OFFICIAL REPORT
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Public Petitions Committee

Thursday 7 March 2019

Session 5

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PUBLIC PETITIONS COMMITTEE
5th Meeting 2019, Session 5

CONVENER

*Johann Lamont (Glasgow) (Lab)

DEPUTY CONVENER

*Angus MacDonald (Falkirk East) (SNP)

COMMITTEE MEMBERS

*Rachael Hamilton (Ettrick, Roxburgh and Berwickshire) (Con)
*David Torrance (Kirkcaldy) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Stuart Callison (St Andrew's First Aid)
Maurice Corry (West Scotland) (Con)
Ellie Meek (Parkhead Primary School)
Colin Peebles (Mearns Primary School)
Millie Robinson (Parkhead Primary School)
Rebecca Russell (City of Glasgow College)
Frances Stewart (St Andrew's First Aid)

CLERK TO THE COMMITTEE

Sarah Robertson

LOCATION

The Robert Burns Room (CR1)

Scottish Parliament

Public Petitions Committee

Thursday 7 March 2019

[The Convener opened the meeting at 10:00]

Continued Petitions

First Aid Training (Primary School Children) (PE1711)

The Convener (Johann Lamont): I welcome everyone to the fifth meeting in 2019 of the Public Petitions Committee.

The only item on this morning's agenda is consideration of five continued petitions. The first petition is PE1711, lodged by Stuart Callison on behalf of St Andrew's First Aid, which calls for basic first aid to be included as an integral part of the primary school curriculum and for funding to be provided to develop high-quality teaching materials and establish training for primary school teachers so that they can deliver training to pupils.

Mr Callison, chief executive of St Andrew's First Aid, and his colleague Frances Stewart are here to give evidence this morning, as is Colin Peebles, who is a teacher at Mearns primary school in Glasgow. I am also absolutely delighted to welcome to the meeting some young people: Rebecca Russell, who is a student at City of Glasgow College, and Ellie Meek and Millie Robinson, who are pupils at Parkhead primary school in West Calder. Their demonstration of their skills before the formal meeting is probably the best start to a meeting that we have experienced in a long time, and I thank them very much indeed for it.

The panel members will all have the opportunity to talk about why they think the petition is so important, but first of all, I invite Mr Callison to provide a brief opening statement.

Stuart Callison (St Andrew's First Aid): It is a great pleasure to be here on behalf of St Andrew's First Aid, which is one of Scotland's oldest charities and the only dedicated first aid charity in Scotland.

This morning, we are asking the committee to urge the Scottish Government to do more to promote basic first aid as part of the curriculum in all Scottish primary schools. Curriculum for excellence provides scope for that—for example, one of its outcomes is that children should know and be able to demonstrate how to keep themselves and others safe and how to respond in an emergency—but as things stand, it is very much down to individual local authorities whether these essential skills are taught to pupils. In practice, first aid learning depends heavily on the knowledge and enthusiasm of individual teachers, such as Mr Peebles.

Scotland's Information Services Division recently highlighted the stark fact that the death rate from heart disease for those in the most deprived areas of the country is six times higher than that for their wealthier neighbours and that those people are 36 per cent more likely to die from a stroke. Moreover, youngsters living in those areas are more likely to encounter violence or health issues arising from the misuse of drugs and alcohol. However, children in those areas are far less likely to learn first aid in their schools or through membership of youth organisations such as the cubs or brownies.

We believe that if children and young adults are equipped with these skills at an early age, they will become lifelong advocates of first aid and make a huge difference to their families and their local communities. We are calling for the provision of high-quality and age-appropriate teaching materials as well as training and support to enable teachers to deliver first aid knowledge to their pupils in short, focused workshops that are integrated into the curriculum as they see fit.

As our young people have demonstrated, we know that children can benefit from an understanding of what to do when someone is choking, how to put them in the recovery position and perform cardiopulmonary resuscitation, how to do some basic bandaging of wounds, and even how to recognise and help when one of their classmates is anxious or distressed—in other words, mental health first aid.

We actively support the campaign by the British Heart Foundation and the Scottish Government to promote the teaching of CPR. However, vital though that is, it is only one of a set of basic first aid skills.

Financially speaking, this is a modest measure, with significant societal benefits. As we fully recognise the time and resource pressures that our schools face, we have designed this as a cost-effective, value-for-money solution. We propose to develop high-quality teaching tools to make the job easier for people such as Mr Peebles. There are, of course, many such tools scattered around the internet—we can all find them—but there is nothing that is very comprehensive or tailored to curriculum for excellence and, indeed, some of the tools are probably not really appropriate for primary schools.

We believe that it would be beneficial to develop such materials in conjunction with Scottish teachers themselves. We propose to train one

teacher in each school who will then cascade that learning down through their school and the local authority area. We calculate that implementing a first aid training programme in schools along those lines would cost not much more than half a million pounds in the first year, with the cost falling thereafter. That would be the equivalent of around £270 per primary school. In the longer term, if first aid education were included in initial teacher education, that would reduce the continuing professional development burden on schools and take the cost down further.

The benefits to society outweigh such a modest investment. First, such a programme would increase the number of trained bystanders ready to help in an emergency. Even at an early age, children are receptive to first aid training and are keen to share their knowledge with family and friends. When the Danes introduced a similar programme in the early 2000s, they increased the number of bystander interventions in emergency situations from around 20 per cent to more than 70 per cent in 10 years, largely because of kids going home, telling mum, dad, uncles, cousins and the rest about what they had learned and showing them what to do.

Teaching first aid in schools is very inclusive—it is appropriate for all levels of development and all races, colours and creeds. Researchers have noted that first aid training contributes to increased confidence and self-esteem among young people, and the young people here this morning are the perfect example of that.

As a skill for life, first aid training can also help young people to be more risk averse, particularly when it comes to the consequences of binge drinking and drug use, areas where it has been shown that teenagers who understand the risks are less likely to take part. In addition, they are able to help their friends when they get into trouble. Simply knowing how to put someone into the recovery position, for example, can be enough to save a life in such situations.

Finally, the committee might be aware of the Westminster Government's announcement in July 2018 that first aid training would form part of compulsory health education in all English schools from 2020 onwards, in the belief that it would support academic attainment and school performance and that disadvantaged pupils would experience the greatest benefit. We believe that, in this instance, Scotland could benefit from following suit.

We are happy to take questions.

The Convener: Thank you very much for that. We do have some questions, and we are particularly keen to hear about the experiences of the young people who are involved; of Frances Stewart, who is involved in a lot of training; and of our primary teacher. I will ask a couple of questions, as will my colleagues, who should feel free to direct their questions to whoever they think will best be able to answer.

Mr Callison, you have already touched on this, but can you confirm why it is best to start with primary school children rather than other parts of the education system? Moreover, why should we start specifically with schools in areas of high deprivation?

Stuart Callison: I will ask my colleagues who have been teaching first aid to answer that.

