OFFICIAL REPORT
AITHISG OIFIGEIL

# Public Audit and Post-legislative Scrutiny Committee

**Thursday 22 November 2018**

Session 5

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Pàrlamaid na h-Alba

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# Thursday 22 November 2018

## CONTENTS


| | Col. |
|---|---|
| **DECISION ON TAKING BUSINESS IN PRIVATE** | 1 |
| **SECTION 23 REPORT** | 2 |
| "Children and young people's mental health" | 2 |


## PUBLIC AUDIT AND POST-LEGISLATIVE SCRUTINY COMMITTEE
**26th Meeting 2018, Session 5**

**CONVENER**

*Jenny Marra (North East Scotland) (Lab)

**DEPUTY CONVENER**

*Liam Kerr (North East Scotland) (Con)

**COMMITTEE MEMBERS**

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Bill Bowman (North East Scotland) (Con)
*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*Alex Neil (Airdrie and Shotts) (SNP)
*Anas Sarwar (Glasgow) (Lab)

*attended

**THE FOLLOWING ALSO PARTICIPATED:**

Donna Bell (Scottish Government)
Stephen Brown (North Ayrshire Health and Social Care Partnership)
Bernadette Cairns (Highland Council)
Dame Denise Coia
Nicola Dickie (Convention of Scottish Local Authorities)
Paul Gray (Scottish Government and NHS Scotland)
Dr Lynne Taylor (NHS Grampian)
John Wood (Convention of Scottish Local Authorities)

**CLERK TO THE COMMITTEE**

Lucy Scharbert

**LOCATION**

The David Livingstone Room (CR6)

# Scottish Parliament

## Public Audit and Post-legislative Scrutiny Committee

*Thursday 22 November 2018*

*[The Convener opened the meeting at 09:05]*

## Decision on Taking Business in Private

**The Convener (Jenny Marra):** Good morning, and welcome to the 26th meeting in 2018 of the Public Audit and Post-legislative Scrutiny Committee. I ask everyone to switch off or turn to silent their electronic devices.

Agenda item 1 is a decision on taking business in private. Do members agree to take agenda item 3 in private?

**Members** *indicated agreement.*

## Section 23 Report

### "Children and young people's mental health"

09:06

**The Convener:** Agenda item 2 is evidence on the section 23 report "Children and young people's mental health". I welcome the witnesses on our first panel. Dr Lynne Taylor is lead consultant psychologist and clinical director, child and adolescent mental health services, NHS Grampian; Bernadette Cairns is head of additional support services, Highland Council; Stephen Brown is director, North Ayrshire health and social care partnership; and Dr Dame Denise Coia is chair, joint Scottish Government and Convention of Scottish Local Authorities task force on children and young people's mental health.

For the *Official Report* and any members of the public who are watching, when we refer to CAMHS, we are, of course, referring to child and adolescent mental health services.

**Colin Beattie (Midlothian North and Musselburgh) (SNP):** I would like to focus on NHS Grampian to start with. I was interested in its written submission, which states:

> "A new strategic multiagency meeting has been commissioned focused on supporting mental wellbeing in order to prevent mental ill health."

Can you give us a wee bit of information about that and what the expected outcomes from that work might be?

**Dr Lynne Taylor (NHS Grampian):** Certainly. Good morning, and thank you for giving us the opportunity to share information with the committee.

We have developed a pan-Grampian child and adolescent mental wellbeing group, which was commissioned by and is chaired by the director of public health, Susan Webb. The purpose of that group is to think about mental wellbeing and mental ill health across what we currently know as the four tiers. The group has been thinking about not just tiered language but using models of language around, for example, i-THRIVE, which is a different model for people getting help, getting more help, and getting risk support. The group met again just recently.

We are trying to develop a pan-Grampian vision of mental wellbeing and to provide a framework for children and young people across all the tiers that are available in the third sector, education, council and health services. We have identified that there are three areas in Grampian that we would like to focus on and target our interventions in. One area

is parenting programmes, so that similar parenting programmes are delivered for all families across the Grampian region, whether they live in Aberdeenshire, Aberdeen city or Moray.

The second area is adverse childhood events and thinking about targeting interventions for children who have problems in that area.

The third area is anxiety management. In CAMHS, for example, we have money from NHS Education for Scotland to run the low-intensity anxiety management, or LIAM, programme. Our psychologists in CAMHS provide teaching, supervision and consultation to school nurses, and support for learning staff and guidance teachers on the ground so that they can deliver successions of treatment to young people in schools with our supervision. We would like to develop that programme and roll it out across Grampian.

That is some of the work that we have started. It is done across all tiers and is on wellbeing and a joined-up vision between health, council, education and third sector services.

**Colin Beattie:** I realise that it is early days, but how will you measure success? What will success look like?

**Dr Taylor:** We have had some discussions about that and have just run a workshop with all our stakeholders to give examples of good practice. It is recognised that we need to have a process for the gathering of evidence that provides a minimum data set on functioning and wellbeing outcomes for children and young people not only in CAMHS but in tiers 1 and 2 of services. We have thought about global assessment scales, such as a simple scale of zero to seven for severity of symptoms, the improvement that has been seen in symptoms and the level of functioning that young people have. If, for example, someone was suffering from anxiety, we would add on a specific anxiety measure at the start of treatment and the end of interventions to make sure that we could demonstrate not just the efficiency but the effectiveness of our action.

**Colin Beattie:** I hope that the other witnesses will excuse me for staying with NHS Grampian. NHS Grampian's submission states:

> "It has been estimated that approximately 23% of the workforce capacity is being lost due to travel between CAMHS sites".

That is because the services are delivered across four separate sites. That seems extraordinary. Is there a way of making things more efficient? Is that one of the improvements that you are looking for? Where are you going on the issue?

**Dr Taylor:** We undertook a transformational redesign of CAMHS as a whole in 2015. Services were fragmented and were being delivered out of four separate sites. We have a site in Moray that is excellent, but the staff who served Aberdeen city and Aberdeenshire were working out of different buildings, and it was very difficult to deliver safe, effective and efficient care. On top of that, we had internal transitions in our service. There was a department for children up to the age of 13 and a separate service for children between the ages of 13 and 18. Part of the purpose of the redesign was to provide a whole-service approach to children and young people aged zero to 18 so that there would be no transitions.

As part of that redesign plan, we have been campaigning and working with our local asset management group, and we have successfully secured £1 million from the Scottish Government to develop an existing NHS premises. The opening date for the refurbished building is 1 April. That will mean that all the CAMHS staff will coalesce in one building, which will be a fantastic resource that will include an education and resource room, to help us to develop our wellbeing work with our tier 1 and 2 colleagues.

The 23 per cent loss in capacity is the result of something such as a nurse travelling between two or three buildings to support a medic who has an unwell patient. There has been no facility in which all the staff could coalesce in one building.

**Colin Beattie:** You are saying that you will bring together all the staff from the four existing sites on one site.

**Dr Taylor:** Yes.

**Colin Beattie:** Does that mean that the patients will have to travel to you?

**Dr Taylor:** The site is very close to the hospital. We are using an innovative way of delivering treatment—attend anywhere is an NHS system, which involves the use of encrypted virtual clinics that enable children and young people to be seen in a secure way using information technology. If someone is participating in such a clinic in school, the guidance teacher might join them.

We are also looking at rural and remote clinics that would be based in schools and general practitioner practices so that people can be seen as close to home as possible. Our Aberdeenshire team will be based in the new building, but it will do more out-and-about work locally and will use the virtual, attend anywhere clinics, which are proving to be extremely successful. The feedback from young people is that they really like that system.

**Colin Beattie:** It is clear that there are specific challenges, given the geography of where the service is delivered.

You mentioned the delivery of a virtual service. How effective is the virtual service that is delivered

using IT compared with the standard face-to-face service?

**Dr Taylor:** It has been used in other areas, and the evidence on the outcomes is that it is as successful. However, we need to be very careful about the children and young people for whose treatment we feel that that is a suitable delivery medium.

For all first appointments, the young person would come to the CAMH service or would be seen locally by a clinician face to face. If we felt that there were any risk factors at all, we would continue to provide face-to-face treatment. For some families and young people, it is a very exciting new and novel way of providing treatment. Young people are used to using media in that fashion, and the evidence for it is quite good. Such virtual treatment is not the only way forward; it is just one aspect of the provision that we are considering delivering in Grampian. We are thinking about different ways in which we can deliver care to young people, and we are doing so not only to help us to improve waiting times.

10:15

There is another interesting offshoot of the attend anywhere provision. CAMHS staff are under lots of pressure—we have a really dedicated workforce—so it is hard for us to attend school meetings for children and young people, for example, because that requires travel time to schools and reduces capacity in the service. We have used attend anywhere to enable the CAMHS clinician to join the school meeting from their clinic base, which reduces travel time and helps the connectivity between schools and the CAMH service, delivering more joined-up working.

With the new building in Grampian, we are very much going for a regional centre of excellence. We have a strong vision and ambition to deliver fantastic care for children and young people in our region. I cannot stress enough how dedicated and hard-working the staff are in making sure that we achieve that aim. That is where we want to go with that.

**The Convener:** Thank you. We have started with a snapshot from Grampian, which was very useful. Dr Coia, you have chaired the joint task force for the Scottish Government and COSLA and seen the Auditor General's report, which highlights some issues. Will you give us an overall flavour of what you see as the challenges and obstacles to service improvement?

