, what would it mean for our partners' service provision?

There is an element of providing unscheduled care. I hope that people will be supportive of the fact that Police Scotland is not taking the position that forces down south have adopted, where certain areas have said, "We are stepping back and we're not going to do that." We think that our legislative purpose is different. However, we will have to work with our partners to find out where that line stops. At some point, we will have to remove ourselves and go back to what I would call traditional core policing requirements. The reality, though, is that dealing with mental health issues is now such a requirement, and what was once seen as traditional needs to be redefined. Will mental health issues always have an impact on policing? Yes. Will policing in Scotland always step up anyway and make a commitment to deal with the most vulnerable people in society? Yes.

We need to consider how we could get care services from statutory and non-statutory partners to fill the gap that occurs when an individual is not admitted to hospital. What should we do? Should we walk away and leave them in a vulnerable state? As we heard in the earlier evidence, post-Covid, many people have lost their support networks and some of them just do not have family support. We often find ourselves filling that gap—not through choice, but because we are invested in protecting vulnerable individuals.

Graham Simpson: I am sure that officers on the ground will tell you—as they will tell any of us—that the police are risk averse. That is not a criticism, by the way; it is just the reality.

You mentioned the situation down south. Ultimately, the solution will come down to finding the best way of dealing with people who have mental health problems and who need help. The question is: are the police the best people to do that? The answer is sometimes yes, but it is often no. That has been examined down south. The police there have a system called the right care, right person approach. Humberside Police took that up and it believes that, on average, 1,400 officer hours every month have been saved by adopting that different approach. If it was applied across the whole of England, it could save up to 1 million police hours a year. That shows that it is a good thing from a resources point of view to deal with things differently.

We should not completely rule out what is being done in England. We should look at whether we can learn from it, because we do not want Police Scotland to be tied up dealing with cases that are not its job.

Derek Frew: I completely agree. We do not feel that it is the police's job to fill that gap, to be blunt, but we have made a commitment that we will not take the approach that the police in England and Wales are taking without a proper plan, engagement and consultation with partners and understanding the right care, right person model. His Majesty's Inspectorate of Constabulary has commented on it, and we will consider and review it as well.

We have a workshop with partners coming up on 22 November to help us to work towards a new model for Police Scotland. We can do that only through collaboration. We realise that, with the funding envelope that Police Scotland has and the reducing police numbers based on that, we need to come up with a model not only for mental health but for efficiencies across the board, and we are doing that. That step on 22 November is important because we cannot design that service without professionals from other bodies. We have to listen to lived experience. HMICS uses an advisory group and we will see how, in the future, we will listen to lived experience. We will use our service design team to come up with new approaches and models, but those will not be based on just stopping and pulling back, because that is not what the public—and certainly people with vulnerabilities—require.

We have good practice going on across Scotland. It is hard to get a consistent approach because there are different health boards and third sector organisations. It is challenging to try to get a model that works everywhere.

Good learning is coming out of the NHS Forth Valley area on a risk assessment process. You talked about us being risk averse, Mr Simpson. As you know, we think about what happens and whether we would be subject to an investigation by the Police Investigations and Review Commissioner. We are looking at the work that has been done in Forth Valley with police, partners and the PIRC on a proper clinical risk assessment that allows us to take an individual to hospital and then to move back based on the assessment. However, that is done through partnership. We are considering whether that model can be scaled up and thinking about geographical areas where we can pilot it in 2024.

Graham Simpson: That is—

The Convener: Graham.

Graham Simpson: Yes?

The Convener: Sorry to interrupt. It is just to alert you to the fact that Mike Burns, Pavan Srireddy and Chris Williams also want to come in on the question.

Graham Simpson: Oh, do they?

The Convener: Yes. It is not a dialogue; it is a round-table session.

Graham Simpson: It is, and it is good to know that other people want to come in on this important question.

I was about to say that it is encouraging to hear what Derek Frew said about the project in Forth Valley—I would like to know a little bit more about that—and the discussion that is coming up on 22 November. It is great that we are examining the issue. It would be good if we could get to a system whereby, even if police are called out, they can contact somebody else who can take on the case.

Convener, I do not know who you want to bring in.

The Convener: I will bring in the witnesses in the order that I mentioned.

Mike Burns: As a social worker of 30-plus years' experience who has delivered services on homelessness, addictions and mental health, I have nothing but admiration for the way that Police Scotland—excuse my voice; I am full of the cold—works with the most vulnerable and those in crisis here in Scotland.

I will give some examples of how we are trying to plug that gap. To my knowledge, there are only two commissioned multi-agency services working alongside NHS Lothian and NHS Tayside: Edinburgh crisis centre and Hope Point community wellbeing support centre in Dundee. Those attempt to address some of the issues that Police Scotland highlights in delivering what we would call a physical walk-in mental health crisis service. There are some areas of good work out there, but they are few and far between.

Dr Srireddy: I echo a lot of what Derek Frew and Mike Burns have said about the very different context in Scotland—our working relationships with Police Scotland are far more collaborative. I have grave concerns about any move towards the unilateral approach that was adopted by the Met Police to withdraw and then look at what needs to be put in place. That puts people at real risk, and those are some of the most vulnerable people.

The police are going to be part of the collaborative approach that Derek Frew described to find the right model for us in Scotland. There are elements of learning to be had from experiences down south, but I also want to highlight that there are lots of examples of good practice here. Derek and Mike Burns mentioned a couple of those. Another example is the mental health assessment units, which act as a diversion from A and E so that officers do not need to be stuck there for five, six or eight hours. If you have a mental health crisis, you go straight into the mental health assessment unit, where you are seen by a specialist, rather than having to go through the generic process.

However, all those things need to be funded, which is the real challenge. The difference with the Humber example is that the investment in mental health services, as a proportion of overall health spend, is about 13 per cent, which is almost exactly double what is spent by some of the health boards in Scotland, where the average is about 6.57 per cent. You get what you pay for. Ultimately, that is the challenge.