Colin Peebles (Mearns Primary School): The training should start further down in primary school, because younger children are more malleable, more receptive to new things and keen to learn—they are the proverbial sponges, soaking up knowledge. As a result, starting the training earlier rather than later is a fantastic idea. As Stuart Callison has said, the bystander effect is reduced when people have a little bit of knowledge such as how to put someone in the recovery position. Pupils can take that knowledge further and build on those skills as they go through their education.

In our school, we start the training in nursery school and primary 1 with very basic things, such as knowing about the emergency services and being able to recognise risk. That progresses to having the ability to perform CPR and knowing how to put people into the recovery position by the time they get to the senior school. I cannot speak for my secondary colleagues, but that is why I advocate such training at an earlier stage.

The Convener: Do you think that your school is unusual in having such a thought-through programme right from the earliest stages?

Colin Peebles: I cannot speak for other schools. I think that Stuart Callison has recommended that two hours of training a year be provided; at the moment, we provide 12 hours of training a year. Last year, we had a working party that decided to focus on life skills. When such skills are taught, no matter whether it be first aid, cooking or design and technology, we have mixed-ability classes to ensure that there is very much a level playing field. As has been mentioned, children who come from more deprived areas are probably more likely to experience a situation such as a medical emergency, so having that knowledge at an earlier stage is a great thing.

Brian Whittle (South Scotland) (Con): Good morning and welcome. I particularly welcome Millie Robinson and Ellie Meek, who were fantastic this morning. They made an old man feel much better. Everybody should have a Millie or an Ellie close by; I would certainly like one.

We are aware that first aid skills are taught to uniformed sections—the beavers, the cubs, the guides and the scouts, for example. That means that children as young as six years old in the beavers, for example, acquire these skills as life skills. Do you think that teaching these skills to children at that young age should be mirrored in schools?

Colin Peebles: Not every area has beavers, cubs or scouts. In every area, most children will go to school, but not every child will go to one of those clubs. A catch-all can be done in a school, as opposed to covering maybe a quarter or a fifth of children—whatever the number is—in clubs.

Stuart Callison: The merits of having a focused approach in our schools is that everyone will learn. There are outstanding examples in Scottish schools in which first aid is taught. We would like everybody to have the opportunity to learn.

Rebecca Russell is one of our most active recruiters of young people. Perhaps she can comment as well.

Rebecca Russell (City of Glasgow College): I am with the Stanley company of St Andrew's First Aid. We started off the year in September last year with only two cadets who had come back over the summer. My friend Cara and I took it upon ourselves to go around our local primary and high schools, such as Hillington primary school and Rosshall academy—we had ties with those schools because we used to go there. We did a wee demonstration at the schools and spoke a bit about what it is like to be a cadet. We had an open day, and 19 cadets came out of that. We were really proud of that and really happy.

We occasionally went back to Rosshall academy and spoke to the kids we had done the talks to. They were really enthusiastic about first aid, and they said that they would love to be taught because they wanted to learn more. We get more out of that than from knowing what we know and how to put that to the kids. The youngest of the cadets is nine and the oldest is 16. They come every week and absolutely love it.

Brian Whittle: I still remember as far back as when we did CPR in primary school. I think that that was in primary 6 or 7. Are you suggesting that training should start as soon as children go into primary school, or should it come in later on in primary school?

Stuart Callison: All the materials that we would produce would be age appropriate, but it is possible for children to be introduced to the concepts from primary 1 and 2 onwards, even if we are talking about something as simple as knowing how to get help in an emergency—if, for example, mummy or daddy has collapsed. Such situations have arisen, and kids as young as four or five who have been aware of basic first aid have successfully been able to call for help.

I think that some primary schools in Edinburgh have introduced CPR to children as young as five or six. At that age, children will not have the physical strength to do CPR, but they are introduced to the concept, and it has been demonstrated that the concepts will last longer if we start younger. A five-year-old will probably not be able to do effective CPR, but they are far more likely to refresh those skills when they go on to secondary school and in later life.

We propose having age-appropriate teaching available for classes right the way through the school.

Colin Peebles: It is important to note that, if first aid becomes normal at an early age, it stays normal. As a result, if someone collapses, a person will not pretend that they did not see that. Unfortunately, that happens in some cases. A person can start to get the knowledge and confidence at an earlier age. As Stuart Callison said, CPR by a five-year-old might not be effective but, if they are aware of the motion and are able to continue the skills as they become bigger and stronger, that is great.

10:15

Brian Whittle: I have a question for Millie Robinson and Ellie Meek, because I am trying to get them back for hurting me so much earlier. [*Laughter.*] Would they feel confident enough to teach their classmates the skills that they have learned? They tried to teach me the skills, but I was terrible.

Millie Robinson (Parkhead Primary School): I gave a three-minute talk to my class, and I got my youth leader to bring in a dummy. I gave a demonstration and told my class why I do first aid.

Brian Whittle: How did your classmates react to that?

Millie Robinson: I think that they learned something from it.

Brian Whittle: Great. That is super.

The Convener: Frances Stewart was nodding when we were talking about training. Does she want to talk about the training that she does?

Frances Stewart (St Andrew's First Aid): I will touch on something that the guys have already said. I have worked in first aid for many years, from teaching those who are very young to taking workplace courses. One of the biggest barriers to anyone helping someone who has taken ill in the street is fear. People do not know what to do and they are frightened that they will do something wrong. We should get young children used to first

aid, even if that just means children seeing a dummy on the floor and knowing how to touch it, what it feels like and how deep to press. That will mean that children will not have that fear any more.

I have a son who is just about to turn two years old. He cannot do CPR—I am not saying that—but he knows what a dummy looks like. When he gets older, he will not be frightened, because he already has an awareness of what mum does. He already has an awareness of how to help somebody, because he has seen me do it. If we can get rid of people's fear at an early age, it will be far easier for them to act when things happen. We should say to children at an early age that, if they see somebody lying on the floor, all they need to do is call for help. If we get children to colour in an ambulance that has 999 written on it, they will not be frightened as they get older. It is like using building blocks: we will need to keep reintroducing things, but we will not need to start from scratch. I have trained primary 1s. We give them proper training; we do not just talk to them. We show them that they can do massive things, even though they are so small. We can shape their behaviour.

We want to ensure that no one is frightened of asking somebody whether they need help. They do not need to know everything—they do not even need to remember all the training—but they need to know that they can do something. Doing no first aid is much worse than having a shot. People should not be terrified of doing something. The younger someone is when they start the training, the better chance we will have of shaping them into first aiders as they grow older.

The Convener: Does Rebecca Russell want to talk about her experience? The committee was struck by the fact that first aid skills literally save lives and that they are amazing and important skills for people to have. Earlier, she spoke informally about incidents that she has been involved in. Would she like to share that with the committee?

