OFFICIAL REPORT
AITHISG OIFIGEIL

Public Audit Committee

Thursday 7 October 2021

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 7 October 2021

CONTENTS

PUBLIC AUDIT COMMITTEE
6th Meeting 2021, Session 6

CONVENER

*Richard Leonard (Central Scotland) (Lab)

DEPUTY CONVENER

*Sharon Dowey (South Scotland) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*Craig Hoy (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Caroline Amos (Mental Health in Schools Working Group)
Hannah Axon (Children and Young People's Mental Health and Wellbeing Joint Delivery Board)
Donna Bell (Children and Young People's Mental Health and Wellbeing Joint Delivery Board)
Stephen Boyle (Auditor General for Scotland)
Alex Cumming (Scottish Association for Mental Health)
Martin McKay (Unison)
Dr Catriona Morton (Royal College of General Practitioners)
Alex Pirrie (NHS Grampian)

CLERK TO THE COMMITTEE

Lynn Russell

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Public Audit Committee

Thursday 7 October 2021

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Richard Leonard): Good morning. I welcome everybody to this, the sixth meeting of the Public Audit Committee in this session of Parliament. Before we start our business today, I remind everybody in the committee room that social distancing measures are still in place. If you are moving around, entering or exiting the room, please wear a face covering.

Our first item of business is to agree to take agenda item 3 in private. Is that agreed?

Members *indicated agreement.*

Child and Adolescent Mental Health Services

09:00

The Convener: The principal item on the agenda is a round-table discussion on something that has been a recurring theme for our predecessor committee, Audit Scotland and the wider Parliament and public: the current state of child and adolescent mental health services in Scotland.

I will ask members of the committee to ask questions on particular thematic areas, but I want to stress that this is a round-table discussion. It is quite informal and there is nothing to prevent panellists from asking questions of one another if that is felt to be useful. If you want to come in and speak and you are in the room, indicate that to me or the clerks. If you are joining us by videolink, you can use the chat box function; put an R in there and we will take you as soon as we can. I remind everybody that, technically speaking, you do not have to activate your own microphone—it will be activated for you.

Finally, do not feel obliged to answer every question that is put. It may be that, as the conversation develops, particular areas apply to some of you and are probably less applicable to others. Come in whenever you want by indicating, and please feel free to have quite a free-wheeling discussion, albeit that we have to stick to a timetable.

I would like to invite everyone to introduce themselves, starting with the MSPs on the committee. I will then come to those joining us virtually before returning to the witnesses in the committee room.

Sharon Dowey (South Scotland) (Con): Good morning. I am an MSP for South Scotland.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): Hello. I am the constituency member for Kilmarnock and Irvine Valley.

Craig Hoy (South Scotland) (Con): I am a member for South of Scotland and, for the record, I am our party spokesman on mental health.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I am the MSP for Midlothian North and Musselburgh constituency.

The Convener: I turn to the people joining us via videolink, starting with Martin McKay.

Martin McKay (Unison): Good morning. I am Unison's delegated representative for mental health nursing and mental health.

Hannah Axon (Children and Young People's Mental Health and Wellbeing Joint Delivery Board): Good morning. I am a policy manager with the remit for mental health, and I am here representing the Convention of Scottish Local Authorities co-chair on the children and young people's mental health and wellbeing joint delivery board.

Donna Bell (Children and Young People's Mental Health and Wellbeing Joint Delivery Board): Good morning, everyone. I am the director of mental wellbeing and social care at the Scottish Government and joint chair of the children and young people's mental health and wellbeing joint delivery board.

Alex Cumming (Scottish Association for Mental Health): Good morning, everyone. Thank you for the opportunity to join you this morning. I am assistant director with SAMH, and the lead for children and young people's services.

Alex Pirrie (NHS Grampian): Good morning, everyone. I am the service manager for child and adolescent mental health services in NHS Grampian.

Caroline Amos (Mental Health in Schools Working Group): Hi. I am the chair of the mental health in school working group.

The Convener: Thank you very much for taking part in this morning's round-table discussion. As I said, I am going to start with questions from MSPs, but panellists should feel free to come in when they want to make a contribution or a point. Sharon Dowey has a question to get us under way.

Sharon Dowey: I will direct the first question to Mr Boyle, the Auditor General. Audit Scotland's blog presents quite a bleak picture of performance in terms of access to child and adolescent mental health services, particularly given the significant investment that has been made. The blog says:

"But the picture today is similar to 2018, despite significant investment."

Do we have any idea of the extent of the funding and whether we can track that spend against outcomes?

The Convener: Sorry—I apologise for omitting to introduce the panellists who are in the committee room before my very eyes. Catriona Morton, do you want to introduce yourself?