We need dedicated investment in all components of the service. From specialist services, where there is a statutory role for somebody who is presenting in crisis and might be a risk to themselves or others all the way through to multi-agency examples, such as those that Mike Burns has described, or other third sector partners. We have not seen that joined-up process of making long-term investment decisions—not year-by-year decisions but long-term investment decisions—especially with regard to third sector support and commissioned services that allow for a collaborative shift away from the police acting as first responders in a lot of those circumstances.

The Convener: Thanks, Dr Srireddy. I am going to bring in Stephen Low, as we have not heard from him yet. I will then bring in Chris Williams to make a brief comment, after which we will move on.

Stephen Low: I want to make the point that a lot of this is failure demand. A lot of our people are quite upfront about the fact that they do not have

the capacity, numbers or range to help people before they reach the crisis point that involves the police. Indeed, they are getting involved with people only after incidents and behaviours that have involved the police. If you want to reduce demand on the police, there is a strong case for interventions to be made downstream, so to speak, in services such as housing and the various psychological therapies and so on that people have been talking about. We should not have police involvement to the extent that we do, because we should not have as many people in crisis as we do, and there are ways to prevent that, if we are serious about it.

The Convener: Thanks—that is helpful.

Dr Williams: I was going to make that point. We have some good examples of multi-agency working, but the one element that we have not flagged up is that some people have insight that they have a mental health problem and that they need help, whereas other people do not have such insight, and it may be their friends and relatives who are flagging up concerns, either to health services or to police, especially if there is any suspicion of a threat of violence or another situation in which the police can offer specific skills, capacity and resources. With an ageing population, we are seeing more and more vulnerable people with carers or relatives who live far away where there are concerns about wellbeing.

09:45

Graham Simpson: That has all been really useful, and I thank everyone for contributing.

I should say that my understanding of the Metropolitan Police system is that they respond to 999 mental health calls only where there is an immediate threat to life. I am not sure how someone is meant to judge that over the phone; it seems to me to be a rather blunt system. Perhaps we can improve the way in which we deal with things.

Convener, I do not know whether I have time to ask the witnesses about the model that is used in Trieste. I do not know whether you want me to do so.

The Convener: Yes, I do. If anyone has any views about that model, which is highlighted in the report from the Auditor General and the Accounts Commission, we would be interested to get their views. It involves a more community-based organisation, and it is a walk-in service. Perhaps Anne Rowan would have a perspective on that. Anyway, I will bring in Graham.

Graham Simpson: It is mentioned in the report that, in Trieste, Italy, they have set up what is essentially a new way of dealing with mental health. The system operates through a network of mental health centres that operate 24 hours a day. People do not need an appointment—they can just walk in. It has not only improved the way in which mental health is dealt with in that area; it is also cheaper than what was there before. That is not why they do it—it has just ended up that way.

You do not have to comment if you have not read that section of the report or if you do not know about the model, but if you have read it and you have any views on it, we would be keen to hear them.

The Convener: Both Anne Rowan and Mike Burns have indicated that they want to come in, and I think that Christiana Melam wanted to come in on a previous point. Anne and Mike might be the ideal candidates to tell us about their insights into that approach. We will begin with Anne.

Anne Rowan: I have known about the Trieste model for as long as it has taken me to recover from the death of my son. There is the Trieste model, the Pieta system in Ireland and the Maytree foundation. I have based Chris's House on the principle that anyone in crisis can access mental health services at any time, 24 hours a day, seven days a week, 365 days a year. I am very proud that we in Chris's House have a very high success rate.

We are not a big player—we do not, and cannot, advertise. Dr Srireddy mentioned funding; we do not get funding. We are self-funded, which limits us in how much we can expand.

I set up Chris's House with my vision. My educational background is in social science, but I have got bolt-ons since I started Chris's House. It is a very successful model. The problem in our country, as opposed to the experience with the model in Italy—there is something in Brazil or Peru as well—is red tape. As has been mentioned, people are frightened—they are risk averse. We are all tied up with red tape.

I understand that the Edinburgh crisis centre live-in service is no longer working. That is what I am hearing. I do not know whether I am right—Mike Burns can correct me if I am wrong. Red tape has meant that, in relation to health and social care, live-in centres are classed as institutions, and it cannot get the service properly in place because of the regulations. We get tied up with regulations.

In Chris's House, I am glad to say that we are independent, and we work on a person-centred basis to address the person's needs. When we can influence outside agencies—housing, social work or anything else—we do, but we are not recognised in the way in which a statutory service is recognised, so we do not have the teeth that

other organisations have. Hopefully, that will come in time, once we have proven how successful we are.

Everyone needs to have access to a service when they are in crisis. People are not in crisis in three weeks' time or in two days' time. We do not organise crisis; it happens when it happens, and people have to be attended to.

That is all that I will say on the issue. I hope that that provides an answer. It is a very good service.

The Convener: Thanks, Anne—that is very helpful.

Mike Burns: To answer Graham Simpson's question, as somebody who has studied the Trieste model for a number of years, I can say that an earlier intervention in crisis will always be more cost effective. We know that: all the research is there, and you do not need to be Albert Einstein to work that one out. The point that Anne Rowan makes is really good: we have some difficulties in this country around registration, and we note the role of the Care Inspectorate in relation to how models are developed in Scotland. I would encourage the committee to consider that, and to talk to people with lived experience about the really positive outcomes that a model such as the Trieste model has been able to achieve for them.

Christiana Melam: I agree with what most people have said, apart from on the Italian model.

We have a crisis model, which is why the police are dealing with people with a mental health crisis. All the public sector operates to a crisis model, and most of the cases that organisations see are a cry for help.

We need to change behaviour—we need to recognise that we have to effect behavioural change. That is why the third sector is not as recognised as it should be. Even community link worker posts are not sustainable, despite their delivering fantastic services. That also concerns GPs and the community sector. Patients have actually said, "This saved my life." Despite that, in Glasgow, the number of link workers is about to be slashed by a third. There has to be an acknowledgement here. What are we talking about when we talk about mental health? Are we talking about mental health in terms of poor mental health? Are we serious about preventing people from deteriorating?

We have a massive example in the Highlands, where custody link workers work with the police under a community justice partnership programme. We have examples here. Link workers are taking referrals from the police. That has to involve a pathway. From establishing what the need is, we can design pathways and consider using step-down models. We need to speak with community programme providers and link workers to find out what they are already doing, how they are working with the criminal justice system, what the need is like and how to increase capacity from there. We cannot do that if we do not recognise that we are not just an optional addition as a workforce.