**Dame Denise Coia:** Over the past couple of months, we have been out and about looking at and talking about the issues in health, social care, housing and justice with the children and young people, the families of rejected referrals and a significant number of young people from the youth commission and other organisations. What has come up from everyone, which led to my recommendations, was complete consensus about the issues and the fact that the problems with mental health for children and young people in Scotland are increasing exponentially. That is not related to the incidence or prevalence of serious mental illness—that is unchanged. The rise is in emotional distress in young people at school, arising from issues around bullying, body image, depression and anxiety. That has increased massively and we have a huge amount of data on it from the Scottish surveys.

The other area that has been causing significant issues in Scotland concerns neurodevelopmental disorders, including Asperger's, autism and attention deficit hyperactivity disorder, and the varying provision for those. Sometimes the provision is in CAMHS, but sometimes it is in paediatrics, outside CAMHS. Those two areas have grown significantly, which accounts for the massive increase in referrals, not just to CAMHS but across the system.

The recommendations look at child and adolescent mental health in a completely different way, dividing it into four strands. One strand is about neurodevelopmental disorders. Those require quick assessment, which children are struggling to get at the moment, specialist support from the third sector, and input from acute paediatrics. The problem with community paediatrics at present is that it is having to move back into the acute system, so there is a dearth of community paediatrics. The support needed in that neurodevelopmental pathway is specialist, and it is mainly those families that are in the rejected referrals report. There are serious issues about how we are managing neurodevelopmental disorders in Scotland.

The second strand is a generic strand of emotional distress, which is about supporting children in schools by putting additional input into schools, the third sector and primary care. That needs to be a third sector that is focused on mental health problems. Although we believe in universal third sector services for children and young people, they have to pick up mental health problems and that is the big gap in the generic strand.

The third strand is specialist mental illness, which is the province of CAMHS teams. It has to have fast-track referral, with assessment either immediately or at least within four weeks; that is the aspiration in the task force.

Finally, people told us about a group that we call the at-risk children—children who are born into poverty, physical abuse, sexual abuse or families with addiction problems, many of whom end up in

care. The responses to those children need to be supportive services that are much more wrap-around and far more generic, because those children are very traumatised and over-anxious and often act out some of the issues.

The strands come from what people told us—they are not my recommendations. We are now putting them into work programmes to deal with, because the responses in each of those areas are very different. Part of the issue in CAMHS is that people are not getting the right service at the right time and in the right place. It is the job of the task force and our delivery plan to tackle that. The recommendations have found favour across the board with COSLA, with the third sector and in health. People recognise those strands as a good way to commission services.

Moving away from the conceptualisation, however, another issue for me is that of growing a workforce. Although there is a workforce out there, at the moment when people cannot employ a fully trained psychiatrist or clinical psychologist, they freeze the post. However, there is an enormous number of psychologists out there who require only a one-year MSc. We have doubled the number of people in training this year and there will be 19 new members of staff coming out. There is therefore a workforce—despite the issue that people raise about not being able to provide a service because they do not have a workforce. There is a different workforce, and it will include the third sector, primary care and probably a lot of psychology and nursing.

The final issue for me is related to resource. The Government is completely committed to CAMHS, there is cross-party commitment to child and adolescent mental health, the policy is great, and the commitment of the people on the ground who are delivering the service is great. However, children up to the age of 24 are one third of the population of Scotland and the resource has to be targeted at that group of individuals. We have to highlight and call out the issue that although everyone is taking cuts, mental health services—particularly child and adolescent mental health services—are, proportionately, taking bigger cuts than everyone else. Mental health services are not a priority on the lists of the community planning partnerships and we need to call that out. We need to say that there is no use in putting new resource in the front door if it is being frozen at the back door. That is the biggest issue at the moment.

**The Convener:** That overview was extremely helpful for me and my colleagues. I will ask you one more question and then I will move on.

You outlined the challenges and a framework for how mental health services should look in the future, and you touched at the end on resource challenges. On the issues of spend and knowing where that money is across Scotland, the Auditor General's report could be summarised by saying that it is a real mess at the moment. What challenges and timescale do we face in getting to a service level that you would find acceptable?

**Dame Denise Coia:** We have a good relationship in the task force across health and social care, and the joining together of COSLA and central Government is extremely good. In our delivery plan, we are looking at how we develop a framework that helps the system and councils to know what they need in their areas—that will be different in each area—and what good looks like. We have lots of good practice around Scotland and we want to support people to move into that good practice. We will also support people to look at the resources that they already have. Although a lot of new resource is going in, there are existing resources across the whole of a locality area that could be better utilised in dealing with mental health.

Our aim is to go out and support the commissioning and the frameworks, highlight good practice and call out the issues. We have the young people on the youth commission co-chairing the task force, and they are doing a lovely piece of work at the moment. They are going around every part of Scotland and looking at what is out there. They are the voice and the ears of the task force on what happens when we put out the guidance and the recommendations. We need to know how that all gets picked up locally.

**Liam Kerr (North East Scotland) (Con):** Dr Coia, you said that mental health incidents are increasing exponentially and that there has been a massive increase. Can you clarify for us whether there is something new in the world of young people that is causing mental health problems, such as social media, or is it that children and young people have always had mental health challenges but we might now be better at diagnosing or understanding those issues?

**Dame Denise Coia:** I think that it is a bit of both. Across the developed world—it is interesting to look at international comparisons, particularly with countries in Europe—this is a problem that everyone is experiencing. It is nothing new.

It is important to say that there is no increase in mental illnesses such as schizophrenia, bipolar disorder and so on, but there are issues for young people growing up in developed countries. At the moment, we do not have enough research evidence, although there is some research evidence on the impact of social media. Some nice work has been done in Scotland that shows that if a young person is on the phone for more than five hours, that is not helpful to their wellbeing, particularly if that young person is a girl.

In the task force, we think that we need to pull some of that research together. We live in the age of social media. There are really good things about it—the issue is perhaps more to do with how schools educate young people. We see education as crucial. Some schools in Scotland are doing fantastic work to educate young people on how to use social media more responsibly and how to deal with the multiple demands that are made of them. Some of the issues are related to pressures and expectations to do with succeeding in life.

Having met different teenagers over the past two months, I do not recognise their world. It is a complicated world, which I am having to learn about. The youth commission and the Youth Parliament are vital to this work, because they are the people who can tell us what is actually required. We must listen to them to find out what young people need to navigate their way through that world. That is what we must address in the task force.

**Anas Sarwar (Glasgow) (Lab):** I have a follow-up question. Dr Coia, you mentioned cuts at the end of your opening statement. Just to be clear, were you talking about cuts that are being made by integration joint boards and health boards? Are the cuts connected to the reduction in council budgets and the pressures on health board budgets because they are not increasing in line with health inflation? Which specific cuts were you referring to?

**Dame Denise Coia:** I think that "cuts" is the wrong word for it, to be absolutely honest. We live in an age of austerity and we are all grown-ups in the age of austerity. We know that we all have to meet our commitment to try to live within our means. That is an important point to make.

The issue for me is that, as we attempt to live within our means, we must make sure that we give a fair percentage of our resource to those under the age of 24, who make up a third of Scotland's population. It is important that we keep calling people out when that does not happen and that we do not prioritise other areas at the expense of children and young people if there are as many needs in the area of children and young people as there are in other areas.

There are issues around how we prioritise the resources that we have. I have two things to say about cuts; first, if we look at the figures, we see that we spend more than most European countries on child and adolescent mental health services overall, so we need to get good value for what we spend. My other concern is about people freezing posts in child and adolescent services when they might not be freezing posts in other areas; they can do that because the data is more difficult to find.

It is a question of prioritising the breadth of child and adolescent services, including community and third sector services, and ensuring that that happens in the rest of the system—in the acute sector in the NHS, in local councils and in IJBs. The big issue is that the providers must ensure that they give equal priority to child and adolescent services, and we are not seeing that around the country.

09:30

**Anas Sarwar:** I want to clarify something. You used the word "cuts" in your opening contribution. New money, which is welcome, has to make up for some of the cuts that are taking place. What did you mean by "cuts"?

**Dame Denise Coia:** That is exactly what I said at the beginning. There are cuts when there is a reduction in resources at the same time as new money is being put in at the top. There is no point in putting in new money at the top if people use it just to keep the service at the same level.

**Anas Sarwar:** From whom is there a reduction in resources?

**Dame Denise Coia:** The reductions in resources are universal. They are across Scotland, including in third sector organisations in which people have to provide generic services that do not provide the mental health add-on.

**Anas Sarwar:** Dr Taylor rightly referred to the use of technology. Is better access to FaceTime, for example, or whatever app is used, reflected across the country? Is that being looked at across the country, particularly in the context of emergency services, when people need urgent support from a mental health specialist?

**Dr Taylor:** There is perhaps one other board that is looking at using the system that we are looking at. The attend anywhere system has certainly been used a lot. For example, I know that orthopaedic services are using it in the central belt to see people in remote and rural areas on the west coast. The system is very effective if it is used in the correct way, and the feedback from young people is that they really like it.