Dr Catriona Morton (Royal College of General Practitioners): Good morning. I am a general practitioner and I am here as deputy chair of the Royal College of General Practitioners Scotland, where I am also the lead for policy. My day job is working as a GP in Craigmillar in Edinburgh.

The Convener: Stephen Boyle, before answering Sharon Dowey's question, would you like to introduce yourself?

Stephen Boyle (Auditor General for Scotland): Good morning, everyone. I am the Auditor General for Scotland.

On Ms Dowey's question and the investment that we have seen in response to our 2018 report, the blog that Audit Scotland produced in August references some progress and the challenges that remain in what is an extremely complex system. We have all seen the increase in demand from children and young people for mental health services, much of which has been exacerbated through the pandemic.

In direct response to your question, Ms Dowey, about whether we are yet seeing the impact of the investment in improved outcomes, there are two factors. There has not been enough time or data to make the correlation between improving outcomes and the investment that has been made. We recognise the range of initiatives, new frameworks and new guidance that have come about following the recommendations in the 2018 report and that some of those are planned to be implemented between now and 2023.

I will finish with an observation. By 2023, we will be five years on from our original report, in what is already a very challenging environment, with all the more need for urgent progress to support Scotland's children and young people with their mental health.

The Convener: I am sure that we will return to some of those themes.

I want to ask a question of the co-chairs of the delivery board. Perhaps Donna Bell could answer first, then Hannah Axon could come in after that. Audit Scotland's blog said:

"there is a steep hill to climb and making it to the top will mean listening to and learning from the experiences of children and young people and their families."

Would you agree with that analysis? What action are you taking through the delivery board to get us further up that "steep hill"?

Donna Bell: It is always helpful to have contributions from Audit Scotland on our work. It has identified issues very similar to those that the joint delivery board has identified and has been working on for a number of months and, in previous forms, years. We are all agreed that change is still needed to make the necessary improvements for children and young people. Stephen Boyle started to discuss the pandemic, which has had a significant impact on children and young people, in addition to the increased demands that there have been over recent years.

The joint delivery board has prioritised engagement with children and young people. We now have regularly participating in the joint delivery board three young people, who are very able and very helpful contributors. That is an excellent start.

We also have a children and young people's participation officer who supports us in the joint delivery board, engaging with young people about how services and support are working for them. They routinely feed back to us at the board about those experiences and what we should be doing to make the necessary change to support children and young people better.

The Convener: Can you confirm that those young people are members of the joint delivery board?

Donna Bell: Yes, they are.

The Convener: What about other family representatives? Do they have a voice at that table?

Donna Bell: Yes. We have a representative from the National Parent Forum of Scotland who is a member and joins us routinely to give a parental point of view. We realise the impact of issues that might arise from children and young people having mental health concerns and the impact that that has on their families. Engagement with parents is very important. The colleague who comes from the National Parent Forum of Scotland is a very helpful and engaged participant on the board.

The Convener: Hannah Axon, can you give us a local government perspective on that "steep hill" and where you see things going? How far away does the summit appear to be from where you are?

Hannah Axon: It is a steep hill and it is a challenge for all of us. From a board perspective, the scope of the work that is being undertaken is encouraging. The board has a focus on preventive work but is also looking at a set of deliverables that includes community support, crisis, neurodevelopmental services, CAMHS and the support required for our staff. A broad cross-section of work is being progressed, which is encouraging.

We have good local government representation across that. With our colleagues from the Association of Directors of Education in Scotland and our educational psychologists we are bringing the right people together to have these discussions and move up the hill.

On children and young people's representation, that is happening in all parts of the board's work. We have children and young people around the table at the board, and we use a set of youth engagement principles across the broad scope of the work. Task and finish groups are looking at the delivery of each aspect of the work. We are thinking about how we involve children and young people in those steps in a way that is valuable and means that we can take that work forward.

We also look at how we involve children and young people at the local level. For instance, in the community support framework there is an ask that there is consultation with children and young people. That is being built into the approach that is being taken, both by the board and in the resulting work at the local level.

The Convener: Alex Pirie, you are also a member of the joint delivery board. Do you have any perspective on the "steep hill" and where we are on it, and on the engagement of young people and families?

Alex Pirrie: As Hannah Axon said, we are working with a broad scope. It is a steep hill, but we are definitely going in the right direction. The key thing that we have to do is listen to the voices of lived experience, because those people are the experts in their own lives. The task and finish group that I sponsor is on the implementation of the national CAMHS specification and the development of a support programme. We are working with participants to get the voices of lived experience to help shape the direction of travel.

We have to be mindful about how we engage children and young people. A key learning point for the joint delivery board has been—[*Inaudible*.]—practical for them to join us. Most of them do not want to be meeting during school times and so on. It is a steep hill to climb.