The Convener: Thanks, Christiana: that is a point forcefully made. I will come to Pavan Srireddy next; I will then turn to Colin Beattie to put some questions. Could you comment on the Trieste model, perhaps, Pavan?

Dr Srireddy: I am very aware of the Trieste model. I have studied it, and I have looked at it and evaluated it in detail for more than a decade—and it has been around for more than three times that long. The Trieste model is what guided the shift to community mental health in Scotland. It is not new; we have worked on it for the past 20 or 30 years. Unfortunately, it is a job half done. We made the shift, we shut the asylums and we have moved into the community—but then we kind of lost interest.

I would disagree whole-heartedly with Christiana Melam's point that the public sector model is a crisis model. Our model is very much about looking after people in the long term, including people with severe and enduring mental illnesses. I am making a distinction between poor mental health and severe and enduring mental illness.

I am talking about people with bipolar disorder, psychosis, severe obsessive compulsive disorder or severe eating disorders, which are, in some cases, lifelong conditions that have a huge impact. For the past 20 years in which I have been working as a psychiatrist, I have seen those people, and I will see them for the next 20 years while I continue to work as a psychiatrist. We build long-term relationships with people.

The challenge has been that we have made an investment in the community and started the process, but we have lost sight of it. There needs to be a focus on prevention but not at the cost of investing in specialist services as well. It is not an either/or model. It is a bit like saying, "We'll invest in smoking cessation, but we don't need to worry about cancer services."

We are talking about generational shifts, and prevention takes place across multiple levels. That goes from crisis prevention, which is what specialist mental health services provide, all the way through to looking at housing, employment and educational resources, which is about primary prevention. Sometimes these conversations get simplified into an all-or-nothing position: that somehow, if we invest early, and invest in prevention, we will not have mental illness. That is not the case.

The point that I am trying to make about Trieste is that it is a very good system, but it requires—to go back to what I said—a long-term strategic vision, and a commitment that success is not measured in one-year, two-year or five-year cycles, but in a 10-year or 15-year cycle.

The Convener: Thank you—that is a very clear point of view.

Before we finish this section, I will give a last word to Derek Frew, before I bring in Colin Beattie.

Derek Frew: I appreciate that, convener—I will keep it brief. I want to comment on what Dr Srireddy just said. That strategic vision, over 10 to 15 years, of a 24-hour service, is what will reduce demand on policing. Until there are mental health services that are available 24/7, the police will continue to fill that gap, so I whole-heartedly endorse what has been said.

The Convener: Thank you, and thanks for being succinct.

Colin Beattie: I want to look at some aspects of access to support. I will start with GPs, so I will put Chris Williams on the rack first. In my experience as an MSP, we get people coming in who have mental health issues, to a greater or lesser extent. Usually, we pass the information back to their GP surgery, and we get zero feedback, for confidentiality reasons. Often, the same person is back a month later, still with the same problem, and we never know what has happened.

Although we do not hear in the majority of cases, anecdotally, we hear that, as long as the person is not a danger to others, the surgery is not fussed. However, someone who has a belief that they are under surveillance by the police or MI5 or whatever may be very distressed, because they truly believe that. It seems that nothing is being done in that respect.

I am asking about the role of GPs. What support do you need to better support the mental health needs of patients? Where is the break there?

Dr Williams: First, I will speak generally. All GP practices look at their access arrangements, and we are continually changing how we try to understand where there is need, and how we try to deal with that, above and beyond demand.

Sometimes, we are hampered by old telephony systems, for example, in which there is a limit to how many people can contact the practice at one time. Sometimes, we see a surge in people trying to contact the practice all at once; the Monday morning scramble for appointments is one example. We try to introduce other ways for people to get in touch, such as digital methods that enable people to send in a form. All the time, we are trying to find ways to allow patients to come into the system.

Where we have—as I highlighted earlier—a limited GP workforce, especially where that workforce needs to attend to other tasks, such as educational tasks and supervision of other clinicians and members of the team, we can really become stretched.

On the back of that—as you picked up on, Mr Beattie—continuity is a big thing in general practice. It does not always need to involve people seeing the same GP; it can be different clinicians or members of the team, although I should say that the evidence relates to continuity of general practitioners, rather than studies on the other members of the team. Continuity, when we can afford it, means that someone feels that they are known and are listened to, and that their issues are understood. Even if we cannot fix all those issues, continuity gives people a better sense that they are doing okay.

10:00

I absolutely accept what you say about some of the frustrations that people will voice when they feel that they cannot access a system, sometimes through no fault of their own. Again, however, I highlight that there are a lot of people across primary care, in particular GPs, who want patients to have a straightforward route for access, especially those who need to be seen in a timely way.

Colin Beattie: There is a wide range of mental health issues—it is not just one particular issue for people. The report describes the process of getting support as “slow and complicated”. What happens when people are not eligible for special services but still have mental health challenges? I throw that open to everyone.

The Convener: I think that Pavan Srireddy wanted to come in on the point about the role of GPs—he might have a view on that question as well. If other people indicate, we will bring them in too.

Dr Srireddy: My point is linked to both the questions that have been discussed. First, the challenges in the interface between primary and secondary care include the capacity for communication and the need for mental health expertise to be available within the primary care setting. That is a real challenge, because our primary and secondary care services tend to work with distinct boundaries, so it can be challenging when someone does not neatly fit within those boundaries.

Some of the work that has been undertaken around expanding the provision of mental health and wellbeing services in primary care would have gone a long way in addressing some of those challenges. That includes the initial challenge that

was described regarding how people get access to specialist services, and access to advice in order to determine what the best service for them would be and what the alternatives would be if they do not meet the threshold for special services.

There are really good models. For example, down south, in Cambridgeshire, there is a model that has been in place for several years. In Scotland, the aspiration was that we would expand significantly the provision of mental health specialists and third sector mental health provision within the primary care setting, with the expansion of multidisciplinary teams. That would include input from not only psychiatrists and psychologists but link workers and third sector partners.