Rebecca Russell: Last year, when I was standing in Jamaica Street in the town, having just come out of a gig, I found a young girl—just a year or so younger than me—who was unconscious on the ground. Her friends informed me that she had had a fit and was going in and out of consciousness. My first instincts were to put her in the recovery position, keep her warm—because it had been raining, so it was damp—keep her calm and keep her talking to either her friends or me, so that she could remain aware of what was going on around her. We also phoned an ambulance. The girl was fine. We met up a couple of weeks ago, and she was very grateful that somebody, whether it was a member of the public or one of her friends, had helped her and looked after her.

A couple of months ago, when I had just come out of college and was walking to get the bus to my cadet class, I saw an older man who had fallen on to the road and was lying on the ground. There were people around, and the first thing that they did was to put him in the recovery position and keep him talking. His wife was there and she was really helpful. She knew what was going on and she kept speaking to him and making sure that he was okay. We waited for the ambulance and kept him in the recovery position to keep him stable and comfy, and he made a good recovery as well.

As my colleague Frances Stewart said, young people could be frightened in such situations if seeing someone lying on the ground is new to them. If I was not used to first aid, I would think, "Whoa—what's happened?" I would be a bit unsteady going towards the person. Getting kids involved in first aid at a young age can save people's lives because they will not be as scared to go up to people if they know what to do, even if it is just to phone 999 or get someone older to help. If they know the basics, we know that people will be safe.

The Convener: What strikes me about your examples is that your confidence gave confidence to the people around you. You said that young people who do not have first aid skills might not feel confident. I have not qualified as a young person for a very long time but, in thinking about that, I would still feel some uncertainty and lack of confidence. Having somebody nearby who knows what they are doing can make a huge difference.

Angus MacDonald (Falkirk East) (SNP): This is a great evidence session. It is so good to hear some prime examples of how it has been going so far.

I would like to put on the record an issue that I have with my local authority, and I will name and shame it. Falkirk Council is one of only three local authorities that have not yet signed up to the British Heart Foundation scheme of CPR training and secondary skills, despite my cajoling since August last year.

I welcome the initiative and the petition. We can clearly see the benefits of first aid training being introduced at primary level and, if it is introduced there, we will not have an issue at secondary level.

Mr Callison, will you expand on what you said about the initial cost of £0.5 million in the first year to train one teacher in each primary school? Clearly, there is an issue with access to training and materials. Do you envisage that the £0.5 million will cover materials as well?

Stuart Callison: Yes. We are conscious that we are in austerity-driven times, that local authorities do not have money to throw around and that schools are already very busy. That sum will cover the preparation of materials that teachers will be able to draw down and take off the shelf without too much preparation time being required. The materials will be age appropriate and they will be designed to be user friendly. We wish to work with teachers on that and take a collaborative approach, because we are first aiders and not educationists. We wrote recently to the Educational Institute of Scotland to ask for its support, and I would certainly want it to be involved.

That sum would also cover the staff costs, whether for us or others, to train teachers in a particular local authority on the basis that the skills can then be cascaded down to other teachers. In that way, schools would not need to send a whole lot of staff and we would not need to have an endless number of training courses. Teachers can pick up the training and share it with their colleagues. My colleague Frances Stewart might want to say more about that.

There is also the cost of the equipment, some of which you have seen. The mannequins do not last for ever, but they have a reasonable lifetime. If they are looked after, they will last for a number of years. The initial cost is higher because of the capital investment in equipment. After that, there are the costs of keeping things clean and sterile and so forth. Unless Frances Stewart is going to correct me, that is pretty much it. That is what the proposal involves. As I said, it is a modest measure, financially speaking, but it can produce significant benefits.

Frances has done some of the peer training, so she might want to add to my answer.

Frances Stewart: As Stuart Callison said, we are conscious that schools, like everyone else, are already under intense financial pressure. Schools are also under a lot of pressure to meet their targets, and we certainly do not want to introduce something that will make things more difficult for them to do that. We want to work together. As has been said, our kids are lucky because they come to the cadets, and there are also brownies and things like that. We want to make sure that it is not sporadic; we want to make it inclusive so that every child gets the chance to get this very basic training. We want to back that up with a proposal that will make sure that schools can do it without being put under intense financial pressure or other pressure.

Our costings are based on downloadable resources. Even if we were to start small, there would be downloadable resources and, as it grew, we would have an online portal to allow people to chat. I have been a first aid trainer for years. Obviously, teachers can already teach, but if they start getting a wee bit frightened about what they are delivering on first aid, we will be there to support them through the online portal. We have also included a starter pack, with bandages and wipes and that kind of thing—everything that will enable teachers to carry out the training.

As Stuart Callison said, the costing includes mannequins for schools, which will then belong to them. Schools will be responsible for the upkeep but, as long as mannequins are looked after, they last for years. That will allow schools to use mannequins as and when they need them within the school day—they might decide to do it for two hours or, as Colin Peebles said, for more than that. The resources that we give them will enable them to do the training completely, in a sustainable way and with arm's-length help from us.

Rachael Hamilton (Ettrick, Roxburgh and Berwickshire) (Con): I have a question for Colin Peebles, after which I have a question for the girls. Mr Peebles, based on your experience, how should we encourage teachers to integrate the skills that you have learned into the curriculum?

Colin Peebles: The curriculum has experiences and outcomes, which I am sure you are aware of. I will refer to a few of them. Under health and wellbeing, HWB 2-15a is:

> "I am developing ... understanding of the human body and can use this ... to maintain and improve my wellbeing and health."

HWB 2-16a is:

> "I am learning to assess and manage risk, to protect myself and others, and to reduce the potential for harm when possible."

HWB 2-17a is:

> "I know and can demonstrate how to keep myself and others safe and how to respond in a range of emergency situations."

The process becomes more complex and harder as children go through their primary school career, but it is more or less the same throughout the school. It is already there, and we already do it. In our school, we do not have dedicated mannequins and first aid providers. I have a first aid qualification, and I am happy to do the training. As I said, we had a working party in our school that thought about the main life skills that we wanted children to leave school with, and one thing was first aid and emergency management.

It would be fantastic to have an off-the-shelf resource. We make up our own resources, and teachers share resources with teachers in different schools. However, an off-the-shelf resource that is

prepared by experts in conjunction with teachers is an excellent idea.

Rachael Hamilton: I put on record my thanks to the young people on the panel. Your confidence and calmness are incredible. I would feel really confident if I had to do CPR with you next to me, so I will take the experience away and will always remember it. I know that the convener, Johann Lamont, has had all her staff given first aid training, and I am thinking about doing that for my team, as well. Thank you for enthusing and inspiring us.

Obviously, the training is being delivered in only a few schools at the moment. How would you enthuse and encourage other teachers in Scotland to be like Mr Peebles? What would you say to them to encourage them to do it, too?

Ellie Meek (Parkhead Primary School): I would say to them that it is quite good to know, and other kids should know it as well, so it would be good if they could teach them it. If the teachers do not know how to do it, they could learn it as well.

Rachael Hamilton: Millie, what would you say to other teachers?

Millie Robinson: If they see how useful it is, they will want to do it. If you know it, you could save a life. If they knew that, they would want to do it.