I want to pick up on Hannah Axon's point about the community mental health and wellbeing support framework. My experience in Grampian is that we have done a lot of scoping and planning. We have listened to children and young people and their families in our local communities to find out what is needed. That is why the approach that we are taking in Moray is right for our local area. Aberdeenshire is doing something slightly different to meet the needs of its demographic, as is Aberdeen City. It is a really good framework and we are very engaged in it. It is doing work with, rather than to, children and young people in our communities.

09:15

The Convener: We are going to look in a bit more detail at the Grampian experience.

I turn back to Sharon Dowey, who I think has a question on referrals.

Sharon Dowey: The Audit Scotland blog refers to a task force that was set up by the Scottish Government and COSLA in 2018, which

concluded that earlier guidance and support was required for GPs, health visitors, school nurses and others. What guidance and support exists for those professions in 2021? What changes have been made?

That question is directed, in the first instance, at Dr Morton, after which Mr McKay from Unison might want to come in and anyone else who would like to comment.

Dr Morton: I suppose that the question was about two things: guidance and support, and referrals. Prior to this meeting, we contacted all our faculties in Scotland. The RCGP is very closely involved with them, so I have feedback from GPs across Scotland, particularly in Lothian, where I work. The feedback is very consistent in saying that there is a big yawning gap. GPs offer universal services and holistic care. One of the advantages that we have is that we work very closely with our health visitors and with other members of the family. When a child or an adolescent has a mental health problem, it is often the whole family that is involved.

The feeling is still that the bar for referrals is very high. Some of the feedback was that GPs—I include myself in this—will think "three or four times" before even considering a referral, and we have high levels of referral rejections.

We know how damaging it can sometimes be to the person referred and their family if they get a rejection, because they will often have tried lots of other things before they get to us. Those other things are often provided by schools. Access to those things has been more difficult when schools have been shut; it is also more difficult for children who are excluded from school or who will not go to school. Schools are not open to everybody.

Earlier on in the pandemic, we were generally asked not to refer people unless it was extremely urgent. That went across the board, and we tried to stick to that. The feedback that I have is that the waiting times are often one to two years. That is also a deterrent to making a referral. If you know that somebody is not going to be seen or get treatment for such a long time, that makes it difficult to say to a patient and their family, "This is what's going to happen." Essentially, there are no tier 2-level services.

The other thing that has been more difficult is that some of the third sector organisations that would normally be available to us and to children and families have—completely understandably—had to shut their doors during the pandemic, so they have been less accessible.

I read the 2018 Audit Scotland report on rejected mental health referrals. The feedback that I have had—and my personal experience—is that things do not feel very different from the situation that was described in that report. Although signposting has improved in some but not all areas, the situation does not feel very different.

Sharon Dowey: Your comments are quite concerning, because they are the same as the comments that I have just read in the report that was published in 2018. That is why we are trying to look at where the money is going and whether we can measure what the outcomes are.

Mr McKay, would you like to comment?

Martin McKay: Yes, thank you. Reflecting on the discussion that we have just had, with regard to the blog and the board waiting times data from previous years, it is interesting to note that, apart from a few outliers, a lot of the data is static—in other words, there has not been a significant amount of change on referrals. It would be interesting to have—this ties into the discussion that we have just had about the blocks in the system and the waiting times that are experienced by some people—data on the whole-time equivalent staffing group in CAMHS across the board.

I can certainly speak for my area. I am from NHS Grampian and have worked alongside Alex Pirrie for quite some time. The changes that we have made to the staffing cohort have probably brought about improvements in NHS Grampian. I have worked in mental health services for 30 years, and I have been around CAMHS for quite a significant part of that in different roles. Through service redesign, we have looked to plug the gaps to improve the service. If we are looking to deliver equal access and equal quality of service across the country for the next five, 10, 15 or 20 years, it would be interesting to see whether those models can be replicated elsewhere.

It is concerning to see that some areas have dropped when it comes to their deliverable data; perhaps that has been influenced by staffing changes. That data will be there. Each board has data on what its staffing cohort is, what roles people have and at what band, et cetera. That is one of the things that need to be looked at across the whole of Scotland. In particular, given what Dr Morton said about tier 2 services, we need to consider how we can improve access at an earlier stage to improve outcomes for children and young people. Much of that is down to who they can see, what that person can do and the actions that they can carry out as part of their job role.

From Unison's perspective, the broader the working team that a board has to deliver a service, and the more skills it has, the more effective it will be. That improves the outcomes for service users and their families. It also improves the service and the work experience of members of staff. That all goes to improve the entire experience. Therefore,

we need to look at more than just snapshots of some data. I understand why the referral waiting times are a big priority, because they are measurable and people can latch on to them, but there are a lot of other impacts that we need to focus our attention on to see where things can be improved and where such improvements have been effective elsewhere.