All that has been on hold since the cut to the budget that was announced in the emergency review in December last year, and that is a challenge. What I have described is a much-needed resource. It can be provided, and we have a very good idea of how that can be done, but it needs new investment. The £32 million that was earmarked for that would have delivered on and addressed a lot of those challenges. It would also have addressed the challenge of what alternatives are available if people do not meet the threshold for specialist mental health services.

My other point is that when we talk about someone being rejected by a specialist mental health service, it is not simply about gate keeping or keeping people out. It could be that that person's needs would not be met in a specialist mental health service, within the model of care that is provided in a psychiatric service. It may also be because that may not be helpful to the individual.

There should be alternatives. The challenge is that those alternatives do not exist, and that is where it becomes a problem. Sometimes, a bad alternative is not a substitute for no alternative—it is important to highlight that and keep it in mind.

Colin Beattie: I will come back on one or two of those points. Between primary healthcare and moving into secondary care, who does the triage? How does it work? Who decides on the priority for a particular case?

Dr Srireddy: In practice, it is based on the information that is provided in the referral. The triage is done and the decision is made within the secondary care service, on the basis of what that service provides. In an adult community mental health team, for example, we would look at the information that is provided in the referral by the GP and at whether the individual's needs are best met within the secondary care service. Sometimes, if we can identify an alternative service, we would signpost the individual to that, but that triage process is undertaken by clinicians within the secondary care service.

Colin Beattie: I do not know whether anybody else wants to come in—

The Convener: They do. I will bring them in before you go on to your next question, if that is okay. I am conscious that Unison has a lot of mental health nurses among its membership, so Stephen Low might have a view. I will come to him in a second. However, first—remotely—both Christiana Melam and Mike Burns want to come in on those points.

Christiana Melam: The referral and the way that we describe mental health are linked. There are those who have mental illnesses, as Pavan Srireddy has listed, and those whose state of mental health is a result of other issues that need not a clinical treatment but a non-clinical approach such as link workers provide. We need to figure that out and make sure that people are not bouncing around the system. The specialist services need to be aware of what link workers do and what they are not able to do, so that we are clear on what the middle ground is. When people do not fit into any box, they just bounce around the system and the referral comes back to the GP, whereas link workers who are based in the community or in primary care might be able to pick them up.

We need to discuss and have a look at what the evidence and data say, and to take a personalised approach to mental health. Some people respond better to a non-clinical approach and some respond better to a clinical approach, but placing everyone on one list might mean that people wait on that list inappropriately and that we cannot identify what step-down model they might need.

Colin Beattie: Christiana, while you were talking, I was wondering about the extent to which people are aware of the different types of support. How aware are people in general of the role of community link workers?

Christiana Melam: They are not very aware. I gave evidence to the Health, Social Care and Sport Committee's inquiry on alternative pathways into primary care. We do not have universal access in primary care, which is a challenge. We need universal access to community link workers across all GP practices in Scotland, because the evidence suggests that most of the mental health work happens in primary care—in community care.

Not being able to provide that access means that it is difficult to have a universal campaign. When the current First Minister was Cabinet Secretary for Health and Social Care, I told him that we needed a national campaign to raise awareness of the support that can be provided by

community link workers. However, we need capacity. When people do not value us as something other than an optional addition, that is not sustainable.

Right now, many link workers in Glasgow do not know whether their job is guaranteed. That sort of approach is more like a setback. We bring in an additional workforce, we promise a service to the public and, now that they are getting used to it, we take it away. That is wrong. We need to think about what we are doing. Are we serious about helping people to live well and in good mental health, or are we just ticking boxes? If we are not serious about link workers and what they bring, that is just a let-down to patients.

The Convener: Thanks, Christiana.

I go back to Colin Beattie's question about the report's description of access as being "slow and complicated". I will bring in Mike Burns, then I will come to Stephen Low. Anne Rowan wants to come in on this area, too. Mike—remotely—your view would be helpful.

Mike Burns: To pick up on Colin Beattie's question, one of the best examples in Scotland over the past two or three years has been the distress brief intervention programme, which works with people who are in various states of distress—anything up to suicidal ideation. The recent evaluation of that shows the outcomes that we have achieved and how valuable the programme has been in diverting people away from clinical services or statutory mental health wards or, indeed, the role that the police played, which was highlighted earlier.

One of the difficulties that we have is that, despite that, the Scottish Government will no longer provide dedicated funding for DBI as of March 2024, and that is expected to be reflected in health and social care budgets. As the report points out on page 21, that could result in varying quality and availability of DBI services across Scotland.

To go back to what Pavan Srireddy said about the Trieste model, if you start and build a model that proves to be really good and successful, you need to think long and hard about how you take that forward.

Stephen Low: I will address Colin Beattie's final question, which was about how aware people are of what is available. I do not wish to be harsh on doctors, but people do not always need doctors. However, we are wired to think that you must see the doctor and that, if you have not seen the doctor, you have not seen anybody. A load of alternatives have been available for a while and have progressed. There is much more online access to information and even attempts at therapy. There is NHS 24 and the Breathing Space programme. I could say a lot about how they operate but, nonetheless, they exist.

If we are to create a sustainable set of mental health services, we need to get away from the idea that everybody must always see a doctor, even—I suspect—initially. You might need a doctor to go down the social prescribing route of the link workers that Christiana Melam is arguing for, but you do not always need a doctor to deal with everything. There are other approaches. We need a cultural shift. I am not sure how we develop that but we need more effort to get other clinical professionals and people with expertise involved and available for people. I could talk about staffing, but I suspect that we will get to that later.

The Convener: Thanks. That is a really helpful perspective to bring in.

I turn to Anne Rowan for her view on whether the answer is the link workers and what happens to people who fall through the cracks.

Anne Rowan: Pavan Srireddy mentioned people with long-term mental illness and bad alternatives. There are bad alternatives. The Government is using a lot of peer support workers. There are good peer support workers and very good link workers but there are also people who think that they are armchair psychologists. There is a place for everyone, but people need to know their limitations.