10:30

Rebecca Russell: I have visited a lot of schools to recruit kids and I know, from speaking to teachers face to face, that they are up for the proposal and want it to happen. A lot of them have a first aid background, even if that means only that they know the basics. If the proposal is accepted, a lot of schools will want to get involved because, at the end of the day, it is great to know first aid skills, and they enable you to help people.

David Torrance (Kirkcaldy) (SNP): This morning's pre-meeting session was probably the best start to any committee in my eight years in Parliament. I thank Ellie and Millie for the confident way in which they told me what I was doing wrong with CPR, which is what my result of 29 per cent showed.

You say that first aid is a life skill—something that can be taken forward in life—and is a benefit to your communities. How can we encourage communities to take up first aid skills?

Colin Peebles: Again, I can speak only for my school, but we have contacted parents and asked them to come in. As I said earlier, we have a programme of life skills, of which first aid is just one. We have helpful links with local parents. One parent who is a doctor gave EpiPen training to the entire staff. Other parents who are doctors, nurses and first-aiders come into the school to deliver some lessons for us—they can show the kids CPR and bandaging much better than we can. That kind of thing improves the school's links with parents, and ends up with parents getting more involved in the life of the school. We have certainly found that there has been an increase in parents and members of the community working with us as a result of the programme.

Stuart Callison: The concept of community hub schools has a useful contribution to make in the area. That concept has been piloted in various local authority areas and involves the school being a centre of education and information for the community.

Colin Peebles: Yes. We run courses after school for parents of less able or more deprived children in which we teach them the life skills that we have been teaching their children.

Stuart Callison: We are beginning to work on an initiative with colleagues in the British Red Cross and the Scottish Ambulance Service, which involves work on a joint community resilience programme that will bring together all the initiatives of the sort that we are discussing—community first responder schemes and so on—to provide initiatives such as a falls clinic. That is a service that colleagues in Wales have piloted. Volunteers who are ready and available at short notice go out to help someone in that situation, in order to take some of the pressure off the emergency services. That is a separate but interesting initiative, and it is an example of how, building from that base block, the skills and knowledge that we are talking about could be used to make a contribution towards making communities more resilient and safer, to quite a wide extent.

David Torrance: The petition notes that St Andrew's First Aid trains thousands of people in life-saving skills, across a wide range of age groups. Can you give us some examples of that, and perhaps expand on your BandAge project?

Frances Stewart: I delivered the BandAge project across schools in Glasgow. That project started in 2015, and it is still running. Initially, it ran across four schools in Glasgow—St Roch's secondary school, Springburn academy, Cleveden secondary school and John Paul academy. Those schools followed the project for a couple of years. We delivered the emergency first aid course to the whole of third year—that is the course that the convener's staff have done. Following that, we developed a peer education programme because we did not know how long we were going to be able to keep going into the schools—everything comes down to funding—and we wanted to ensure

that we were making the schools resilient and capable enough to carry on the project. The kids who had the basic first aid training were given training in the peer element, which enabled them to cascade the skills to the rest of the kids in the school. That approach went on to include the feeder primary schools in the area as well as parents evenings, first year days and so on.

I have a couple of success stories from the project. In St Roch's in 2015, a teacher came to the first aid training, and pupils filled the rest of the spaces. A couple of months after the training, we received a call to say that a pupil in the school had taken a heart attack, and that young girl's symptoms had been severe indigestion and slight pains in her shoulders. Unless people have been lucky enough to do the training, they do not always know the heart attack symptoms that are not the ones that stick out. A lot of people had said, "Sit down and have a glass of water, and you'll be okay," but the teacher and one of the pupils who had been on the first aid course knew straight away, because of the training, that the girl's symptoms were more in line with those of heart attack—of a cardiac problem—because they were persistent. Those people saved that wee girl's life, because she went straight to hospital, where she was treated for a heart attack, and she had no long-lasting damage. That was the result of just a four-hour training course in basic first aid.

In the same year, I dealt with a couple of pupils in Cleveden secondary school. One pupil, who had suffered from type 1 diabetes for years since he was very young, did the first aid course and the peer element. For many years, he had not managed his condition properly because he did not quite understand it, as he was young. He came to my classes after physical education, and I knew that he had overdone it, because I could see him having symptoms of going into a hypoglycaemic attack.

Once we had gone through the relevant part of the training, the pupil started to understand the consequences—that touches on what Stuart Callison said. The pupil knew his condition better than anybody, but he did not necessarily know what was going on inside his body and what the consequences were. After doing the training, he managed his condition better. I worked with him for a few years; the peers in Cleveden were fantastic and worked in their local communities all the time. That pupil lived a far better life after that because, from doing a section on diabetes with us, he understood the consequences.

Some members might know the next story, which comes from 2016. It involves David Corrigan, who did the BandAge programme and went on to win a brave@heart award. His story is similar to Rebecca Russell's. He did his basic first aid training with me and, two weeks later, when he was walking down Argyle Street, a man was hit by a bus in front of him. David Corrigan was cool, confident and collected, because he had just done the training—it was just a four-hour course, which is far more of a time commitment than we propose in the petition. He got the man into a safe position, and he used his initiative to go into shops round about to get white roll, for example—people do not always go about with a first aid box, but he knew what would equate to what is in a first aid box. He stopped all the bleeding, got the man into the recovery position, got an ambulance and saved the man's life. That was all simply from doing the BandAge project that we provided.

However, we could go into only four schools, which is why we started to look at the proposal that is in the petition. We want every child in Scotland to have access to what we gave the four schools that we went into, but we need help to do that. We have the first aid knowledge and all the great stories. I am lucky to have worked with all those children, which gives me as much joy as it gives them. We are lucky to do that; we have the expertise and we need help to roll it out across the country.

Stuart Callison: St Andrew's First Aid is proud of the efforts of our volunteers, our staff and our community projects around the country. Our workplace training social enterprise trains about 15,000 to 20,000 people every year. The BandAge programme, which Frances Stewart described, was great, but we want to see impact. The issue should not be about cost, because there are strong arguments for providing training through schools rather than a charitable endeavour. My partner is a teacher, which has probably prompted me to say that teachers are role models for young kids, who learn more effectively from teachers.

It would be easier to organise first aid training as part of the curriculum if that is done naturally and organically through the staff, rather than have organisations such as St Andrew's First Aid, the British Heart Foundation or anyone else come from outside. I am sure that Colin Peebles would agree that it would be difficult to organise that in the school day, as well as organising the time and how that would be rolled out.

On long-term investment, international research supports the view that pupils retain more knowledge if it comes from teachers. Teachers are the best people to pass on the information. A study from 2012, I think, shows that, after only one four-hour training session—Frances Stewart has described those sessions—teachers were able to demonstrate CPR in schools as effectively, if not more effectively, than medical professionals who had been brought in to do the same thing. Our

approach is the way ahead if we want to impact on Scotland as a whole.