Sharon Dowey: Thank you. Does anyone else want to come in?

The Convener: A number of people have indicated that they want to come in. We will hear from Alex Cumming from SAMH first, after which we will go to Alex Pirrie from NHS Grampian.

Alex Cumming: Some of the stats that Dr Morton mentioned, which were in the blog post, are heartbreaking and distressing for families. Hannah Axon's comments about the breadth of work that is going on in the system are key. Overall, it is extremely important that we shift the conversation from just CAMHS to whole-system change.

The guidance that the programme boards have put out about the CAMHS criteria is very helpful, but there is still a total lack of understanding among the wider public about what CAMHS is there for, what it can support and so on. Probably understandably, children and young people and their families still assume and still want CAMHS to be the place where they can get support.

The information that has been provided over the past 18 months as part of the aye feel and clear your head campaigns supports a foundational level of mental health understanding and mental health awareness and being able to have a conversation about that, but there is much more that we need to do collectively around the wider public's understanding of what CAMHS does. People need to understand that CAMHS is not the only way of supporting mental health or the only space to get into in that respect. I am sure that we will come on to talk about tier 1 and tier 2 services at some point this morning.

I go back to Catriona Morton's point about CAMHS referrals by GPs. In the past month, we have had a number of conversations with primary care. GPs are still saying that they are disappointed that some referrals are not accepted and that they do not understand why that is the case. However, I wonder—again, this comes down to the system—whether those in primary care have the time and the space to be able to pull together all the information that is required for referral in a 10-minute appointment. In addition, the barriers around the virtual appointments that are being provided at the moment might make it challenging for young people to express their stories and their concerns in such a way that GPs can fully implement a referral. That might be why a number of referrals come back to GPs for more information. In that context, some of the initial recommendations that we made following the previous Audit Scotland report about a multi-assessment process for referrals should be considered, and we encourage the Government to do that.

We know that, in a well-functioning system, we would not have any rejected referrals, but at the moment our concern is about whether there is meaningful personalised signposting from CAMHS. The service works extremely hard to make sure that communication is compassionate, but we know that, no matter what individuals do, when the letter lands on a young person's doormat, it can be extremely distressing and people can feel quite despondent about it.

We do not know whether individuals are getting additional support and accessing additional services. That is why SAMH is funding an 18-month system-change project in south Edinburgh, as part of which we are speaking to our colleagues at CAMHS, children and young people, families and all those who have been rejected from CAMHS so that we understand how to make sure that the system, the information and the communication are appropriate. The initial findings very much suggest that families and young people need more information. Following a rejected referral to CAMHS, they need to have a guided conversation, because there is a range of services out there and they do not know how to navigate it by themselves. We need to be able to provide them with support.

That job does not necessarily need to be a role for CAMHS, but it needs to be funded, and we are going to be looking at that in the near future.

The Convener: Thank you, Alex. GPs were mentioned a lot in that answer, so I want to bring Dr Morton back in. I will come to Alex Pirrie, Donna Bell and Hannah Axon.

Dr Morton: Everything that Alex Cumming said rings true with me in lots of ways, in the sense that it is not all about waiting times, but we get a feel for how long people have to wait because they come back to us repeatedly. When we refer people whom we consider to be tier 3 or tier 4 who then wait one and a half to two years—not for tier 4, obviously—we get a feel for the distress that they experience in the meantime. On waiting times, those are the sorts of figures that people throughout Scotland have mentioned to me.

Other support is key. Having somebody follow up with people who have been referred to CAMHS and who are not seen would be so much more helpful than signposting. Often, people have done all the things to do with signposting. We have had

feedback about people being referred to CAMHS and then being told to go and see their school nurse or a third sector worker when their condition is far more serious and severe than can be managed by those systems.

On 10-minute appointments, you will know from elsewhere that GPs are working flat out just now. If you are consulting with 30 or 40 people a day, it is very difficult to give time to individuals. However, speaking personally, we would always see a child with mental health difficulties. I cannot imagine not seeing them face to face. This summer, I referred somebody who I saw several times face to face, because the case needed a lot of assessment. This person was in their teens. They were self-harming, they were anxious and they were depressed. They were no longer seeing their friends. They were isolating. I referred them, and the referral was rejected. I consider myself a very experienced mental health GP, and I felt that that was an appropriate referral.

09:30

One of the other themes that we hear from GPs is that there is nothing upstream. What happens is that people just deteriorate until they are at a point where they have to be referred to CAMHS. It would be fantastic to have upstream working.