We are a non-medical or non-clinical centre. The people who work in the centre are psychotherapists; they are at masters level. Although we need clinical services and medication at some points, we need to get to the trauma that has caused people to have long-term mental illness. It is not always just chemical imbalance; something may have caused it. A lot of trauma work needs to be done. We need to be a lot more trauma informed.

On best practice, it is wonderful that Mike Burns mentioned the DBI programme. It is a short-term intervention, but services such as ours are finding that we are the flies holding up the ceiling, because we have nowhere else to send people. We get them when other people are getting paid to do a job that they are not doing. I know that the waiting list to see a specialist or to see the specialist service is longer. I have three psychologists working in the centre.

If somebody presents to me in some psychotic form and I cannot get them to see someone that day, what am I supposed to do? They are psychotic: they are a danger to themselves and maybe to other people. I am very lucky, in Lanarkshire, that the police are aware of us. The police will often bring in people who have been dismissed after being on a train line, for instance.

The police will have taken them to the hospital and brought them back in, but they are deemed fit and deemed to have capacity. A lot of people know the right things to say.

10:15

Everybody has to get a joined-up service, and we need to respect everybody else's input and know what the need is. There is no particular hierarchy. I understand that everybody thinks that their model is the best one but, as somebody said, there has to be a shift to other people, such as peer support workers, link workers and psychiatrists. We all have to work together. We all say that we are working together, but we are not. Very often—as Mike Burns will know, as chief executive of Penumbra—we are fighting fires all the time.

It is very unusual for me to be sitting in any meeting. I do not take time to sit in meetings, because I am busy working with what we are working with on a daily basis. If I gave you our figures, you would probably think, "Wow, that's a small amount compared with the statutory services." It is not a small amount for the size of our organisation. I want our organisation to get bigger and bigger, but we can only do that when people start to work together and respect what the others do.

I do not know if that takes away from the point, and that was a bit long-winded, but I get really upset when people just think that they can work with bipolar people, for example. I would never touch anybody with an eating disorder such as anorexia, because I do not have the team to work with that, so I know that that is not for us.

It is not about getting numbers; it is about getting the best for people. That is why I try to model as near to the Trieste model as I can—because I have lost my son to suicide. We should all sit up and take note. We should stop ticking boxes; we should do the work and do the job. I know that we are all sitting here because we are doing that, but I am pretty passionate about this—I get passionate when I am speaking, and I am no making an apology for that.

There are too many variables in dealing with people's mental unwellness, and that goes for local council areas and the personalities there. People have compassion fatigue, and we need to get things on a level, with an awareness of link workers and of what people can do and are there to do, rather than just ticking the boxes.

Colin Beattie: On the back of what Anne Rowan is saying, it is worth highlighting from the report that there is huge variability in primary care and mental health services, third sector services and peer support across Scotland. I do not know to what extent that arises from greater or lesser knowledge and awareness of the different forms of support that exist, but I would be interested to hear any comments on that and to hear about anything that could be done better. How do we join things up? Anne Rowan has highlighted the point that not everything is joined up. How do we fix that?

The Convener: Chris Williams wants to have a go at answering that question.

Dr Williams: It is a big question. Many of the interfaces are not always reviewed in the continuous feedback loop that we need.

You asked about the referral process. In Scotland, we have an electronic way of passing up non-emergency things. For example, if you have physical health problems, there is a category of urgent suspicion of cancer where you get put on a very fast waiting list, but that option does not exist in mental health.

The system allows information to be structured in terms of how we pass it on. On how that information is then received and reviewed, for example, in my local area, the referrals are reviewed by a team that considers which services are available locally to deal with them, and they give very prompt feedback to me as a referrer. That feedback drives things. It supports the referring behaviour and makes sure that I put the right level of detail in while balancing that with the speed of passing things along the line. Although we are two separate teams, because there is adequate communication, the system functions well.

I mentioned earlier that some systems are under such pressure that the feedback is simply a rejection or a referral. We mentioned conditions such as ADHD where there has been such a massive rise in demand that the specialist services need to try and identify who are at most need or who the service can provide for, and will, in response to a referral, send back a counter request asking whether the patient would wish to take medication and what they hope to get from a diagnosis. The specialist service will try and sense check the referral. Feedback is the key to overcoming those stresses.

The Convener: We are really up against the clock, so I apologise to a couple of people who wanted to come in on that point, but I need to move things on. We have to cover some important areas, and I invite Willie Coffey to lead us off on the next section.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): What an important discussion we are having. It is important for the committee to hear Anne Rowan speak in the way that she has done. That is one of the most moving contributions that I

have heard in my long experience as an MSP, so thanks for that.

I note that, while the committee has been in discussion, the Government has announced an extra £1 million for the community link worker health and social care partnership in Glasgow. Christiana Melam will probably be delighted to hear that wee bit of good news, and there will no doubt be a clamour from other health boards to get something similar.

My question is, how can we improve these services? I am thinking in particular about the Auditor General's comments about the cluttered landscape and structures that we have. We have integration joint boards and health and social care partnerships, but we often do not have compatible systems to share information and so on.

Does anyone have a view on that? I would be obliged if you would give us a few thoughts on how we might improve the situation.

The Convener: The question is on the governance architecture and whether it works and fits together well. Dr Williams is indicating that he wants to come in first and if other people have a view, just let us know. You do not have to have a view, of course.

Dr Williams: I will speak first on behalf of my psychiatry colleagues, who I know were very fearful about some of the reorganisation proposals with the national care service about having clinical staff in a governance structure that is based around social care. Dr Srireddy might wish to pick up on that.

On information sharing, we frequently hear that people in the system do not want to repeat their story and that they think that clinicians and administrative parts of the team can access the information. At the same time, people are finding that information governance barriers are an issue. Those were set up with very good intentions; the issue is the operationalisation and the legal fears around that, as well as the fact that our information technology systems are not yet good enough to easily enable us to have the role-based access that we would need for good information sharing.

The Convener: I will bring in Dr Srireddy, followed by Mike Burns and Christiana Melam.

Dr Srireddy: The previous answer was really helpful. Governance has been a real challenge. Unfortunately, the move to integration has, more than anything else, meant nothing but fragmentation for the area of mental health. There has been duplication of governance structures, and a lack of co-ordination and planning as result of a lack of clarity about responsibility between integration joint boards, HSCPs and boards. In most cases, it is felt that mental health has come as an afterthought.