The Convener: What would the pupils' commitment to your suggested programme be? Clearly, young people who have an interest in such matters will develop further skills and learn a lot from that, but how much pupil time would be involved in your proposal on the basics?

Stuart Callison: I will throw that over to Colin Peebles, who, I think, mentioned a 12-hour programme. We would be flexible. We would listen to teachers when designing a programme. The training could go through the school progressively and could be done with as little as one or two hours a year, or it could be done more intensively. We would listen to professionals such as Colin.

Colin Peebles: It is down to not only individual teachers, but individual schools how the programme would integrate into the teachers' workload. Yes, you could do more training. We have a six-week block and a certain number of pupils will have first aid training, while other pupils will be getting something else. The pupils rotate throughout the school year, so that everyone gets the training over the year.

Although first aid training is a health and wellbeing outcome, it can also be linked to numeracy—pupils can do surveys on what their peers think about first aid—and technology. For example, we quite often get pupils to make small infomercials with their iPad or other technology that is available in the school. The training is also really good for role-playing, including making 999 calls. That can be done as early as nursery and primary 1. There are great examples from the internet, including one of a five-year-old girl who makes an emergency call and directs an ambulance to her mother, who has had an epileptic seizure, fallen down the stairs and is unconscious.

The Convener: We had a petition not that long ago from a family who lost their child because nobody knew where the defibrillator was. Sometimes, the support is there, but the issue is people having the confidence to make an early intervention.

My staff and I got excellent first aid training from St Andrew's First Aid. That made me reflect on the fact that, throughout my working life, there has been one named first aider, who was listed on a poster somewhere. It made me question why we have a poster with somebody's name on it, when you then have to go and find them, and I wondered whether it would be better if we all knew first aid. Given the stories that we have heard, first aid training is really important.

Is there one last thing that anyone wants to say to the committee before we conclude? Stuart Callison made a very important point about the need for broader first aid, not just CPR training. You may have mentioned this in your statement, but will you confirm how the level of first aid training that we provide compares internationally?

Stuart Callison: The honest answer is that more evidence and research are required. How official statistics are collected varies from country to country, so making international comparisons is not always as easy as it might be. The general lack of research on the topic should be addressed. That said, the evidence that exists suggests that Scotland has been poor by European standards—it is close to the bottom of the league tables for bystander interventions, first aid training and the number of current first aiders—that is, people who have trained in the past three years. To be fair, the situation is improving. Initiatives such as the out-of-hospital cardiac arrest strategy—with the caveat about how statistics are collected—definitely show that initiatives of this kind are moving the dial in the right direction.

This is an opportunity to see significant improvements in our international standing. I cited the study in Denmark; there are others, for example in the province of Pavia in Italy, where instituting a primary schools training programme had knock-on benefits for that city compared with the surrounding areas that did not have it, because kids tell others and it demystifies the whole experience.

10:45

We stand very poorly compared with somewhere like Norway—forgive the standard comparison with this place—where more than 90 per cent of people are trained in first aid. That did not happen overnight, but a measure of this sort would move Scotland to a similar level in a relatively short space of time—a couple of sessions of Parliament.

Brian Whittle: You are here because it is not the norm to provide this type of training to young people. Where is the resistance coming from, if you are unable to roll out training in the way in which you would like?

Frances Stewart: There is not necessarily resistance; a lot of it is down to funding. Schools' budgets are already under pressure. We have to apply for funding to provide training. Every year that we have run it, the BandAge project has been funded by outside funders. We do not have an open-ended amount of money to roll training out to every school—it is all costed up for a certain number of schools. We have always aimed at schools in areas of higher deprivation because, as we have alluded to, those are the areas where people might not be able to access the training in

other ways and where it is more likely that something will happen in the street.

I am pretty sure that if the funding was available, every school would want this kind of thing, but it is down to a lack of funding. Colin Peebles has been able to do it in his school—they have been able to fit it in—but a lot of the time teachers think that it will be forced on them, and that it is something else that they will have to add to their existing, pretty heavy workload. We make sure that they know that we want to work with them and make this as easy as possible for them. Again, though, it comes down to us having the funding to go into schools.

I would not necessarily say that there is resistance; it is just that there are goalposts that we cannot get past because of funding issues.

Stuart Callison: We approached the minister at the time, Ms Aileen Campbell, whose response on behalf of the Scottish Government was to acknowledge our efforts and refer to the out-of-hospital cardiac arrest strategy and the work being done by Save a Life Scotland and others.

As I emphasised, though, vital though a knowledge of CPR is, there are many other common emergencies—possibly even more common—where having the same basic level of understanding will help to save lives. CPR is great, but a full first aid programme is even better.

It is not about the cost. Frances Stewart is right that teachers are perhaps thinking that they do not want to take on yet another mandated subject—that is not appropriate in Scotland in any case, because it is not how our curriculum works—but from the outset we have not sought to use anything along the lines of compulsion or mandating teaching. It is more important that we bring teachers along with us and make it easy for them. I am absolutely certain that the teaching profession would be on board with it when it realises or is assisted to realise that the training is not too difficult and that first aid is an important skill.

I am not sure whether there are any real barriers to the implementation of this measure. I cannot think of any compelling reason, given that we are not talking about a huge amount of money, but of course, if there are reasons that we have not thought of yet, we would be more than happy to address them.

Rachael Hamilton: Is it the role of the director of education in a local authority to influence what is in the curriculum?

Stuart Callison: It absolutely is. We recognise that, but feel that there is scope for a stronger steer on this. Otherwise, we will be left with a situation in which some children in some areas will learn first aid or have the opportunity to learn it, and others may never come across it in their entire school career. I do not think that it should be left to such a patchwork approach.

Rachael Hamilton: The out-of-hospital cardiac arrest strategy concludes in 2020. I think that there is room for a refresh of that if the Government wants an additional 500,000 people to be trained in CPR.

Stuart Callison: The strategy has been effective, but there are other measures that could be taken. I would like to mention the petition by Jayden's Rainbow, to which the convener referred. We met Ms Orr and her family and the local MSP, Stuart McMillan, to learn more about the charity's work, and we definitely want to assist them to advance that petition. I recently wrote to Ms Orr to say that we would like to meet all the relevant parties in the area, including the local authority and the MSP, with a view to working with the charity. With our volunteers and the defibrillators that we have that are still serviceable, although they have been replaced by newer models, we can assist. I would like to work with the Scottish Ambulance Service to implement a public access defibrillation strategy in the council area in question in support of Jayden's Rainbow. If everyone works together—in particular, the Ambulance Service needs to provide guidance on where it would be most effective to put those defibrillators—we will do everything that we can to work in partnership to support those efforts.

The Convener: I promised that I would let people make one final point before we think about what to do with the petition. It is not compulsory, but if anyone has one last thing to say, I would be happy to hear from them.

Stuart Callison: I have said more than enough, but our youngest first aiders might have something to say. What has first aid meant to you? Why do you enjoy doing it?