The RCGP is one of 17 organisations that attend the Scottish Mental Health Partnership. There are two medical colleges there, and we talk a lot about mental health provision in medical terms. The other organisations talk about how we can change things now to improve things for the future, so that we do not need so much medical input, but I do not see that here. I see children and young people not getting help at a point where some of what they are suffering from could be improved or reversed earlier. The result is that they struggle on by themselves or with facilities that cannot match the severity of their condition. That is just building up difficulty for the future for our national health service and for the young people concerned, who will take those mental health problems into adulthood. We know that that happens.

I completely agree that we also need that. It is quite heartbreaking to see what happens, because we are talking about a situation that affects not just the child but the entire family. In many such families, the adults, too, have mental health problems, and we are increasingly concerned about safety. We know that alcohol and drug deaths have gone up markedly in Scotland. We also know that domestic violence has gone up during Covid, and sometimes it is very hard to know what is happening to some children unless they present to us or unless we happen to come across them in other ways.

The Convener: Thank you for that powerful testimony from the front line. Other witnesses want to come in, so I will turn to them. I am conscious that time is marching on, but I want to bring in Alex Pirrie first, then the co-chairs of the joint delivery board.

Alex Pirrie: Thank you. I want to touch on some of the things that we are doing in Grampian on the referral process from GPs to CAMHS. We have published quite detailed referral guidance, which is available to GPs on our GP portal on the NHS Grampian intranet. I appreciate that our GPs are incredibly busy, as Dr Morton has highlighted, and are doing 30 to 40 consultations a day, so we have provided visual aids on the referral process and on what might be appropriate cases for referral.

We are also trying to look across the system in Grampian about how to raise awareness of the tier 2 services that are being developed within the community mental health and wellbeing supports framework.

Within Grampian CAMHS we use a choice and partnership approach. When a child or young person is referred to CAMHS, we give them an initial assessment and appointment, which is very much about the assets and options that are available to the young person. It is their choice whether to carry on in CAMHS; sometimes CAMHS is not appropriate for them, so we signpost them elsewhere and write to the GP so that they are aware of that.

We have attended meetings with the GP sub-committee to see how we can improve the interface between CAMHS and GPs. We have also aligned our clinical teams into satellite teams so that they are more closely linked to general practices.

Martin McKay picked up on staffing challenges. We know that we have a national shortage of psychiatrists. In Grampian, we are looking at using other types of staff. For example, we are working to increase the number of nurse prescribers, which should help with patient flow. I am happy to say that the current waiting time for a first appointment for CAMHS in Grampian is six weeks, but I am very sad to hear that in some areas it is one to two years. With the joint delivery board we are developing a support programme to help other CAMHS to move forward.

Alex Cumming from SAMH made the very good point that CAMHS across the board need to be better at publicising what we do and what CAMHS is for. That is one of the things that we in Grampian are looking to do through Facebook and other social media options. I wanted to highlight those things. Thank you.

The Convener: Thank you very much indeed, Alex. I will turn to Donna Bell. Forgive me, I gave Hannah Axon the elevated title of co-chair of the delivery board, which you are not. You are here representing the Convention of Scottish Local Authorities and the voice of local government on the delivery board. I ask Donna Bell to give us her observations.

Donna Bell: Colleagues have already covered quite a lot of the issues that I would raise. It is not common for people to wait two years, but obviously where it happens we absolutely need to improve. I think the position that Alex Pirrie has highlighted on the arrangements that are in place for—[*Inaudible*.]—CAMHS point of view. We know that, for example, in NHS Fife there are arrangements in place for primary care mental health workers to meet children and young people within two weeks. The position is very variable across the country.

Points on other issues around GP referral were well made by Alex Cumming. The referral criteria were agreed with the Royal College of General Practitioners. We are always happy to discuss that. If there is a communications or other matter that we need to follow up on, we are always happy to do so.

I also point out that, in relation to particularly long waits, we have seen issues with neurodevelopmental referrals, which are often very complex. We published neurodevelopmental specifications at the beginning of September and there is additional funding of about £5.25 million to support that. We are aware that in particularly complex cases more action must be taken.

The points that Alex Cumming and Alex Pirrie made about CAMHS being able to signpost or refer children and young people to other suitable community services, and the points about breadth of provision, are very important. One of the key things—Hannah Axon mentioned this at the beginning of the session—is that we are clear, as I think everybody in the sector is, that CAMHS is not suitable for everyone. We need suitable support to be in place—Hannah Axon might be about to talk about the additional support that we are putting in place in the community.

On accessibility, we know that CAMHS is the second-highest user of Near Me. Young people are very comfortable with digital appointments. That has been an important development over the course of the pandemic that we are keen to carry on because it improves accessibility and engagement.

GPs are also beginning to refer people to the community supports that we are putting in place locally. It is early days, but there has been a promising shift. We know, for example, that in the past few months there have been more than 350 referrals from health professionals direct to community services.