**Anas Sarwar:** Is the task force taking that up across the country?

**Dame Denise Coia:** Yes. We have a workstream that is looking at the whole concept of the use of IT to deliver services. What works in Grampian might not work south of there in another area. It is really important that we leave it to people to decide what will work best in their area. We are looking at that and at the out-of-hours services in NHS 24 and in accident and emergency, where there are issues.

**Anas Sarwar:** Dr Coia, you listed all the people whom you rightly engaged with in looking at issues to do with referrals and identifying key actions going forward. You did not mention—although I am sure that you engaged with them—clinicians and GPs and issues that relate to the language that they use in their referral letters, and how those referrals are taken forward. What engagement has there been with clinicians?

**Dame Denise Coia:** We have met the Royal College of General Practitioners, local GPs and our Scottish Government colleagues in primary care. As you have said, there are a number of issues to do with referrals. The vast majority of referrals to CAMHS come from GPs, who have said to us that that happens because they do not have anything else to refer people to. At times, there are alternatives, but they are simply not aware of them.

The issue of referral letters is important. When we met families with rejected referrals, we heard that people had been rejected because the referral letter did not describe the problem in a way that triggered a response when the CAMHS team read it. The GPs and the whole primary care team are asking for more support through health visitors, more primary care mental health nurses and more of the psychology graduates we are talking about, who have one year of training post their degree and who are ideal to work in general practice. The GPs and the whole primary care team are looking for that kind of support, and that is the kind of support that we think needs to be provided to them over the next couple of years.

**Anas Sarwar:** To return to the workforce, has there been any assessment of the proportion of schools in Scotland that have access to a school nurse or, more specifically, a mental health nurse? What is your ambition for what that provision should look like next year, and in three years and five years?

**Dame Denise Coia:** We have visited a number of schools, including schools that have amazing practice in the area and which have used their pupil equity funding incredibly well to set up services. We have talked to the Scottish Government's education directorate, because it is putting together and agreeing the plans on how we roll out the systems. I commend schools such as Kilwinning academy, Wallace high school and those in Cumnock in Ayrshire for the amazing work that they are doing. They have put in place basic services that involve teachers who have had mental health first-aid training and pupils who are mental health champions. They have a baseline of raising awareness about mental health issues and tackling bullying. Superimposed on that, there are counselling services and, in some cases, primary care mental health nurses go into schools or there are family groups. There are different services in different areas, because of the different resources in council areas, but they all work just as well. How schools put in those services is up to them.

The missing link, which all the schools describe, is how they then manage to get referrals without always having to go through GPs. Can the child get into CAMHS? Can they get into third sector services? We are seeing the roll-out plans. That part of the work, which is done jointly with education, is in the delivery plans. Education is crucial to the success of the task force. I will be here with the task force for only two years, so the work has to be done in the next two years. We have a three-month plan, a one-year plan and a two-year plan.

**Anas Sarwar:** Does the two-year plan relate to the First Minister's announcement in the programme for government on every secondary school having access to a mental health nurse, which all political parties have welcomed?

**Dame Denise Coia:** Yes. The counselling and the mental health nurse services will roll out, but the important point is that that must be done in a way that helps schools and primary care in the local area. How that is done and how the money is used in primary care are important points, because we do not want to disturb very good practice. For example, in West Dunbartonshire, family groups are attached to schools and the primary care setting. Capacity needs to be put into that area, rather than there just being one nurse per school, if that is not right for the school. It is important to do the right thing.

**Anas Sarwar:** The results of the exams that kids at school take during their formative years—in fourth, fifth and sixth year—will impact on their life chances for the rest of their lives. Are you looking at specific support that could help those children, in particular, if an issue is flagged up?

**Dame Denise Coia:** Very much so. That is a huge issue. Parental expectations are a huge issue in that area, and so is the transition period between school and tertiary education. We have been talking to colleges about how we support young people in that area. That is crucial.

**The Convener:** Did you meet any educational psychologists on your travels?

**Dame Denise Coia:** Yes. We have an educational psychologist on the task force, too. We have not mentioned them yet, but they are part of the package.

**The Convener:** Are there enough educational psychologists in schools? The numbers have decreased over the past few years.

**Dame Denise Coia:** We start from the position of looking at what functions are required in a

school. The families and the children themselves tell us that they want early assessment of neurodevelopmental disorders. If that requires there to be an educational psychologist or a community paediatrician, that is what is required. Children tell us that they want to be able to go to a trusted person who is attached to the school. As has been said, children might not want to discuss things with their parents in the first instance.

The important thing is not to promote individual groups of professionals. We need to promote the functions that are required in schools, in primary care and in communities. Then, what is available in those areas needs to fill the gaps. If there are still gaps, we need to call out the fact that they are still there.

**The Convener:** Indeed. However, given the declining number of educational psychologists, one of the problems has been that there have not been interventions at school level, so there have been more referrals to CAMHS.

I take it that what you are talking about is a vision for the future, but the reality in schools over the past few years has been quite different from that. Would you agree?

**Dame Denise Coia:** That is exactly true, but everything is interdependent. The big issue for us is what has happened to community paediatrics and the pressure that that has put on the CAMHS teams. Community paediatrics used to do the assessments along with educational psychologists, and both groups are lacking in that respect.

Until I started going out into communities, I was not aware of how community paediatrics has disappeared and how the acute sector has pulled paediatrics back in to work in that sector to fill the gaps there. That might be appropriate, but we need to be aware that it has happened.

**The Convener:** Okay. We might come back to that.

**Willie Coffey (Kilmarnock and Irvine Valley) (SNP):** I refer Bernadette Cairns and Stephen Brown to page 19 of the Auditor General's report. It shows quite a variation in the amount of time that it takes from referral to treatment in the various health boards. For example, NHS Highland's figure is an average of six weeks, NHS Ayrshire and Arran is 10 weeks, and NHS Grampian is about 21 weeks. What is your perspective on why that is and what you would need to do to improve that?

**Stephen Brown (North Ayrshire Health and Social Care Partnership):** Some of Dr Coia's earlier comments probably give a flavour of the picture across the country and the variations in average waiting times.

NHS Ayrshire and Arran has protected the new money that has come in and, at the same time and whenever possible, attempted to fill vacancies as quickly as possible. The fact that we have children's services strategic planning in all three Ayrshire community planning partnerships that are committed to improving the emotional and mental wellbeing of children has helped to protect some of those strands of money and keep capacity in the system so that the young people who are most in need are seen as timeously as possible.

On page 20 of the report, the number of young people that Ayrshire and Arran are seeing within the referral to treatment time target looks great but, as Dr Coia touched on, 18 weeks is a long time in a young person's life. Over and above that is a small percentage of young people who have not been seen within 18 weeks.

There is still much to do. We are looking at doing a load of work on upskilling and building confidence in many of our universal services, from teaching staff to pastoral staff, and on models that are being developed to work alongside community planning partners. This is not a CAMHS issue in the traditional sense, but an issue for all community planning partners. I mean that in its widest sense, which is about how we best use community-led and third sector-led resources.

It helps those waiting times if we make sure that we apply the getting it right for every child agenda and ensure that the right support is provided at the right time by the right professional. If you say it really quickly, it sounds easy, but it is one of the hardest things in the world to do.

**Bernadette Cairns (Highland Council):** I echo that. The figures also look quite good from the NHS Highland perspective. We have two different halves of CAMHS. We have a lead agency model, and I manage the tiers 1 and 2 services, which are additional support needs, educational psychology services, allied health professionals and so on. They are preventative services, so they can respond to and pick up referrals quickly.

Our tiers 3 and 4 services deal with much more complex cases and tend to have longer waiting times. The average wait time might be down, but there is huge variation in that, from a week up to well over six months.

The whole system grapples with trying to get much more consistency in wait times. Rather than looking at an average, we want to try to reduce the variation, because that is how we will get a much more coherent service delivered more consistently.

09:45

**Dr Taylor:** NHS Grampian managed to improve its waiting times by 27 per cent between September 2017 and September 2018. We use the choice and partnership approach—CAPA—model, which is a very good way of looking at capacity and demand modelling. It enables us to flex the system for children and young people to be seen for assessment and treatment.

NHS Grampian is the lowest-staffed board in the whole of Scotland—at one point last year, it had 53 per cent fewer staff than the national average. I came into post at the start of the year. Through the use of our CAPA modelling to look at capacity and demand, we have been able to demonstrate exactly how many staff we need to improve our waiting times. The senior leadership team has agreed to give us £1 million in recurring new funding for CAMHS staffing in Grampian.

It might also be helpful to point out that the point at which boards stop the clock varies. NHS Grampian stops the clock after the second appointment. We class the first appointment as assessment and the second appointment as the start of treatment, but we offer signposting and treatment advice at the first appointment. The model is called CAPA because the first appointment is about choice—it is about giving young people who come into the service choices for treatment, engagement and feedback. We say what we feel that we can do to help them or what community support we feel can help them at that point. The whole process is about engagement.

Our waiting time for choice is only six to seven weeks. Of the people who have waited for longer than the 18-week target period, only six of them have not been seen for their choice appointment. We need to think about the figures in the context of how data is reported. That is an issue that Dr Coia and I spoke about before we came into the room.

In NHS Grampian, a large proportion of our longest waits are for neurodevelopmental work. We welcome the work of the mental health access improvement support team, which has helped us to think about how we can improve waiting times across CAMHS. We are doing a large piece of work with MHAIST to look at neurodevelopmental work because it accounts for about 40 per cent of referrals to our service.