That is exactly how it has felt with the national care service proposal. The reference to mental health takes up just one paragraph, and it has continued to be an afterthought in all the planning. Most of the references have been to social care, rather than thinking about mental health in a much broader holistic sense.

The national care service proposal also seems not to recognise the link between physical health and mental health—it seems to treat those very much as two separate and distinct things, rather than as things that are part and parcel of an individual. It is almost as if we have separated physical health and put it in one section, with mental health in another section, and expect those things to come together automatically.

That has been my personal experience, as a clinician on the ground. We have a huge amount of red tape due to the duplication of governance structures across the board areas and across IJBs, and we do not know what the national care service is going to bring in.

Chris Williams made a point about communication, which is a huge challenge. We all use different communication systems and, if anything, that fragmentation is worsening.

My sense is that a lot of that comes down to a failure to recognise the importance of mental health services and that mental health is something that needs to be a priority for planning and structures. It seems to be pushed into the background and moved to fit in after other decisions have been made.

That is our grave concern about the national care service. Everything that we have seen so far has reinforced that concern: mental health seems to be an afterthought. The proposal for the new service seems to be focused on care provision, and mental health support, care and treatment comes as an afterthought to be fitted in as an either/or, rather than thinking specifically about needs with regard to mental health services.

That is a real challenge, and it is a real challenge to have that concern heard. That contributes to the fragmentation and the lack of joined-up working and integration that we have touched on at various points all through this discussion.

The Convener: Thanks. On the point of governance in particular, I turn to Mike Burns for his thoughts, and then I will come to Christiana Melam, and to Stephen Low in the room here.

Mike Burns: I whole-heartedly agree with everything that Pavan Srireddy said. I do not know what shape or structure the NCS will take, but until

we have that in front of us, our concern is that mental health will be the poorer for being lost within a structure that will possibly be dominated by older people's services. That is a big concern.

I have the privilege of co-chairing the biggest test of change in social care in Scotland, in Aberdeen City Council's Granite Care Consortium. There, we have managed to put mental health on an equal footing alongside older people's care, learning difficulties and personal care. Our whole drive is to move away from a time-and-task model to one that is focused on outcomes for individuals.

That has to be the direction of travel for everything that we do in mental health and in social care. Unless we focus on outcomes for people, we will continue to focus on the services that we can deliver as opposed to the services that we need to deliver.

The Convener: Thanks, Mike—that is really well put. I go to Christiana Melam, before I bring in Stephen Low.

10:30

Christiana Melam: Healthcare is holistic, so it is about joining everything up. Link workers are in a unique position, because we are a community of people who have managed to be embedded in the clinical teams in some GP practices. We find ourselves acting as a very strong link between the community and the clinical services. That means that there is an opportunity to do holistic healthcare, and to do the biopsychosocial work that we have always wanted to do, so that the continuity of care is not lost. The challenge is that we need to be able to follow the person's entire journey, which is not being enabled by the current funding commitment to link workers, which is just about paying for link workers—we are not looking at digital infrastructure and information governance, which would help us to check what we are doing.

The Professional Record Standards Body has managed to produce information standards that are relevant across the four nations. We need to look at that and see how we can strengthen our system. With the work that our members do, the traditional way of running clinical systems does not enable us to capture all the information that we need. A different approach would help us to capture some of the social data and what is going on in the community. That should help to drive data-driven and informed commissioning arrangements, too.

The Convener: Thank you for that. I bring in Stephen Low.

Stephen Low: Would that the inadequacies of the National Care Service (Scotland) Bill were restricted to mental health—however, that is for another day.

We should remember that when that bill was proposed, the minister responsible talked about a system combining social work, social care and community health, as if that was a seamless continuity, when of course it is not. It is obvious from our discussion today how many mental health services, and services that contribute to improving mental health, are inextricably linked with local government, for example, and things like social care and housing. Mental health is not something that could easily be, or should be, separated from everything else, or indeed just lumped in with anything else. We need to have a dynamic.

The National Care Service (Scotland) Bill is an attempt to deal with perceived inadequacies with the Public Bodies (Joint Working) (Scotland) Act 2014. That act in itself was about the 15th go—those who are older than me might remember—at integrating health and social care.

What we should have learned from all that is that it is not structures that matter. We get better delivery based on relationships on the ground, and we need to work on improving them. I do not have a big answer for a centralised, imposed model that would work, and I am not sure that there is one.

What we need is to get these services working together, not, to be frank, legislative action as such. It is about improving services, communications and the resources on the ground. It is not structural change in particular that we need.

Willie Coffey: Thank you for your important contributions.

This is my final question, in the interests of time. The Auditor General's report was fairly critical of the Government's ability to measure performance, quality of mental health outcomes and so on. However, everyone around the table has contributed some great ideas and great local experiences of good practice here, there and everywhere.

What are your views on how the Government can better do that so that we can report on outcomes? That is important. Should we collect the various experiences from around Scotland and somehow gather them together? I would appreciate your views on how we should tackle that. I start with you again, Dr Williams.

Dr Williams: In Scotland, we used to have a system known as QOF—the quality outcomes framework—which was a way of GPs and their teams coding specific information in patient notes. It was of its time, and we abolished it in Scotland

for good reason. It had become box ticking, and was causing a burden.

At the time, we hoped that GP quality clusters would take over, and that, as Stephen Low described, a bottom-up approach to teams and good practice would develop new and better ways of working, not just of coding activity. In QOF, for example, we would capture a mental health review; however, we dropped off from recording mental health reviews for some conditions in general practice. That means not that that activity is not happening but that we cannot track it.

As you mentioned, clinical outcomes are probably our preference for tracking, as is patient experience. However, as yet, and for the foreseeable future, our workforce does not have the capacity to do that. A firefighting approach was mentioned. We are reacting to demand. We are not yet able to be proactive, and I do not see us reaching that space within the next couple of years, to be frank. We would need a further modernisation of primary care. General practice clinical systems are able to capture data on outcomes, but our teams need the time to work together so that, for example, the primary care and mental health workers know how to use those clinical systems to their best effect, so that further generations of clinical systems can be harnessed.