Hannah Axon: The points about community services have been made. I go back to what Alex Cumming said about the need for a systems change, cultural change and awareness. At the local level, we have a huge task around promotion of services. A significant amount of funding—£15 million—has gone into putting community-based support in place since January this year.

The services are still quite young and there is a lot of awareness raising to do with parents to ensure that they are aware of the alternatives for children and young people, and to make sure that young people are aware of alternatives, because many self-refer.

In Clackmannanshire Council an immense amount of work has been done through cinema advertising and through council sports staff doing lots of promotional work with children and young people and more broadly. We are very aware that that needs to be done; it is actively being done at local level and the delivery board is also looking at that. A task and finish group within the board is looking at communication across the system. We are working with GPs on information and on making sure we can support joining up of services.

The Convener: Did you refer to a particular local authority that is using cinema?

Hannah Axon: Clackmannanshire Council is doing that.

The Convener: Thank you.

I want to move on to another area. We have not so far heard from Caroline Amos on this. She chairs the mental health in schools working group that was set up by the Scottish Government. We understand that the group recently produced an online training resource. To what extent has that resource been taken up and how much engagement has there been with it? Welcome, Caroline.

Caroline Amos: Thanks.

That is part of the next stage of our work. Engagement with the resource is being monitored; data on how many people are engaging are being gathered. The resource can be used by everybody—it is not just for school staff. The next step for the working group is to look at the data and to have qualitative conversations with people who use the resource and are engaging with it and have volunteered to participate in evaluation. At this point, we do not have specific data but are ensuring that as many people as possible are aware that the resource exists and that they have access to it.

The Convener: I have two questions. First, when the data is available will you publish it and put it in the public domain? Secondly, at this early stage, have you picked up any anecdotal evidence of the extent to which the package is going down well and is being taken up?

Caroline Amos: The resource is highly accessible and is easy to navigate. It has very useful information on it and has been produced and used in consultation with young people and their families. That relates to the first point that we discussed about how we are involving young people who have lived experience. Anecdotally, I can say that people are engaging with the resource because it is accessible and easy.

Teachers, in particular, have become very used to online professional learning throughout the pandemic. They engage in professional learning at a time and place of their choosing. Anecdotally, we hear that it is a resource that one can pick up, leave, then come back to. It is not something that they have to sit with for a long continuous period.

I do not think that there will be a problem with publishing the data once we have it. It will be useful because one of the actions of the working group, going forward, is to make sure that the resources that we produce are used and have an impact on the people on whom we expect them to have an impact.

The Convener: Is the resource aimed at all school staff or just teaching staff?

Caroline Amos: The resource is aimed at all school staff. It can be accessed by members of the public and by parents, too. It is not just open to specific groups of professionals but is aimed at all school staff.

The Convener: Thank you. I know Alex Cumming from SAMH wants to come in on this point.

Alex Cumming: Thank you, convener, and thanks to Caroline Amos. We were absolutely delighted when earlier in the summer the information and new training for all school staff were distributed across the board.

This might be helpful in relation to statistics: a couple of years ago we produced some training—e-learning that was specifically for teachers and school staff—that was accessed 4,000 times in the first month of lockdown. I have absolutely no doubt that the new training that has been produced by the mental health in schools working group will be well used.

09:45

A bit of feedback that we had from our previous training was that the youth work sector is key. I know that some of the committee papers are about universal support for practitioners. We are just about to launch, for youth workers, a specific e-learning tool on mental health. It is very much foundational at this stage, but we hope that once people have had an opportunity to complete it, they will also see the additional training that Caroline Amos and the team have produced as the next step.

A lot of work is going on in schools on how leadership in schools can allow staff the capacity to access such things. Schools and GPs are all at capacity at the moment, so that will be a huge challenge, but I am sure that leadership in schools across Scotland will work hard to do that for teachers and practitioners.

The Convener: Thank you, Alex.

I will go to Caroline Amos. There has been quite a push for counselling services to be available in secondary schools in particular; I think that some data and analysis came out about that fairly recently. How is roll-out of counselling services going on the ground, either from a Scotland-wide or a North Ayrshire perspective.

Caroline Amos: That is not part of my remit or that of the working group. Within North Ayrshire Council, however, which is where my day job is, we have counsellors. We have had them since the Scottish attainment challenge was introduced. That was a workstream in our attainment challenge commitment, so we have introduced them. North Ayrshire has continued to engage with counselling services and to increase them across sectors. As part of community mental health and wellbeing, we have introduced other counselling services to support our younger young people. That has been positive for us, in North Ayrshire. There is a lot of data in support of that introduction and its impact on our young people, because we have to report to the Scottish Government on the Scottish attainment challenge. I cannot speak about counselling services across Scotland.