In addition, we have recently done some work on rejected referrals. We have started to audit why that is happening and have discovered that 24 per cent of rejected referrals were to do with neurodevelopmental work. We are working on a joint programme with paediatrics to think about how we can jointly assess neurodevelopmental work and coalesce CAMH and paediatric services for the purposes of that work. As our submission says, I am confident that, for Aberdeen city and shire, we will meet the waiting time target after the accommodation move and through the new posts by next autumn. With MHAIST, we are doing a dedicated piece of work on our Moray team, which is where our longest waits are. A lot of work is being done.

**Willie Coffey:** That was extremely helpful. It is clear that there is an issue with the consistency of the data and what it means, even within health boards.

Dr Coia, you mentioned four strands: neurodevelopmental disorders; emotional distress; specialist mental illnesses; and children who are born into poverty. In which of those strands are the biggest and most concerning spikes occurring?

**Dame Denise Coia:** In the neurodevelopmental strand, the biggest issues are to do with access to assessment. Someone who has ADHD or autism cannot access other services until they have a diagnosis. Assessment is carried out by educational psychologists, paediatricians or psychiatrists.

The second issue in the neurodevelopmental strand is that the families—of whom I have met huge numbers, and not just in relation to rejected referrals—are desperate for some kind of drop-in community support. We are talking about children who are behaviourally disturbed and who upset their siblings. Families break up because of such issues. By and large, they get good assessments and good treatment when they go to a CAMHS team. What they are asking for is drop-in centres and some community support from third sector organisations that have experience in that area. That is where the spike is.

With the emotional distress strand, the spike is the gap in the third sector. There are organisations out there that are doing really good work, but it is about how the community, primary care and the third sector deal with mental health problems. It is about not just providing support in communities but dealing with mental health problems and having the skills and expertise in those organisations. We are planning training programmes for individuals, but it is important that the IJBs, health boards and local authorities commission third sector organisations that can deliver support for mental health problems, and some of that can be quite distressing.

For the specialist strand, the spike is in the specialist services getting up to capacity and being fully staffed, as Dr Taylor described. There are two really good models: the CAPA model that Dr Taylor described, which is also used in Glasgow, and i-THRIVE. Those are models based on international evidence, and they reduce waiting

times, so why would we not use them around the rest of the country?

The at-risk group is different as we can really do something for those zero to five-year-olds. It is the group that needs parenting programmes, breakfast clubs and other wrap-around caring services, which are not really mental health services. They need that kind of support so that, by the age of five, they feel that there are other responsible people out there who can support them. That is the group that really should be focused on.

We have a huge opportunity in Scotland and that belongs very much in community planning.

**Willie Coffey:** Over the years, as MSPs, I am sure that we have all had families coming to us on behalf of their children with pretty tragic stories. Dr Coia has already alluded to this, but what is the key thing that we should do to improve how, at as early a stage as possible, we spot children who are at risk, so that the necessary interventions can be made?

**Dame Denise Coia:** For me, that is in education. I will hand over to Stephen Brown, because he is the expert and Ayrshire has done really well in picking up people early in education.

**Stephen Brown:** That is absolutely right. In some pockets of Ayrshire—Dr Coia spoke about a couple of schools—we have been bringing people together. We have spoken a lot today about referrals, and the Auditor General's report talked about children being "bounced" from one part of the system to another. Alongside police and education colleagues and with some CAMHS resource—we are also utilising the school nursing resource—we are working with families, predominately in high schools, but also feeder primaries, at as early a stage as possible to identify, before they get to crisis, young people who might be struggling a bit.

It is a challenge across the piece to protect those services and supports at the same time as austerity is kicking in. We know that all public bodies are struggling at times to manage those demands, but we need to make sure that we preserve the prevention and early intervention agendas. Those will be the public sector demands in 30 or 40 years' time, so it is important that we do that. We have worked hard with local politicians to maintain those agendas and keep them as a priority.

We are moving away from referrals so that the teams around those schools stop thinking, "I'm going to refer to CAMHS" or, "I'm going to refer to a social worker." Instead, they have discussions and conversations with one another. They say, "I'm a bit worried about this young person—could you have a chat and look at what you know about them?" We are beginning to move away from the rigid referral process so that those involved can work as a team. We are finding that it makes a big difference if we have the right leadership in place—it gets the right support to young people as quickly as possible.

**Willie Coffey:** Do Bernadette Cairns and Lynne Taylor agree with that? Is there anything that you would like to add?

**Bernadette Cairns:** We have a similar situation. We use the Highland practice model, which is the national GIRFEC model, for the same reason. People can request assistance or look for partners to assist them when they have a concern about a child or young person.

Our primary mental health workers—who form our tier-2 CAMHS service, which I directly manage—are associated with every single school. We have an educational psychologist and a primary mental health worker who are linked to all of our schools in the Highland Council area. That means that we have specialists who can provide consultation. We spent a lot of time developing a consultation model that supports other practitioners to be able to have a conversation in which they say, "I'm a wee bit worried about so and so because they've not turned up for English for the past couple of weeks and I'm not quite sure what the situation is." That allows us to have a conversation about what might be happening and who could or should be involved, and to pick things up at a much earlier stage. We are seeing the benefit from that preventative work. People have talked about signposting, but looking at who should be involved and where does not always mean a referral to a specialist service. Sometimes it does, but sometimes it is about people who are already around the school or early years setting becoming involved to support the family. That model works best to support our very specialist services to provide what they can for people who have significant mental health issues.

**Bill Bowman (North East Scotland) (Con):** In the section that is headed "Data on performance and outcomes is limited", paragraph 37 says:

> "Not all services and organisations have electronic systems which are fit for purpose so they can improve efficiency, share information and collect data on performance and outcomes."

Do witnesses believe that their systems are fit for purpose?

**Dr Taylor:** From a Grampian perspective, the simple answer to that is no. We have been raising the issue nationally at leads meetings. The data systems are different across all boards and it is therefore difficult to get minimum data sets on outcome measures, such as patients being seen and when the clock is being stopped. All those

issues need to be looked at, and it would be helpful to have data that is consistent and comparable with other Scottish boards to plan and develop services.

With regard to our capacity and demand modelling, we have good data on managing the workforce, future proofing the service and thinking about internal capacity and demand. However, when we look at how data is recorded across Scotland, it is hard to think in a comparative way about how services work—Dr Coia and I were just speaking about that.

**Bill Bowman:** Is the system in Grampian fit for purpose?

**Dr Taylor:** It is fit for purpose in relation to demand and capacity modelling because we use the CAPA model. However, there are more significant pieces of work that we could do. For example, whereas other boards have had data analysts in place, Grampian has not had one at all until October of this year. We are looking to learn from the staff who are in those positions in Tayside and Lothian and to replicate the models that they have found useful.

We do not have consistent data around the effectiveness of the delivery of our services. I am thinking of minimum data sets on outcome measures for young people who come into the service in relation to functioning, severity and improvement. We would like data that measures not just efficiency but effectiveness.

**The Convener:** Liam Kerr has a question.

**Bill Bowman:** I am sorry—I was hoping to hear from the others.

**The Convener:** Sorry. Do other witnesses want to add to that?

**Dame Denise Coia:** The task force is looking at the issue. We are pulling together all the different central data sets—the cleaned-up Information Services Division data. We want to do linkage work with what is going on in communities; there is a big prize to get from that and we will put resource into community link-up.

Local data can also be useful; I suppose that we could call it “dirty data”. It is the data from the CAPA models that tells people what is needed in terms of service requirements. That data is usefully locally but it cannot be compared because it is different in different areas.

10:00

**Bill Bowman:** Do the other witnesses believe that their systems are fit for purpose?

**Stephen Brown:** In Ayrshire and Arran, our systems are constantly improving, in that we are able to produce reports in a variety of ways. I am not sure what the number is now, but when we looked at the issue a few years ago, eight different social work systems and 250 different NHS systems were in use across Scotland. We have one system now for schools—the schools information management system, or SEEMiS. The difficulty is that although there are really good systems in among all that, they do not always talk to one another. That is what Dr Coia is talking about. How do we ensure that those systems can talk to one another as effectively as possible and in a way that allows us to see a young person’s whole journey rather than one particular component of the service?

**Bernadette Cairns:** The situation is similar for us. We do not have one system that cuts across the local authority and the NHS, so quite a lot of the data gathering that I do on the effectiveness of the teams that I manage involves reading across different systems. It is a manual comparison rather than a systematised process.

**Liam Kerr:** I would like to go back to Willie Coffey’s discussion about referrals and talk in more depth about rejected referrals. According to the Auditor General’s report, more than 7,000 referrals were rejected last year. Is data collected on why those referrals were rejected? If so, what are the key reasons for those rejections?

**Dr Taylor:** Thankfully, someone in our service has been able to start auditing that. As part of our redesign, we have adopted the national CAMHS referral criteria, which was developed in 2012 to address the issue of referrals to the service, and we have increased the number of staff who can refer to CAMHS. Previously, only GPs and school paediatricians could refer, but headteachers and educational psychologists—people who might know the child or young person better than their GP—can now more easily refer into our service.