The Convener: Willie Coffey's point was about how we capture outcomes and whether the performance measurement systems are adequate. Pavan Srireddy, you wanted to come in on that, I think, so I will bring you in next, then I will turn to Christina Melam.

Dr Srireddy: I will quickly say that I agree with the points that Chris Williams has made about systems and workforce capacity. Those are two of the biggest issues: having an appropriate and adequate IT system and the infrastructure to support the recording of information and data, and having the workforce capacity. Clinicians do not want to spend most of our time recording data rather than seeing patients, so we need the systems to manage that.

Another big challenge is prioritisation. One of the most telling things in the Audit Scotland report is that, in the section about improving services, the first thing that it talks about is psychological therapy targets. Psychological therapies account for less than 10 per cent of total mental health service activity, but there is an overwhelming focus on just that one single metric because it is easy to measure. What we do not know is how long someone might need to wait when they are in crisis; how long they might need to wait if they need admission to a hospital bed; or how many people have died while waiting for admission to a hospital bed. We have no idea about any of those metrics, and there is an overwhelming focus on psychological therapy targets to the exclusion of all other clinical priorities.

I do not necessarily say that focusing on psychological therapy targets is not a good thing. However, that skewing of priorities is dangerous. I use the word "dangerous" not lightly but because of the effect on priorities and focus. That is the concern. To really understand what is happening in our services, we need a suite of measures. We need a broad-based approach to measuring how services are performing, not to focus on one thing and get stuck on that.

Secondly, we need patient-reported outcomes. We need to hear from the people we serve how they are benefiting from that service. That is completely absent. We focus on activity and expect that to be a measure of everything being wonderful. Again, that is a challenge.

Thirdly, the Government has done the work. I was involved in developing the work on indicators six or seven years ago. A broad suite of indicators was developed. The report highlights that those remain experimental and that there has been no investment in the infrastructure that is needed to measure them.

That is the challenge that I face as a clinician. Do I spend my time ticking boxes on a system or do I use it to see patients? I know which I would much rather do. When patients need care, I would much rather be seeing patients than spending lots of time on IT systems. That is the challenge, because the underlying administrative and IT infrastructure to record the information just does not exist. It is left to individual areas to find different systems, and they need to prioritise where they spend their money.

The Convener: Thanks. In the interests of time, I ask Christiana Melam to make a very brief intervention at this point. I will bring you in, Christiana, then I will invite Sharon Dowey to put some final questions to you all.

Christiana Melam: As the report highlighted, Aberdeenshire Council's mental health improvement and wellbeing service uses a tool for its community link workers. However, as other witnesses have said, we are talking about a complex situation. We need to have minimum data sets to capture link workers' information, but we also need a suite of tools that we can use. I think that a Scottish Government team was exploring evaluation and measurement tools. I would like that work to be restarted, and we would very much like to engage with it.

The Convener: Thank you, Christiana, and thanks for being so brief.

I hand over to Sharon Dowey to get some more evidence on the record for us in the few minutes that we have left.

Sharon Dowey (South Scotland) (Con): I would like to ask a wee question about recruitment and retention. What are the reasons for the high vacancy and turnover rates in our mental health workforce? What impact is reliance on locum workers having on service provision?

The Convener: Stephen, do you want to kick that one off?

Stephen Low: On recruitment and retention, it is a matter whether we want to deal with the crisis that is happening practically everywhere in the workforce. We need to pay staff more money and improve staffing levels. I am not saying that those are the sole things that need doing, but anyone who suggests that we will solve the crisis without doing those isnae really serious at all.

For example, the vacancy rate at Breathing Space, which offers a good service and is widely applauded, is currently sitting at 20 per cent. As NHS 24's recruitment web page shows, it is not trying to recruit; what it is advertising is not vacancies for band 6 nurses but recruitment fairs for them. That is how short staffed it is. Part of the problem is money—just money. Historically, nurses felt that their pay should be similar to that of police officers and teachers, but they do not perceive that now. That is part of the problem.

The other aspect is a lack of flexibility. Again, NHS 24 is the obvious example. It provides an essential out-of-hours service, but the jobs that it advertises are for five, six or eight weekends out of eight. Strangely enough, it is struggling to recruit. We need better staffing so that there is more flexibility, and that ties into the situation with locum and bank workers. Skilled staff are going for those ways of working, because they get to choose their own shifts and there is not enough flexibility in what the NHS offers them.

Fundamentally, we need to resource the system enough to allow that level of flexibility and make it seem an attractive option for people. There is more to it, but that is where I will finish.

The Convener: Again, we are quite tight for time so I will bring in Mike Burns, whom we have not heard from for a while. Will you comment on vacancy turnover rates and the whole staffing picture, Mike?

Mike Burns: There is a major issue in that respect. Speaking as a member of the Coalition of Care and Support Providers in Scotland, I would just point out that we are trying to establish a fair pay for fair work campaign across the third sector. Many experienced, skilled and highly qualified people work in mental health services in the third sector, and if we were to tell them that they were worth only the minimum wage, retaining and recruiting them would always be difficult. The campaign's current aim is a minimum wage of around £13, which is just £1 above the national minimum wage agreed by the Living Wage Foundation. This is not rocket science: we have to invest in the services that we want to deliver better outcomes for the people whom we want—or need—to support.

10:45

The Convener: Pavan Srireddy and Christiana Melam want to come in on that point.

Dr Srireddy: It is a hugely complex issue, and in that respect, I want to share with the committee the report of the Royal College of Psychiatrists on recruitment and retention challenges. I can send it subsequently.

From a medical workforce perspective, we think that several factors have contributed to the situation. We are seeing high turnover rates, with staff leaving due to burnout. I do not use the word "crisis" lightly, but it feels as though we are in a death spiral. The more staff who leave, the greater the burden on the staff who remain, and that has a huge impact on the burnout rate of that workforce. That is one challenge.