The Convener: I presume that the delivery board has some oversight of counselling services. Can Donna Bell answer the question more directly?

Donna Bell: Hannah Axon will be able to contribute on this, as well.

We know that all our locality authority partners have confirmed that access to counselling support services is now available throughout Scotland. We do not have specific data on the number of appointments and outcomes yet; Hannah might be able to give a bit more feedback on that.

A colleague from the Scottish Government learning directorate is a member of the board; their feedback is that school counselling has been very

well received. Uptake has been very good. Also, teaching staff and other school staff welcome the additional intervention for providing support on top of pastoral care. I should not be dropping my colleagues in it, but Hannah might want to say more about that.

The Convener: I said at the start of the session that witnesses can ask each other questions; it is not just a matter of fielding questions from members of the Scottish Parliament.

Donna Bell: I know, but it feels a wee bit unfair.

The Convener: Hannah—over to you. Do you want to come in?

Hannah Axon: As Donna said, there is access to school counselling in all local authorities, and we have had the first round of reporting on it, which has generated data that I think the committee has seen. Just shy of 10,000 children and young people having accessed counselling. On the outcomes data on children reporting positive outcomes, I will have to come back to the committee with a figure, but I think that the data on that is encouraging. It is very early days—we are looking at the first round of reports.

It is interesting that we are beginning to see some trends coming out of the data—for example, more young women and more girls than boys are accessing counselling. There is something to consider in that. We have some interesting thinking to do about how we align our community services and support where school counselling is not the option that a person is ready for or would choose. It is early days, but what we are learning is interesting and positive, at this point.

The Convener: It is useful to have that on the record.

My final question for now is for Alex Cumming from SAMH. This is challenge poverty week. We know from the Audit Scotland report in 2018 that, a child who lives in a low-income household is three times more likely to suffer mental health problems than a child living in a more affluent household. There is an issue about the effect that poverty has on mental health, self-esteem, self-harming, anxiety, stress, depression and so on. Those issues will be accentuated for children who are being brought up in poverty. Educational performance will be affected as well as overall life chances. Is enough being done to recognise the scale of that challenge and the inequality that it produces?

Alex Cumming: Just this week, we have been having conversations about the fact that inequality of access to services is almost our number 1 priority going forward. There have been a couple of comments about virtual access and the use of the Near Me service. We absolutely have to continue to use that, as it has led to improvements and helped with access to services, but we know that it is probably still families and communities with slightly greater resources that are accessing those services or are driving towards accessing them. Whatever happens, we need to have services that are community based and that are accessible.

There has been talk of 20-minute cities. I know that this is not possible everywhere but, in more urban areas, we want to ensure that services are available to people 20 minutes from their doorstep. That is probably not always possible in areas such as Grampian, where Alex Pirrie is from, but it is absolutely key and critical, particularly with mental health services.

Of course, we all could and should be doing more. I would not say that the issue is not a focus of all the colleagues who are here, but we definitely need more focus on it.

The Convener: Dr Morton, your practice is in a relatively deprived part of the city of Edinburgh. Do you have any reflections on the impact of poverty and inequality on the mental health of the people who you see?

Dr Morton: It is difficult to sum that up quickly. We know that poverty has a huge effect on mental health, alcohol and drug addiction and wellbeing. Prior to the pandemic, we consulted with about 11 per cent of our population every week—that was our consultation rate—and around half of those consultations were largely to do with mental health. That figure has gone up. We had a quieter time at the height of the pandemic, but people with mental health problems are in distress. People who have never been mentally ill before are presenting with new mental illness, and people who were already mentally ill are a lot worse.

One thing that has helped us is that Edinburgh health and social care partnership has been good at identifying the most deprived practices in Edinburgh and making sure that they are prioritised for mental health nurses. We have mental health nurses in our practice, which is part of the new GP contract. The college has asked for that more generally, but very few practices have those nurses. That is transforming, because we are often the first port of call, and we also know other members of the family. That approach is extremely helpful for children's health. However, we cannot take on work that other agencies should do.

In relation to the rejection rate for referrals from deprived areas, I would argue that there should be a lower bar for people from those areas, because there is often a lot going on in the families that might not always be apparent initially.

The Convener: I will try to move the conversation on a little. Craig Hoy has a number of questions.

Craig Hoy: My first question is mainly for the Auditor General—it is just a point of clarification, really. At point 8 in the blog, you note:

> "Falling referrals to CAMHS look like the one bright spot".

I was slightly surprised that the number is down, but I note that you add the caveat that there are probably extenuating circumstances. A recent report from the Royal College of Psychiatrists pointed to data from Public Health Scotland that showed that, in the second quarter of this year, there were 10,193 referrals to CAMHS, which was the highest ever figure and equates to one in 100. Do you have any update on the data that might point to that figure being almost a mirage?