Millie Robinson: I think that I enjoy it because you get to help people and to meet new people. I think I just enjoy it.

The Convener: That is a pretty good start.

Rebecca Russell: I started doing first aid when I was 10, so I was still at primary school. My company, the Stanley company, feels like a family, because we are so used to one another. We bounce off one another and are there to help.

I am now at the City of Glasgow College, where I am doing a child health and social care course. I would like to be a child nurse when I leave college and university, and that is all down to first aid. It started off as a hobby. Every Thursday night, I would go for an hour or so to learn the basics. Now that I am helping to teach kids, it has made

me realise what I want to do as my job. Doing first aid training has made me who I am and has let me find out what I want to do.

The Convener: Frances, do you want to say anything?

Frances Stewart: First aid is the skill that we want to teach, but we want to create confident, supported and resilient young people. Our young people always have a lot of pressure on them. More and more, a lot of them are struggling in different areas of their lives. As a society, we all have a responsibility to give those kids as many skills as possible and to give them the confidence to be all-round individuals. That is what we want to do—that is our end point. First aid is the skill, but we want to support young people across Scotland to be resilient.

Brian Whittle: Hear, hear.

The Convener: Colin?

Colin Peebles: I echo that entirely. The four capacities talk about successful learners, responsible citizens, confident individuals and effective contributors, and I think that first aid sums that up.

The Convener: If ever an example were needed of the confidence that is given to young people who do first aid, the three fantastic young people we have here today are just such an example. They display a degree of confidence and calmness in front of a committee that older witnesses often do not display. They are a living example of the fact that first aid is about more than just bandages.

We have learned a huge amount. I am thinking, in particular, of the comment that was made about mental health first aid. I am sure that we would want to encourage the idea of a young person being able to support their pal who is feeling distressed.

We have to think about what we want to do with the petition. We have written to the Scottish Government and we are awaiting a response. I would be interested in what the teaching unions think. I am pleased that you have been in contact with Ms Orr and Stuart McMillan and that you are trying to offer practical support for that petition. Other charities and organisations have an interest and we would also want to hear from them.

David Torrance: Can we write to the local authorities to see what the barriers are to putting first aid into the curriculum for excellence? It depends on how many responses—

The Convener: We have already written to the local authorities, but we could underline that we would like to hear from them and probably COSLA on whether this is something that they are interested in and what the barriers would be to delivering it.

Frances Stewart made the point that there is not necessarily resistance, but there are problems. We may be pushing at an open door; we may not understand the challenges.

Brian Whittle: I echo your comments, convener, that first aid is not just a life skill; it is about confidence. The confidence of the young people here today is a credit to them.

I am an advocate for allowing access to education outside the norm, whether that be first aid, sport, art, music or drama. In this particular instance, what they learn can save somebody else's life. The evidence that we have heard is compelling.

It strikes me that one or two other petitions in this arena are floating around. Perhaps we can pull them together to do a piece of work.

Angus MacDonald: Given the information that we have received this morning from Stuart Callison and the information in the original submission on the situation in Denmark and possibly Italy and Germany, I am keen to get a Scottish Parliament information centre paper on exactly how such schemes have been rolled out elsewhere—Norway was also mentioned. It would be good to have a look at those examples.

It is not the norm or protocol in this committee to applaud the panel but we had to avoid the urge to applaud when you were all giving evidence today.

The Convener: I would not have given you a row if you had applauded. [*Laughter*.]

Rachael Hamilton: It would be worth while asking what the Scottish Government's intentions are for the out-of-hospital cardiac arrest strategy and whether this scheme could be part of that ambition. Getting an additional 500,000 people trained in CPR is very much part of what these young people and St Andrew's are doing.

Would it be worth writing to the Minister for Public Health, Sport and Wellbeing, Joe FitzPatrick, about the aspect of public health and the preventative agenda, and whether there is any way that this could be promoted as good practice?

The Convener: As I say, we have been in contact with the Scottish Government since the first hearing of the petition. We want to flag up to it the *Official Report* of the meeting and ask it to have a look at the evidence covered, because I think that there is a straight health dimension and there is a public health dimension.

What I found most compelling about the out-of-hospital cardiac arrest strategy is that you are more likely to have a heart attack and less likely to get help if you live in a less privileged area. In

terms of fairness and justice, it cannot be right that you are less likely to have somebody around to help you.

It is a powerful point that although training must include CPR, it cannot be just about that because there are other important things to cover. As we have seen, the young people have responded to all sorts of incidents, which some of us would have stepped back from.

We want to reflect on the written submissions at a future meeting and perhaps flag up to SPICe that we would be interested in some international comparators. If we have not already done so, we could make contact with the teaching unions to see whether there is any resistance there. My sense is that any resistance will be if delivering the training simply creates extra work and expectation without any underpinning support. We would also be interested in hearing from the Scottish Government on how such an approach is a practical delivery of some of its policies.

We certainly want to reflect on the evidence that we have heard—there are a whole range of strands in there. If you want to flag up anything else because it would be useful for our considerations, please feel free to come back to us.

I think that I speak for everybody in thanking all the panel members very much for the thought-provoking and interesting evidence that you have given today. The experience before the meeting was very entertaining as well, which is also a novelty.

I thank you all very much for your attendance. I will suspend briefly to allow the panel members to leave.

11:00

Meeting suspended.

11:06

On resuming—

Child Abuse (Mandatory Reporting) (PE1551)

The Convener: The next petition is PE1551, by Scott Pattinson, on mandatory reporting of child abuse. The briefing paper sets out the background and previous actions on the petition.

In December 2015, the committee agreed that it would wait for the United Kingdom Government to consult and for the Scottish Government to respond to that consultation. A summary of that consultation and the UK Government's action was published in March 2018.

The Minister for Children and Young People wrote to the committee in October 2018 to advise it that

"As things currently stand, the Scottish Government will not introduce legislation making mandatory reporting a legal requirement."

There are a number of reasons for that, which include the reason that, following consideration of the evidence and views raised in the consultation, the Scottish Government agrees that the case for a mandatory reporting duty or duty to act has not been made. That appears to echo the content of submissions that the committee received. The majority of organisations that made submissions did not appear supportive of mandatory reporting. They cited concerns that a move towards mandatory reporting may have significant unintended consequences and that the current legislation should be given time to bed in and to be used to its full extent.

The petitioner has responded to the committee. He made some observations in his submission, but he also stated that that was his final submission.

Do members have any comments or suggestions for action?

A lot of work has been taken forward on trying to understand the impact on survivors of abuse and supporting survivors. The inquiry into child abuse is part of that work, but there are broader issues for people who have been abused in a family setting. We have to decide whether the proposal would help that work or make a difference rather than saying whether that is simply the way in which we will support survivors. We do not want people to think that, because we did not necessarily support the petition, we do not recognise the terrible challenges that survivors of abuse still live with, often into adulthood. I was very struck by the fact that such a wide range of people did not think that the particular approach of mandatory reporting would help.