We are starting to look at the data on referrals from that wider pool of staff. We are looking not just at rejected referrals but at what those cases have been re-referred for. The figures show that 24 per cent of such re-referrals are for neurodevelopmental problems; about 18 per cent are for anxiety; and the remainder—about 21 per cent—are for low mood. We are doing a bit of work on why those referrals were rejected and why they have been referred back to the service.

We have also identified that our rejected rates and re-referral rates are higher for the under-12s than for the adolescent population. We need to think about the particular reasons for that. Nevertheless, it has been helpful to start unpacking the issue.

**Liam Kerr:** The submission that you very helpfully provided says that NHS Grampian is now getting

"referrals from a wider range of professionals."

As far as you are aware, have the changes that you have just described led to a reduction in rejected referrals?

**Dr Taylor:** We opened up the new referral pathway only in April this year, so I do not think that we have enough data yet to allow us to look at that in detail. The number of rejected referrals has not been going up exponentially since then—it has remained relatively constant. On paper, the number of rejected referrals looks very high and it is important for us, as a service, to think about why that is happening. We do partner agency work around tiers 1 and 2 and, as colleagues have said, conversations can take place if we pick up the phone and check in with people. We are developing a telephone service so that a GP or a headteacher can phone an on-call CAMHS clinician and ask whether it is appropriate for them to refer a particular young person or whether there is other information that it would be useful for them to think about. It is really important that we have more conversations with the partner agencies that refer to us.

**Liam Kerr:** I will come back to that in a second. First, though, I put my question to the rest of the panel. Do you collect data on the reasons for rejections? If so, what are the primary reasons?

**Stephen Brown:** We certainly collect and look at that data in Ayrshire and Arran. There has been some discussion around the fact that young people who were potentially struggling have been referred to CAMHS inappropriately. That was perhaps because no one knew what was available locally, so the teacher or the GP decided that, in the absence of anything else, they would refer to CAMHS.

As a result, there have been huge waiting lists for CAMHS in some places. Among those waiting will be young people who are perhaps showing behavioural issues in schools, but there will also be young people who are self-harming, or young people with suicidal ideation or possible early indications of psychosis. The question is how we wade our way through a whole sea of young people.

I would expect there to be a number of rejected referrals, certainly in the short term, as we begin to change models. We are keeping a close eye on those rejected referrals, as Dr Coia and Dr Taylor have outlined. We are trying to see whether those young people are then referred back to other systems that will give them the right support. We are trying to track that through to make sure that it happens.

Over and above that, locally, we will look at whether we are reducing inappropriate referrals to CAMHS in the areas around Marr college and Kilwinning academy in Ayrshire, for example. I think that we will reduce such referrals but it is too early to say yet.

**Liam Kerr:** I would like to pick up on that point, unless Bernadette Cairns has something specific to add in answer to my question.

**Bernadette Cairns:** I do not have anything different to add. I think that the point about conversations and consultations is well made. Our focus on consultation has reduced the number of rejected referrals, although we sometimes consider them to be redirected rather than rejected. Having the conversation with the specialist beforehand allows the potential referrer to know where best to refer to so that we get the best service to the child at first bounce rather than moving them round the system. It is really important that we hold on to that.

**Liam Kerr:** I would like to explore that point, because it is crucial. According to the Auditor General's report, it boils down to there being three reasons for rejected referrals, of which two focus on the referrer. The suggestion is that it is to do with poor communication or lack of communication. That leads to the question that Bernadette Cairns has started to answer. How will you support referrers to change that poor communication?

**Bernadette Cairns:** As I said, we have spent quite a bit of time doing training. We have been having conversations with GPs, schools and health visitors about which young people it would be appropriate to refer to the different services that are out there. We have invested in training so that they can contain situations much better, and feel more confident about doing so.

Usually, a referrer's first port of call will be the primary mental health worker who is linked to them, with whom they will have a consultation—they know who that person is because they are the local worker. In that conversation, they can start to explore how they might be able to support the young person themselves or, if there is a need to bring in another service, what that service might look like and where they should put that support. That consultation can also provide a direct route to tier 3 CAMHS or the community service at tier 4.

Often people do not use the right language—they do not communicate the child's needs effectively. Primary mental health workers can frame those referrals much more appropriately so that the information is clearer for the people who pick them up. That has been a really helpful process to put in place.

**Liam Kerr:** Thank you. I have one final question, which I will direct to Dr Taylor. On page 20 of the Auditor General's report are the figures for the number of children and young people starting treatment within 18 weeks of being referred. You will immediately understand why I am directing this question to you, Dr Taylor, because the figures for NHS Grampian appear significantly lower than those for the other boards.

In answer to Mr Bowman's questions, I think, you suggested that your board has the lowest staffing; you also talked about the systems not being fit for purpose and said that significantly more could be done. You also talked about stopping the clock at a different time. That leads me to two questions, which I will roll into one.

First, is this about, as the Auditor General suggested in paragraph 33 of the report, boards interpreting the standard—the clock stopping—-in different ways? If so, how many young people have been affected by that? Would you change things so that you are better aligned with everyone else?

Secondly, is this about funding? Concerns about NHS Scotland resource allocation committee funding have been raised in the chamber many times. NHS Grampian appears to receive significantly less funding.

Can you talk me through the reasons for your figures and whether they are to do with funding and/or how things are assessed?

**Dr Taylor:** It is a bit of both. We have looked at that issue quite a lot across the Grampian system.

The figures are from 2017-18. As I indicated earlier, by using our CAPA model, we have improved performance by 27 per cent. Since the start of this year, we have employed nine new staff; before then, our staffing had not increased at all between 2013 and 2018. That was partly because money had been taken out of our core CAMHS service by our partners in the council. The core posts in CAMHS had to be filled by the board to address that deficit.

By doing capacity modelling through CAPA, we have been able to clearly demonstrate to the senior leadership team exactly what our gap in staffing is, and we have a very detailed workforce plan. As I indicated, the senior leadership team has committed to giving us £1 million for new posts.

Staffing is absolutely key. We have gone from having 52.3 whole-time equivalents to having 60. However, the national average still sits at 92.8, so our staffing is significantly lower than in the rest of the Scotland. That is certainly one factor.

However, I am really encouraged by the transformational redesign that we have been doing, and I feel very confident that, with the progress that we are making, we will be able to meet waiting times targets in Aberdeen city, Aberdeenshire and Moray. That is about our using efficiency in the service, looking at the number of patients with whom there is joint working, for example, and the types of referrals that come in.

To go back to your point about data, I do not think that we should do something different. You talked about first and second appointments, the first of which are to do with assessments and the second of which are to do with treatment. In Grampian, we quite pride ourselves on the fact that the data shows that only six patients have not been seen within eight weeks for their choice appointment. The waits are mostly in our neurodevelopmental assessment area. We also prioritise young people according to clinical need. Emergency cases are seen within 48 hours, and urgent cases are seen within seven days.

However, I agree that there is a data issue relating to when the clock is stopped and not necessarily comparing like with like across the boards.

**Alex Neil (Airdrie and Shotts) (SNP):** I want to widen the debate out a wee bit. I am interested in the causes of mental ill health and how we prevent and treat it. What struck me most about the Auditor General's report was exhibit 1, which shows that children who are brought up in low-income households are 300 per cent more likely to suffer mental health problems than their peers in better-off households.

As with physical health, it strikes me that, if we are really going to be able to address the problem in the long term in the way that we all want to address it, we need to address the issue of poverty. As we know, poverty among children throughout the United Kingdom, including in Scotland, is rising exponentially, and as long as it increases, we are chasing our tail. Do you agree with that?

**Dame Denise Coia:** I certainly agree with that. We are putting the bucket under the leaking roof and not repairing the roof. There are significant child poverty issues in Scotland. I mentioned the strand of at-risk children to tease out that very issue. I want us to focus on that strand as a way of getting us to begin to focus on the prevention agenda and the whole public health agenda.

For these children, this is very much about good parenting and having support systems in place. It is also about third sector organisations providing services such as breakfast clubs and supporting schools by running after-school programmes, given that sometimes it is safer for a child to be in an after-school programme than back at home.

10:15

I agree that we should tackle the issue. In our recommendations, we were trying to do two things. We wanted to make sure that we tackled the issue, but in a way that might allow us to make some progress by putting it in a strand about which we could say, "Here is the group that we are going to focus on." In the two years of the task force we might only focus on a couple of areas. We have identified children in care—and there are huge issues with those children in relation to mental health and how they get into care. We also identified the children of asylum seekers, who really struggle in households that face significant poverty. We have identified some key areas.

We can all talk a good game. We all talk about and agree on how dreadful the situation is, but my concern is what we do about it. For me, that means commissioning third sector organisations and getting them into a place where they can target some of their work. Maybe "target" is the wrong word—I better not use "target", or, indeed, "cuts". We need to encourage people to understand what is going on underneath, as has been said, and focus on that.

**Alex Neil:** I have two things to say. One is that the evidence that Denise Coia has given this morning is among the best evidence on any subject that the committee has taken in the two and a half years that I have been a member of the committee. It has been fascinating.

Secondly, as with closing the educational attainment gap, closing the health gap and reducing crime in the long term, it seems that there is one underlying theme here: we do not have a hope in hell of achieving any of these things unless we have a much more ambitious programme for dealing with poverty, and child poverty in particular. Is that a reasonable statement to make, as far as mental health is concerned?