There is also a very specific question about the use of locums. I highlighted the current vacancy rate of 30 per cent, because the official figures measure only the vacant posts—that is, posts that we have not been able to recruit to usually for months, if not years, at a time. Twenty per cent of our consultant workforce is made up of locums, and there are real challenges with that, not least the fact that a large proportion of locums do not have the appropriate or necessary qualifications. For example, they do not have the certificate of completion of training required to be a specialist in that post.

Secondly, consultants do a lot more than just see patients. We do that, but we also provide training, input into learning from mistakes, suggest improvements to services and undertake critical incident reviews, teaching and supervision of other staff within the team. If you want to expand the range of professionals in the team, you need that supervisory capacity and support for training and teaching. All of that goes away with locums, because we do not undertake any of those functions with them, and as a result, we have a critical loss to the system's capacity not just to improve but to change, which is what is needed. That is partly what I mean when I say that we are in a death spiral. The numbers have become so low that it has become virtually impossible to provide a safe service, let alone a good-quality

service in large parts of the country. It is an emergency that we need to sit up and look at.

The Convener: Thanks, Pavan. Christiana Melam, do you want to come in on vacancy and turnover rates?

Christiana Melam: With regard to our workforce, the good news is that we do not have a shortage of people who want to do the work. Our challenge is retention, which has to do with capacity. For example, Public Health Scotland has published the fact that we have a little under 6 million registered patients across GP practices in Scotland. There should be at least one link worker per 10,000 people, so that should equate to about 591 link workers. However, we have only about 300, so we are unable to meet demand, because this work is about giving people time.

The other issue is the lack of value placed on link workers—we are not fully valued. We have just had the announcement that the Glasgow link worker crisis is about to be resolved, but our members cannot get a mortgage, because they are all on temporary contracts. If you see a vacancy for something that is not even stable, you do not want to apply, and that is not very good.

I looked at the consultation on the statutory guidance for the Health and Care (Staffing) (Scotland) Act 2019 and saw that it is due to come in in April 2024—but can you imagine it? We are not even listed there, so what am I doing on this panel? We need to be listed, because we are part of the health and social care workforce. This is about making people feel valued and making the profession attractive as well as providing support. I have been speaking to NHS Education Scotland. It needs to provide education packages, continuous professional development and training opportunities for us, so that we can ensure that this is truly a fairer Scotland for all.

Sharon Dowey: Thank you for that. Given that we are short on time, Dr Srireddy, if you wanted to provide any further information, it would be helpful if you could do so in writing.

Can you comment on the effectiveness of the new mental health workforce roles, including any views that you might have on the recently published "Mental Health and Wellbeing—Workforce Action Plan 2023-2025"? Does the plan give you a sense of how we are going to achieve what it sets out?

Stephen Low: That is the thing. There are many good things in the plan; it is very much in favour of good things and against bad things, and it reads well. We are pleased that attention is given to workforce planning. However, the question is: will the means be provided to deliver it? It is less about the specifics of the plan than the determination to pursue it, because, frankly, many grand statements are made in it. Will effort and resources go into delivering them? That is the question—the issue is not the plan as such.

The Convener: Does anybody else want to come in on the workforce action plan?

Dr Williams: I mentioned primary care reform. There is a willingness to change how we are set up. Primary care mental health workers are a very useful addition to our services for patients, and they are very accessible, but I wonder whether our primary care improvement plans across Scotland have sufficient resource to take advantage of those primary care mental health workers—that is, the people who are based in primary care with line management through primary care.

The Convener: Dr Srireddy wants to come in on the workforce action plan, then we will turn to the final question.

Dr Srireddy: I will try my best to be succinct.

I completely agree with Stephen Low's point. The plan is not lacking in ambition, and we support almost all of its ambitions, but, unfortunately, the detail of how those ambitions are likely to be achieved in the timeframes is lacking. More important, the investment that is required is lacking, too.

Perhaps I can put that in context. It takes a minimum of 15 to 16 years to train a consultant psychiatrist, so if we want to address the 30 per cent gap in the consultant workforce in 15 years' time, we need to make those decisions now. It goes back to a longer-term strategic need for planning and investment and sticking with it for multiple cycles, but, unfortunately, we do not see that in the workforce plan. We do not see any commitments to that longer-term need for investment in the plan as it currently exists.

The Convener: This will be the final question.

Sharon Dowey: Action 15 in the "Mental Health Strategy: 2017-2027" is to

> "Increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. Over the next five years increasing additional investment to £35 million for 800 additional mental health workers in those key settings."

Derek Frew and Dr Williams, what access do you have to mental health workers?

Dr Williams: The usage of that action 15 money is opaque. From a general practice perspective, we feel that that resource has not made its way through to many areas. That said, if workers are now aligned with police services, there is huge benefit from that, and I would not want to see any slowdown in that side of things. However, my fear is that some of that money has been subsumed

into secondary care services or where it was not specifically intended to be targeted.

Derek Frew: I will answer the question as best as my corporate knowledge allows me to. We have had action 15 funding, but it has been piloted in a pocket. It is not widespread across all custody areas in Police Scotland, as far as I am aware. My concern—and this goes back to our earlier conversation—is that it will be moment-in-time, not sustainable funding.

The Convener: The final word on this question goes to Christiana Melam. I am delighted to invite you to make the final contribution.

Christiana Melam: Thank you so much. We need universal access to link workers. The report has highlighted that some GP practices do not have link workers, and I have to wonder whether Chris Williams would not like to have more of us. We are there to look after the patient's holistic wellbeing, so I do not really buy the idea that having 800 additional mental health workers is all about having a variety of workforce. We need the Scottish Government to commit to the number of community link workers that it will recruit and to demonstrating that we truly want to demedicalise life issues in Scotland.

The Convener: I thank all our panellists for their contribution and the time that they have given up. It is two hours that they will not get back, I am afraid. I also appreciate the fact that they all prepared before coming along here to give evidence, so I thank them very much on behalf of the committee for the top-quality evidence that they gave us. It has been illuminating, informative and, at times, moving.

I also remind the witnesses that, as Sharon Dowey said, if they want to make any submissions on any areas that we did not get to but on which they would have liked to comment, they should by all means put something down in writing. We will be delighted to accept it.

I now draw the public part of the committee meeting to a close.

10:56

Meeting continued in private until 11:11.

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