Brian Whittle: The petition raises quite a lot of uncomfortable considerations. The first question that struck me when the petition was lodged was why on earth we would not report or intervene in child abuse. The convener alluded to the fact that a lot of child abuse happens within a family setting. First of all, I was surprised but, from reading the evidence, I recognised that the majority of organisations that submitted evidence did not think that mandatory reporting was the way to go. As the convener said, a lot of work is being done. We have done a lot of work in the committee on the particular issue and surrounding issues, and I am not sure that we can go any further with the petition. That is my gut feeling.

The Convener: I note that the Minister for Children and Young People, in her written submission in October 2018, said:

> "Officials will continue to monitor and evaluate the effectiveness of the Scottish child protection system working closely with stakeholders and any relevant U.K. Government officials."

It gives me some confidence that she did not simply say that there is no issue and she recognised that the Government must constantly be open to ways in which the child protection system could be made more effective.

Angus MacDonald: I echo that. The salient point in the Scottish Government's response in October 2018 was that there is no "compelling" argument for mandatory reporting at this time. There is also a strong argument for allowing the current legislation to bed in.

I do not see how we can take the petition further, given the responses that we have received.

The Convener: As there are no further comments, are we suggesting that we close the petition, recognising that the petitioner can of course petition the committee again at a later stage? In closing the petition, we recognise that the Scottish Government has said that it is involved in a great deal of activity on this issue and that it has committed to continuing to monitor and evaluate the effectiveness of the child protection system.

Are we agreed that we will close the petition under rule 15.7 of standing orders, on the basis that there does not appear to be any support for the action that is called for in the petition, although there is clear evidence that there is recognition across the Parliament and far beyond of the importance of being alive to child abuse issues and the need for a robust child protection system?

Members *indicated agreement.*

Shared Space Schemes (Moratorium) (PE1595)

The Convener: The next petition is PE1595, by Sandy Taylor, on a moratorium on shared space schemes. The committee last considered the petition in September 2017, when it noted the outcomes of a seminar on shared space schemes and anticipated that the petitioner would take part in a working group in relation to findings in the seminar report.

In his latest submission, the petitioner reports that he has had difficulty in arranging the meeting that he wants with the Minister for Older People and Equalities, and that he is concerned about responses received from Transport Scotland. He points to the UK Government guidance note, "Using shared space to improve high streets for pedestrians", which has been temporarily withdrawn for updating. He suggests that the Scottish Government should take similar action as he understands that schemes are currently under construction in Scotland.

Rona Mackay, who was a member of the committee, is unable to attend today's meeting. She is well aware of the issues that the petitioner highlighted, as he is her constituent.

Do members have any comments or suggestions for action?

Angus MacDonald: It is interesting to note from the briefing papers that the UK Department for Transport has recommended that local authorities pause the development of shared space schemes while the department reviews and updates its guidance. Given the situation south of the border, it might be worth writing to the Scottish Government once again to ask whether it still holds the view that a decision on shared space is an issue for local authorities, rather than for national Government.

I note the petitioner's point that he has approached the issue on a national, rather than local, basis, which was highlighted to us when the petition first came to the committee. I also note that it is a equality and human rights issue.

I am slightly surprised that, despite the best efforts of the petitioner and his MSP, Rona Mackay, a meeting with the Minister for Older People and Equalities has not been secured. That is a route that everyone would expect them to go down in order to raise the issue, so perhaps we can encourage the minister to meet the petitioner.

I hope that the shared space issue can be looked at, not only as an equalities issue but as a planning issue.

11:15

The Convener: My recollection is that the message that came back from the Government was that it wanted to engage with the issues that the petitioner had raised and that he should be involved in a working group. We can try to establish that.

I agree with Angus MacDonald on the point about making the Minister for Older People and Equalities aware of why the issue matters so much to particular groups. It might seem that it is just a planning issue but, as we discovered, there is an equalities dimension that we might not have considered if it had not been for the petitioner.

Brian Whittle: I agree with Angus MacDonald. Although planning is part of the issue, the real issue is anyone being excluded from the areas,

which is the opposite of what they are designed to do. Given that the petition has been sitting here for some time, our encouraging the minister to at least hear the petitioner out would give his invitation some weight and credibility.

The Convener: When he gave evidence, the Cabinet Secretary for Transport, Infrastructure and Connectivity was quite positive about responding to the issues that were highlighted in the seminar. The UK Government is updating its guidance, because it sees an issue with shared spaces, so we want the Scottish Government to clarify its position. It might think that it does not have a role at all and that the matter is up to individual local authorities, or it might be that guidance will come out. We should also ask the minister to reflect on the usefulness of engaging with the petitioner.

Rachael Hamilton: Has there been any indication that the petitioner will be included in the working group, or has he just been given the invitation?

The Convener: My sense is that the Scottish Government is saying that the issue is a matter for local authorities, but it would be useful to ask that question, too. I understand why the intention might not be for the minister to engage directly with the petitioner, but my sense, from what has been said in the past, was that there was an expectation that the petitioner would be involved in a group with an interest in the issue. That might have been a simple misunderstanding on my part, but it would be worth while to clarify that.

We will write to the Scottish Government to ask it to clarify its role in relation to shared spaces. We will also suggest that it would be useful for the minister to meet the petitioner—if at all possible, because we recognise the constraints on her time—to provide clarity on how the Government sees the petitioner being part of the work. Do members agree to that approach?

Members *indicated agreement.*

Dog Breeding (PE1640)

The Convener: The next petition is PE1640, by Eileen Bryant, calling for action against irresponsible dog breeding. Last year, we took evidence on the petition from the Cabinet Secretary for Environment, Climate Change and Land Reform, during which she highlighted a number of initiatives and other measures, including consultations, that were being taken to address the concerns and issues that were raised in the petition. We invited the petitioner to respond to the evidence but, unfortunately, a submission has not been received.

The clerk's note advises that the Government is expected to report shortly on its consultation on dog, cat and rabbit breeding activities. The note also refers to Christine Grahame's final proposal for a responsible breeding and ownership of dogs (Scotland) bill. The final proposal has secured the required number of supporters—I understand that the current number is about 32—from across the parties that are represented on the Parliamentary Bureau to allow it to proceed as a member's bill. Members will be aware that that is subject to the Scottish Government advising on whether it intends to introduce legislation in the same or similar terms. The Government must provide any such notification by the end of this month.

Do members have any comments or suggestions for action?

Angus MacDonald: I should declare that I am one of the 32 members who have signed and supported Christine Grahame's proposal for a responsible breeding and ownership of dogs (Scotland) bill. It is fair to say that the petition has done its job, as Christine Grahame's proposed bill covers the issues that are raised in the petition. I hope that the bill will progress soon. So, well done to Eileen Bryant, the petitioner.

The Convener: Are you suggesting that we close the petition?

Angus MacDonald: I suggest that we close the petition, given that things have moved on significantly since it was lodged.