**Stephen Brown:** I agree with that. As I said, NHS Ayrshire and Arran does well in terms of referral to treatment times. From a North Ayrshire perspective, one of the things that I am most ashamed of—I am speaking on behalf of the community planning partnership—is that we have overseen the level of child poverty going up from 29 per cent to almost one in three children living in poverty. That brings its own pressures to many parts of the system, including mental and emotional wellbeing.

An American study called "The Great Smoky Mountains Study"—it sticks in my mind because it sounds like a great study—has been tracking the wellbeing of children from the most deprived areas in North Carolina over a long period of time. About two years ago, the researchers noticed that there was a sudden spike in the emotional and mental wellbeing of children and in their educational attainment—everything seemed to go up for a group of the young people. When the researchers looked a bit more closely, they realised that the spike was geographically driven and found that the children involved were from a native American Indian reservation that had opened a casino, with every family on the reservation benefiting to tune of $4,000 a year. Although that is not a great deal of money, the wellbeing of every single child suddenly started to outstrip that of their peers in the study. The best way of tackling child poverty is to put money in parents' pockets.

**Alex Neil:** Absolutely. Do the representatives from NHS Grampian and NHS Highland want to come in? Even in Grampian, there are significant pockets of poverty in what is a relatively rich region, and rural poverty is a big issue in the Highlands.

**Bernadette Cairns:** Absolutely—

**The Convener:** Before you answer, Ms Cairns, we could sit all day and discuss—

**Alex Neil:** I know that, but there is an important point to be made.

**The Convener:** I know that. I am just about to go back to Ms Cairns, but we should wind up with this issue, and then move to our next panel.

**Bernadette Cairns:** We need a whole-service and whole-system approach, because the things that we have talked about are all interlinked. There has been quite a lot of discussion throughout the country about adverse childhood experiences, which also link to poverty. If we do not get this right in the very early years and at school, across the piece, we will do our children a disservice. That connection and a whole-system approach are important for our children and young people.

**Alex Neil:** I agree with you, convener, but it was an important point to make.

Finally, I want to ask a more specific question. I am very interested in what has been said about the improved performance in NHS Grampian and the clear link between staff resources and performance. That raises a wider issue for Denise Coia, but I am happy for anyone to answer. One of my frustrations when I was the Cabinet Secretary for Health and Wellbeing was that so many good things were going on across the health service, but—my God—trying to get people to share or adopt good practice was a nightmare. Could we not do a lot more to share and adopt good practice when we come across it? The major improvement in NHS Grampian in a relatively short period of time is a good example of that.

**Dame Denise Coia:** We have a practical solution to that, which we have discussed

previously. Part of the task force's remit in the next two years is to run workshops and conferences in order to spread and showcase good practice. One such workshop in February will launch the task force. We have been asking about showcasing some of the work in NHS Grampian, so that we can show how it could be done in NHS Ayrshire and Arran, for example. We should bring along schools, so that they can show the work that they are doing and how it links to primary care. We are going to have an online platform so that some of that work can be done digitally, too. We have fantastic practice in Scotland, and we should keep the momentum going by showing what works.

**Dr Taylor:** The mental health access improvement support team has been with us and it has asked about sharing with other boards the work that it has done with NHS Grampian. That is another avenue through which we can all learn from one other and share work. We are moving into a phase 2 piece of work with MHAIST, and we very much welcome its involvement with NHS Grampian, which has helped our thinking. We can also learn from the practices that other boards have found useful.

**The Convener:** I very much thank all the witnesses for their evidence.

10:22

*Meeting suspended.*

10:26

*On resuming—*

**The Convener:** I welcome our witnesses for the second panel this morning: Paul Gray is director-general for health and social care in the Scottish Government and chief executive of NHS Scotland; Donna Bell is director for mental health in the Scottish Government; and, from COSLA, Nicola Dickie is chief officer for children and young people, and John Wood is chief officer for health and social care. Colin Beattie will kick off.

**Colin Beattie:** There is a certain consistency in the fact that statistics and figures tend not to be available in any great quality. What progress has been made in developing quality indicators for mental health services?

**Paul Gray (Scottish Government and NHS Scotland):** I will start and then bring others in. The first thing is to acknowledge that your point is correct. I do not want to sound as though I am disagreeing with it—we do need greater consistency. Some of Healthcare Improvement Scotland's work in relation to NHS Tayside will produce evidence about how we might have greater consistency. We have also commissioned work on data collection to support that. Donna Bell can say more about the detail.

**Donna Bell (Scottish Government):** You heard earlier from Dr Coia about the work of the task force, its engagement with local areas to get under the skin of the data that those areas are collecting and how it is trying to deliver more consistency on that. Over the coming months we expect to have a better understanding.

**Colin Beattie:** What sort of timescale are you talking about? You said a few months; is there a target date?

**Donna Bell:** We do not have a target date, yet. Dame Denise will publish her delivery plan in December, and we expect to set it out then.

**Colin Beattie:** Will all NHS boards then be reporting in a consistent way?

**Donna Bell:** There is work under way to look at the consistency of data. We will engage with IJBs and boards in the coming months to agree the approach to reporting.

**Colin Beattie:** Specifically, will that result in a better understanding of the demand for mental health and wellbeing services at all levels?

**Donna Bell:** That work needs to be done. You heard some compelling evidence from the previous panel; for example, they set out work that is going on in Grampian to understand demand. We hope that that will be replicated elsewhere.

**Colin Beattie:** You are specifically working towards that.

**Donna Bell:** Yes, and that is what Dame Denise will include.

**Colin Beattie:** Why are children and young people's needs not being met, according to the Auditor General's report, and what are you doing to change that?

10:30

**Paul Gray:** I do not want to exclude COSLA colleagues from the responses and I will make way for them, but first I will say three things. Child and adolescent mental health staffing has increased by nearly 70 per cent over the past 10 or 11 years, which is a significant increase. However, those who are clinically qualified would say that there has also been a sharp increase in emotional distress among young people in schools, and neurodevelopmental disorders also appear to be increasing.

We need to understand the clinical underpinnings of that increase in order to respond appropriately. There have been service increases, and funding of £250 million has been announced to increase services further, but we want to make

sure that those increases are aligned with appropriate levels of clinical advice. We do not want simply to put people in post so that we can say that we have added numbers; we need to put the right people in the right places.

I had a useful engagement with the youth commission advisory panel on that, which I am happy to speak about, but I am conscious of the committee's time constraints, so I will leave it to you whether you follow it up.

**Colin Beattie:** Does COSLA have a view?

**John Wood (Convention of Scottish Local Authorities):** We welcome the initial recommendations from Denise Coia to COSLA and the Scottish ministers. The direction of travel that she has set in the first few months of the task force has been welcome.

A lot of the data that is harvested, either politically or in the Audit Scotland report, is focused on the end product and what happens after the fact. We could better focus our efforts on improving our understanding of the causes of poor mental health and I hope that that will come from the strand of Denise Coia's work that looks at data. The previous panel also touched on the need to focus a lot more effort on collecting better data on the causes of poor mental health.

**Colin Beattie:** Is it your position that we do not have a clear understanding of the root cause of mental health issues among children?

**John Wood:** Our understanding is not as it should be, although it is improving. A lot of that is down to the changing nature of the issue. As was mentioned in the earlier session and by Paul Gray, emotional distress is creating a lot more activity in the system.

**Colin Beattie:** Do you know why there is more emotional distress?

**John Wood:** I hope that a product of Denise Coia's task force's work will be to get a better understanding of that. As has already been said, we do not yet understand the impact of social media on young people's lives. An interesting statistic produced by the behavioural insight team at a presentation about public health a couple of weeks ago showed a clear correlation between the boom in social media and levels of adolescent self-harm in the US and the UK. That evidence is just emerging, but there are now numbers to support the anecdotal evidence around the impact of social media. That is one aspect among many that we are—probably as a whole system—trying to catch up with and get our heads around.

**Colin Beattie:** What does COSLA do to support councils in tackling the problem?

**John Wood:** We hope that Denise Coia's task force will produce a bed out of which improvement work will come. In terms of raising it up the political agenda, we hope that the statements that we have made about the task force and our response to the Auditor General's report have helped to raise it for our member councils as well.

**Colin Beattie:** There appears to be considerable reliance at all levels on the task force producing the raw data that we need to understand the root causes and so forth. Is that correct?

**John Wood:** It is certainly the case that a lot of emphasis is placed on it. We would also look to the IJB chief officers, who I know have been doing a lot of good work on mental health and getting a better understanding of what contribution the integration authorities can make to improving children and young people's mental health outcomes.

**Liam Kerr:** The Scottish Government and COSLA have already mentioned the data inadequacies. What are the Scottish Government and COSLA doing to understand and collate what is spent on children's mental health services in Scotland?

**Paul Gray:** That is part of the improvement that we want to achieve. We already have some data from boards, which we can share with the committee if that would be helpful. We want to be able to trace expenditure through to outcomes; we are not as good at that as we should be. We already have plans to increase the number of people in different disciplines who are involved in the delivery of a response to mental health requirements in children and young people. That is measurable, but we need to step through to measurability of outcomes, which we need to get better at.

**Liam Kerr:** I will come back to that.

I want to put the same question to COSLA; it is purely about how we understand what is currently being spent. From the Auditor General's report, it appears that we do not know what is spent directly on children and young people's mental health because of the existence of different ways of measuring. How are we addressing that?

**John Wood:** We would want to look at the global resource that is available, rather than just the health spend, which is probably a bit more traceable; I hope that Paul Gray agrees. Instead of looking at what is spent on acute services and on CAMHS, we would rather have a conversation about shifting the balance of spend into preventative services, the spend on which is always extremely difficult to quantify. We would not want to get caught up in a numbers game of setting local targets on spend on different service

areas, because the make-up of service delivery can vary widely, with only some bits of the system being the responsibility of the IJB and services being delivered across different agencies.

**Liam Kerr:** This might be more of a question for the Scottish Government. In the programme for government, the Scottish Government announced that an extra £250 million would be provided over five years to support mental health services, but given the data problems and the lack of consistency in data capture and what is measured, how will we know whether that money is spent on the things that make a difference to children and young people's mental health?

**Paul Gray:** As I tried to say in response to Mr Beattie, it is partly a case of understanding what the root causes are and partly a case of understanding what we can do preventatively—in other words, what work we can do to avoid reaching the acute presentation stage.

We have said that £60 million will be available for additional school counselling services, which will support 350 counsellors. That is directly measurable—either we will or we will not have that provision in place. The plan is to have it in place. I could go through the list of the other measures, but I will not do that, because of time. That is part 1. When we say that we will have so many people doing something, that is a measurable thing and we can tell whether we have done it.

Part 2 is what outcomes are achieved, which is harder to measure. For example, a young person in their teens might go to a GP with a presenting issue, alongside which there is a mental health issue. There is a question about the level of granularity that we would want to associate with that. The young person might say, "I've got an upset stomach and I'm not eating," and the GP, through their professional intervention, might detect that there is a symptom, but that there is also a cause of that symptom.

That is where it becomes more complex. The disposal might not be to give them medication or advice on eating or something for a stomach upset; rather, it might be talking therapy or some other opportunity. I give that example because it is slightly broader and it shows where we have to be careful. Like John Wood, I am not trying to overanalyse the issue, but I want to ensure that we get the right outcome.

**Liam Kerr:** I accept that, but the question that I would throw back to you is: how will the public know that an extra spend of £250 million over half a decade is going to the right place and is actually delivering results? There must be a methodology—or at least one must be being created—that will allow you to measure a definable outcome from the £250 million.

**Paul Gray:** What is being proposed includes things that we know work—we are not simply guessing that they might be a good thing to do. However, if Dame Denise Coia comes up with recommendations either about root cause or prevention that say that we might want to adjust something slightly—for example, that it would be better to have 320 counsellors and 95 more school nurses—we are not going to be foolish and say that the numbers are absolute and we are going to stick to them. However, we have set aside funding and, on the evidence that we have so far, we know that counselling services and school nurses are likely to make a difference. We are also talking about putting 80 additional counsellors into further and higher education, because people do not suddenly stop needing those when they reach 18. We are putting in the things that the evidence supports, but we are listening to the further emerging evidence to ensure that we have the approach as right as we can get it.

That is why I referred to the youth commission advisory panel. The young people who have given and are giving us advice through that have themselves experienced mental health problems, and they are telling us how they would like to access services and what they feel about avoiding the stigma of having a room in the school that says "Counsellor" on the door. That creates a stigma rather than a desire to take up the service. The counsellors are needed, but how we provide them has already been adjusted through the opportunity to speak to those young people.

**Anas Sarwar:** We heard earlier from Dr Coia about the welcome fact that we have new money coming from mental health services, but she also used the word "cuts"—she talked about cuts coming in advance of the new money and a lot of the new money having to fill the gaps that have been created. Where have those cuts come from? Do you recognise that?

**Paul Gray:** I recognise that health boards have to make 3 per cent efficiency savings year on year, as they have made every year for many years. I did not hear the evidence from Dr Coia, but I understand that she somewhat modified her statement during the evidence. I am not pretending that we do not make efficiency savings year on year—any health service that did not make such savings would not be doing its job properly—but there has been a 69 per cent increase in child and adolescent mental health service provision since 2007. There is another £250 million, and I have enumerated some of the types of professionals that we think will be provided by that, based on the evidence that we have so far. The issue is how we ensure that we have convergence between that and the increasing incidence of neurodevelopmental issues and general emotional distress among

young people, which John Wood and others have referred to. I can tell you what the numbers are—that is my answer.

**Anas Sarwar:** Are you aware of any health boards that have cut mental health services because of budget pressures?

**Paul Gray:** I do not have specific detail. If the committee is asking me to provide specific detail, which it is entirely within its rights to do, I am happy to provide that.

**Anas Sarwar:** You cover health and social care, so there is a local council perspective. Are you aware of any cuts to local government budgets that have impacted on the provision of mental health services, whether those are direct services or services provided through third sector organisations? What is the scale of any such cuts?

10:45

**Paul Gray:** I would rather let COSLA respond to points about local government. It would be appropriate for me to do that.

**Anas Sarwar:** Are you aware of any such cuts?

**Paul Gray:** I am aware of services having been reconfigured, and I am aware of services having been delivered differently. I am not personally aware of specific cuts in local authorities, but that does not mean that they do not exist.

**The Convener:** Would Nicola Dickie or John Wood like to respond to that question?

**John Wood:** It would be difficult to trace whether local authority budgets that are allocated to mental health services have been cut. I do not think that we have detailed information to offer on that. We have seen an overall reduction of 4 per cent in the local government budget over the years, although that will not necessarily have had an effect on mental health services as defined by some people. The preventative benefit of local authority services, a lot of which are provided by third sector partners on our behalf, comes through the preventative services to which we want to direct attention when we talk about children and young people's mental health. Those services are vital in preventing people from getting to the sharp end of services.

**Anas Sarwar:** I am aware of cuts that have been made to third sector organisations in my local authority that provide mental health services because of budgetary constraints on the council. COSLA, which looks across the country, must have examples of such cuts.

**John Wood:** We have very difficult conversations with the third sector organisations about the availability of budget to maintain the services that we would like to maintain in partnership with them.

**Anas Sarwar:** Are you able to analyse the resources that councils provide for direct services or to third sector organisations that councils fund and how that funding on mental health issues has gone during the past, say, five years?

**John Wood:** We could provide such information if there was a request from the committee. We would probably point to our recently published document "Fair Funding for Essential Services 2019-20", which sets out in quite a bit of detail some of the specific funding pressures that there are on local authority services at the moment.

**Nicola Dickie (Convention of Scottish Local Authorities):** It is difficult, because we are trying to protect communities. Much of the evidence that we heard in the earlier session was about the resilience and robustness of communities. If we take it that local government is providing much of the leadership in those areas, any cuts that come through the local government settlement will ultimately affect those communities and how resilient and robust they are. Our school communities are included in that wraparound support.

We probably do have some specific examples of what you are asking about, but we also have the global figure and we are looking for a whole-system shift. We must recognise that different parts of the system are being treated in a different way when it comes to financial sustainability.

**The Convener:** It sounds as though you do not really have a clear picture of where the cuts are being made.

**Nicola Dickie:** We have global figures for where we have pockets of support; it is more difficult to put our finger on specific points. In the earlier evidence session, we heard how poverty affects young people's mental health and wellbeing. How can we track that back to something having been changed in one place? That is where we would start to get into difficulty.

**The Convener:** If you do not know where the cuts are falling, how can we redirect money to where it would be spent more effectively?

**Nicola Dickie:** The COSLA essential services document will tell you exactly where the cuts have come in global terms. What I cannot say with any degree of certainty is that a specific cut in one place has had an effect elsewhere on young people's mental health. The work that Denise Coia and her task force are doing when they go out and hear from the people who are delivering the services is starting to give us a flavour of that. The strain that the system is under makes it difficult for

us to cope and ensure that our communities are resilient.

**Anas Sarwar:** I completely accept that, and I take the wider point that you make about the impact that the reduction in budgets is having across services. However, some kind of analysis from COSLA—specifically around mental health services—would be helpful, particularly at a time when we have a national strategy under which we want to increase support for those services but councils are having to make very severe cuts. They are not doing that out of choice; they are being forced to do it because they have to make their budgets balance. Some analysis of that would be appreciated.

**The Convener:** Alex Neil has a supplementary question on that point.

**Alex Neil:** I think that it works the other way round as well. I will give an example of that. In my constituency, North Lanarkshire Council has introduced the 365 club to ensure that every kid gets decent meals throughout the year. It is too early to say, but I suspect that that will lead to a reduction in the need for expenditure on mental health services, for example, because it is helping to address poverty. I do not know whether it is possible to analyse what is happening both ways. Sometimes a cut will be made not because of a budget cut. Sometimes there will be a cut in demand as a result of a better service being provided elsewhere—it is two-way traffic.

**Anas Sarwar:** I completely accept that, Mr Neil. Poverty reduction will lead to a reduction in the need for mental health services, but the challenge is that poverty reduction will not happen immediately with the introduction of a breakfast club, so we will still need mental health services to support people who are in poverty while they pursue that route out of poverty. It is really important that we look at the services now—

**The Convener:** Question.

**Anas Sarwar:** I think that we have made that point.

Mr Gray, I want to return to the workforce. I spoke to Dr Coia about the analysis of the number of school nurses—particularly mental health nurses. That key commitment from the Government is recognised and supported right across the Parliament.