Rachael Hamilton: I agree that the petition has forced the Government's hand into considering the areas that the petitioner highlighted and perhaps bringing forward legislation. I feel that that will move more quickly than the committee could, so I agree that we should close the petition.

David Torrance: I support that. I, too, signed the bill proposal.

Brian Whittle: I agree.

The Convener: We agree to close the petition under standing order 15.7 on the basis that the Scottish Government and other agencies continue to take a range of measures to address the issues that are raised in the petition and that, subject to any indication from the Scottish Government that it intends to introduce legislation on the matter, the proposed member's bill recently lodged by Christine Grahame is expected to cover those areas of concern.

In agreeing to close the petition, we recognise that there has been progress as a consequence of the work that the petitioner has done, and we thank her for lodging her petition. I think she can be satisfied that it has come to a satisfactory conclusion.

Prescribed Drug Dependence and Withdrawal (PE1651)

The Convener: Our final petition for consideration this morning is PE1651, by Marion Brown on behalf of Recovery and Renewal, on prescribed drug dependence and withdrawal. I welcome Maurice Corry MSP to the meeting for our discussion on the petition.

Members have a note by the clerk, along with copies of recent submissions that were not publicly available when the meeting papers were issued but that are now online. As I have stated previously, it is not always possible for the clerks to review, process and publish written submissions by the time that meeting papers are issued due to the significant volume of correspondence that is received on not just a particular petition but on the 70 to 80 other petitions that are under the committee's consideration.

The clerk's note refers to the Scottish Government's submission of December 2018, which states that the chief medical officer has established a short-life working group on prescription medicine dependence and withdrawal. It is anticipated that the group will meet three to four times, and it is expected to report its findings in the second half of this year.

Members will see that, in her most recent submission, the petitioner requested expressly that

"the full evidence of this Petition ... be taken into account by the SLWG as formal evidence of Experts by Experience".

That is highlighted in the Scottish Government's submission as a specific focus of the short-life working group.

Before I ask whether members have any comments or suggestions for action, I ask Maurice Corry whether he wants to contribute.

Maurice Corry (West Scotland) (Con): Thank you for having me here to speak to the petition, convener. I realise that the matter has gone to the short-life working group in preparation for the next stage, but I have a concern to do with psychotherapy. May I ask a question about that? Have any psychotherapy experts and patients been invited on to the short-life working group or attended meetings thereof?

The Convener: That is not something that I would know, but we can certainly ask about it.

Maurice Corry: I suggest that the committee consider recommending that to the short-life working group.

The Convener: For the record, and to help us, perhaps you could say why you make that suggestion.

Maurice Corry: It is vital that the report "The Patient Voice: an analysis of personal accounts of prescribed drug dependence and withdrawal submitted to petition in Scotland and Wales", which was published in October 2018, be taken into account. We need to consider people's experiences and what is happening, and that report provides evidence of actual patients' experiences when taking prescribed medication.

I have been made aware, by psychotherapy experts, that veterans with post-traumatic stress disorder, which I know quite a bit about from my side of the business, have been put on similar courses of medication to those that have been described and that they have experienced terrible consequences such as suicidal or homicidal tendencies. An example of a relevant project in this country is the horses for forces programme in the Borders, which uses psychotherapy. I have seen the positive results of that programme, and I ask that you consider that for your recommendations, if it is not too late.

The Convener: We can certainly refer to the fact that you have made that request and to the arguments for it. On the petitioner's request that the evidence to the committee be forwarded, I will take guidance from the clerks about whether that would be permitted and is compliant with the law. Most of it is on public view anyway, so we could make that evidence available to the group, so that it is aware.

One thing that is clear from our consideration of the petition is that there are strong feelings on the issue and strong evidence of people's direct experience. Obviously, it would be useful for the working group to be aware of that—it may be alive to it anyway, but just seeing the volume of the evidence has its own impact. It has had an impact on the committee.

Maurice Corry: I have one more comment to make, convener. The report that I mentioned, which was published in August 2018 by the all-party parliamentary group for prescribed drug dependence, is obviously very apposite. I presume that that has been taken into consideration, but I would certainly commend it as something that should be followed up.

The question of alternative methods should also be considered. Certainly, the armed forces have a lot of experience of those. Sadly, the suicide rate is still not good, but alternative methods have been looked at and, in some cases, are used as treatment. As I say, that sometimes involves the use of animals such as horses—I have also seen it involve dogs—and the outcomes are certainly positive. I commend that approach and implore the working group to take it into consideration.

Brian Whittle: I echo Maurice Corry's suggestion that lived experience is hugely important. I am sure that we all have constituents or people that we know who are in this situation. In one case, someone was prescribed drugs for chronic pain and then became addicted to those drugs, which changed their behaviour to a point near suicide. The person decided to come off the drugs and was given no help whatever to do that—he was left to his own devices. He is now left with a choice of either being in chronic pain or being addicted to painkilling drugs. It is really important that the working group looks at that sort of stark evidence, so I echo Maurice Corry's thoughts.

Rachael Hamilton: The clerk's note points out that the short-life working group involves

"a wide cross-section of the Scottish clinical and patient support community".

Perhaps we should ask the Scottish Government who is being considered as part of the patient-support community rather than the clinical part of the working group.

The Convener: We have a note, which is in the public domain, that sets out who is on the working group. Irene Oldfather is a member, and I know that her wok on dementia has been led by experience, such as the experience of carers and so on. I would not pretend to know about the other members of the group. We can certainly flag up to the group the representations that have been made about the importance of those with experience being heard in the process.

I think that we will want to defer further consideration of the petition until after the short-life working group has reported its recommendations, which I assume will be open for public response.

Maurice Corry: I have one final comment, convener. One thing that I have discovered, from looking into the issue, about the relationship between medical professionals and their patients is that there seems to be a feeling that patients are not believed and that their views are stifled. We have noticed a bit of that happening with veterans. I mean no disrespect to anybody, but there is a question about understanding that and the communication between the two groups. I ask the committee also to pass that on.

The Convener: That has been a theme in the committee's consideration of a number of petitions, on issues such as ME and mesh implants. It is about the extent to which there is a gap between what clinicians believe is happening and the direct experience. It is not that clinicians do not want to know about the direct experience but that they may see it in different ways. It is about recognising the importance of reflecting on that experience.

It would be useful to highlight the submissions that we have received, not just because the individual testimony is powerful but because the volume is striking. Obviously, those who are engaged in the working group will have to achieve a balance and understand all the different issues that they need to reflect on. However, the stories of people who were prescribed drugs that became more of a problem than the thing that the drugs were prescribed for present a challenge, and we hope that the short-life working group will reflect on that.

As there are no further comments, do members agree to defer further consideration of the petition until the working group has reported its recommendations but to highlight to the group this conversation and the submissions that we have received on what, for many people, is a difficult and challenging issue?

Members *indicated agreement.*

The Convener: I thank Maurice Corry for attending.

Meeting closed at 11:30.

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