**The Convener:** Question.

**Anas Sarwar:** Do you have a timescale for the introduction of mental health nurses in secondary schools across Scotland?

**Paul Gray:** I do not at this stage, Mr Sarwar, but we hope that the guidance and plan that will come out of Dr Coia's task force will assist with that. I will be happy to ask the chief nursing officer to provide the committee with an update on mental health nursing in general and with a specific focus on mental health nursing for children in different settings. It is important that we join up the settings.

**Anas Sarwar:** Convener, I have a final question.

**The Convener:** Please be brief.

**Anas Sarwar:** Do we know whether, among the 7,000 rejected referrals, there were any incidents of self-harm, attempted suicide or suicide? If so, how many cases were there?

**Paul Gray:** I would like to provide accurate information to the committee, so I will answer that question in writing.

**Anas Sarwar:** Thank you.

**The Convener:** That is fair enough. Thank you.

**Bill Bowman:** I asked the previous panel about data on performance and outcomes, which is limited. The issue of data has been raised by a number of people this morning, but I do not have a feeling for the timescale over which things will be improved. Can you be a little more specific on that?

Also, in paragraph 36, the Auditor General talks about your developing new quality indicators with six different measures, but the boards will be allowed to cherry pick which indicators they report on, which will not add to the comparability of data in the future. Will you undertake not to let the boards have that ability and to provide us with a timescale? The report says:

"There is no confirmed timescale for this work."

**Paul Gray:** As Donna Bell said a moment ago, we will draw the timescales out of Dr Coia's report, which is due very shortly. I have heard the committee very clearly on that point.

On the issue of cherry picking—as you put it, Mr Bowman—I am happy to give the committee an undertaking that we want to have comparable data across Scotland. I am very clear about that. However, I also want to be clear, so that I do not mislead the committee, that that comparability should focus on outcomes. I am not going to insist that the way in which we deliver services in Easterhouse should be exactly comparable with the way in which we deliver services in the Black Isle, because that would be foolish. Nevertheless, I do want outcomes to be comparable.

Also, when we say that we will count the number of people who are being employed as a result of the additional investment, we will do that. So, the answer to your question is yes.

**Bill Bowman:** Is there any timescale for that particular item, or is your answer the same as it was to the previous question?

**Paul Gray:** Yes. I am not going to pre-empt Denise Coia's report.

**Bill Bowman:** But you will give us a timescale?

**Paul Gray:** We will.

**The Convener:** Can you give us the timescale for Denise Coia's report? When do you expect to receive it?

**Bill Bowman:** Can you give us a timescale for the timescale?

**Paul Gray:** We expect to receive it in December.

**Willie Coffey:** Mr Gray, you mentioned the £250 million extra funding that has been made available by the Scottish Government. Has an apportionment taken place for the health boards, and does each authority know the share that it will get? Will the money be somehow protected—I hesitate to use the term "ring fenced"—for those services? A previous panel member told us that some of the funding for mental health services in, I think, Grampian was pulled away to be used elsewhere.

**Paul Gray:** That is currently the intention. Let me be precise and clear: we are looking to ensure that every high school has a counselling service, and there are other services, which I have mentioned, such as school nurses and counsellors in further and higher education. Another important development, which is not so numerical, is the enhancement of support and professional learning materials for teachers, which will give every council access to mental health first aid training for teachers.

We also propose to allocate £65 million to the development of a community mental wellbeing service for five to 24-year-olds. In due course, that service will offer immediate access to counselling, self-care advice and family and peer support, because no person operates as an individual with no contact with anybody else. Sometimes, family and peer support is an essential component of what we draw together.

**Willie Coffey:** I also want to know about the assessment and referral processes, which Liam Kerr touched on. In appendix 3 of the Auditor General's report, we can see that quite a variety of people make referrals. The suggestion was made that there is a tendency to push everything toward CAMHS, which might result in the rejection or redirection of the referral. Are you looking at those processes to make them a lot better? It will not be money that achieves improvements in the situation; at the beginning of the processes, assessments should be more accurate, to ensure that children are directed to the correct service.

**Paul Gray:** I will speak briefly and then hand over to Donna Bell.

In Canada, some years ago, there was an approach to public service delivery that was called the no-wrong-door approach. In other words, wherever a person made contact, there was a means of getting them to the help that they needed. That would be my ideal approach, whereby young people would not need to work out whom they needed to ask. Whether they were to ask their teacher, GP, dentist or hairdresser—I mean that quite sensitively—whichever person was able to spot that there was a need ought to know what to do. That will take years but it is the ultimate aim.

Donna Bell might be able to say a wee bit more.

**Donna Bell:** You heard some really great evidence from Stephen Brown about the whole-system approach that is operating in Ayrshire and Arran, which is enabling children and young people to get the help that they need when they need it. The approach is beginning to be replicated elsewhere in Scotland, and we encourage others to work in that way.

**Willie Coffey:** Is it too early to expect the figures to come down, so that there is not the same delay and redirection, which takes time and causes further delay? Are we improving the approach at the moment?

**Donna Bell:** You heard from colleagues in Grampian who have been able to demonstrate a 27 per cent reduction in waiting times, so there are some promising approaches. Perhaps our colleague from COSLA would like to add to that.

**Nicola Dickie:** Yes. We are aware of the good practice that is going on in the whole-system approach. Yesterday, I spent some time at Musselburgh high school, where people were discussing how they have already used some of their pupil equity funding to increase the confidence of everyone in the school community to have such discussions and, if required, to make referrals.

There are pockets of good practice, and you heard Dame Denise Coia allude to the fact that we need to share it. The fact that we are going to have a delivery plan with things that we can do in the short and medium terms, and then things that will take longer, means that I expect that good practice will start to be shared in order that we can get some of those results. If there are some wins there, let us get on and get them.

11:00

**John Wood:** The view has come through quite strongly from our elected members that we need to maintain a focus on specialist services and celebrate the generalist. That is a reflection of Paul Gray's hairdresser point. Given the various ways in which people interact not necessarily with hairdressers but with the system—whether it is with the third sector, the local authority, social work or health—as long as there is a one-public-sector attitude among the workforce and people are aware of the services that are available in their local area, that will improve signposting and, I hope, eventually improve referrals.

**Alex Neil:** I asked Denise Coia's team about sharing good practice. You guys are obviously very much in a position to ensure that that happens. We heard about the transformation that took place in NHS Grampian in a short period of time. It has not been completed yet but it is on the way. What are the Scottish Government and COSLA doing to improve the adoption and sharing of best practice?

**John Wood:** One of Denise Coia's early priorities was to look at the sharing of best practice. I also point to the welcome statements that we heard from the Cabinet Secretary for Health and Sport on—as she put it—spreading good practice and not just showing one another what good practice is but fertilising it across local partnerships to make sure that it embeds in other areas.

**Alex Neil:** I have been hearing about that for years and years. How will you monitor it? It does not just happen.

**John Wood:** I do not know about monitoring. It is important that we resource the sharing of good practice and support improvement. Services do a good job of learning from one another, but the pressures at the local level are such that investment in more improvement support across health and social care partnerships would be welcome.

**Donna Bell:** Denise Coia's task force is a partnership approach, so all the appropriate people are around the table, sharing practice. It is incumbent on us all to make sure that good practice is embedded at the local level.

Healthcare Improvement Scotland is also doing some specific work with all IJBs on reducing waiting times, using a collaborative approach. Approximately 40 such projects are under way across the country. That is a good example of how good practice is being developed and shared across the piece. I point to that as one area of work that is being done.

**Alex Neil:** Another good example is NHS Grampian's CAPA system, which allows the board to look at resources, what is coming in and what is going out. Have there been any moves to share that good practice?

**Donna Bell:** That is exactly the sort of practice that we would expect the collaborative approach that Healthcare Improvement Scotland is leading on to promote and share. There are other good examples across the country.

**Alex Neil:** We are all agreed that poverty is a major driver of poor health, whether it be physical or mental health. There have been some interesting examples of local initiatives not just in Scotland but elsewhere, which are driving down levels of poverty, including child poverty. This is not just a health issue; it is an education issue, a social security issue and all the rest of it. Is any attempt being made to look at such initiatives across the Government and share them as good practice?

**Paul Gray:** Yes, Mr Neil. Sally Loudon and I are co-chairing a review of integration with a view to putting a report to the ministerial steering group, which is co-chaired by the cabinet secretary for health and the president of COSLA. We will be speaking about the sharing of best practice. You are right: we have best practice and we showcase it, but we are not as good as we should be at embedding it across the country.

We want to respect the fact that there are many localities, which are all different—I have made that point already—but, when we see good outcomes, we need to ask ourselves more robustly how we are going to achieve those outcomes if we do not adopt those approaches. The imposition of common approaches has its limitations, but the desire for common outcomes must be a key objective.

**The Convener:** At the start of this session, you referred to a HIS report on CAMHS in Tayside. What do you know about that report?

**Paul Gray:** I know that it is in draft form, but I have not seen it.

**The Convener:** What is HIS's policy on publishing such reports? Are they all to be put in the public domain? It is my understanding that the report was finished, and I have been trying desperately to track it down.

**Paul Gray:** As far as I am aware, it will be published.

**The Convener:** That is good. Thank you.

As members have no more questions for the panel, I thank you all for your evidence.

11:06

*Meeting continued in private until 11:23.*

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