Stephen Boyle: I think that you are right—there is a pandemic-orientated aberration in some of those statistics. As Dr Morton highlighted in her previous contribution, referrals and access to services more generally would have fallen right at the height of the pandemic, and we think that that is what is informing those statistics. We do not yet have validated data to confirm that that is the case, but what I am hearing in this conversation is that those circumstances probably led to the drop that we reported in the blog.

Nonetheless, there are clearly very significant factors behind the rates of referrals. The point that we are making more widely is about the emerging but incomplete data on what happens to referrals and to children and young people who are engaged in the system but who are rejected, and the extent of the wait times that we sought to highlight through the blog.

Craig Hoy: Just assuming that, broadly, we have the highest ever level of referrals, we also seem to have the highest ever level of rejected referrals. In a 2018 report, SAMH and NHS National Services Scotland's Information Services Division produced 29 recommendations on bringing down the number of rejected referrals, and I think that all of those recommendations were accepted by the Scottish Government.

My questions are for Hannah Axon and Donna Bell, and perhaps Alex Cumming from SAMH. How effective has the Government been in implementing those 29 recommendations? What level of comfort or discomfort do you have with the overall level of rejected referrals? Is there a level that you would be comfortable with, because you think that CAMHS are not the right route for some individuals? If 25 per cent of referrals are being rejected, would you be comfortable with 10 per cent, for example?

Hannah Axon: We want minimal rejected referrals. Once our community services are up and established, the principle will be that young people are caught earlier and get the support that they need before a CAMHS referral is required, but I do not know whether anyone has determined what an ideal level of rejected referrals within the system would be.

I defer to Donna Bell on the question about the Scottish Government's actions on the recommendations.

Donna Bell: We have made significant progress on the 29 recommendations. I am happy to give the committee a breakdown of the actions that have been taken against each of them. Some of the recommendations have now been superseded by actions taken and commitments made, but I am happy to provide that cross-reference for the committee if that would be helpful.

It is difficult to answer the question about what an acceptable level of rejections would be. I suppose that, ideally, there would be none. It might be useful to ask the clinicians about that, as clinical opinions differ about what is needed. The important thing, which we have talked about quite a lot already, is that appropriate support is in place for the people who are not accepted by CAMHS. I would probably align quite closely with Hannah Axon and say that there should be minimal rejected referrals, but I would not want to commit to a percentage.

10:00

The Convener: Do any of the other panel members want to come in on that point?

Dr Morton: I realise that I have spoken quite a bit—sorry about that.

I think that the ideal would be to have virtually no rejected referrals. If you have a congruence of understanding between the GP as referrer and CAMHS, that should be achievable. The referral criteria were mentioned earlier. I think that GPs understand them—we believe that we do—but we refer people who we believe are in tier 3 and who are then rejected, which is difficult.

Alternatives to referral make a difference. If it feels like you have nowhere else to refer somebody who has significant and enduring problems, that ends up being a CAMHS referral. I have been encouraged to hear about the community developments that we have been talking about. I also work as a referrals adviser for NHS Lothian, and I know that lots of things can be done to help that mutual understanding so that we get the right person to the right place, but the problem is that, often, there is no other right place for that person.

It has been encouraging to hear the discussion, but it is difficult for GPs to keep up with rapid systems change. Third sector organisations and access to them are changing all the time. It is almost a full-time job trying to keep up with that. There is an issue about how we inform GPs and keep them live to the new possibilities that are opening up.

GPs are sympathetic to CAMHS. What I said earlier may have sounded quite stark, but helping to manage children and adolescents in distress, and listening and speaking to them, is very difficult and emotional work. The GP view is that there is just a capacity issue—that is often what it comes down to.

Alex Cumming: I will respond directly to Mr Hoy's request or query in a moment.

Dr Morton is right about community-based services. We know that some of the procurement processes have only just come to an end, so we do not know the impact yet. It is important that link workers in GP practices and the mental health nurses that Dr Morton mentioned are super-aware of everything that is going on locally so that they can upskill the rest of the staff in the practice to provide the information and reduce the referral rate.

Ideally, in a well-functioning system, there would be no rejected referrals. I appreciate that, for all of us, the term "rejected referrals" is quite emotive and distressing. In our CAMHS audit, one of the recommendations was that the term should not be changed and that we should continue to use it until we have appropriate systems in place, so that we know that individuals are genuinely being redirected rather than just signposted. From what we see, it is still very much signposting. We know that young people are not accessing the services in the community, or they do not know how to access some of them.

We are starting to get all the building blocks, and there are a lot of really positive stories out there but, until we have everything fully in place and fully implemented, I encourage the Scottish Government to retain the rejected referral terminology.

I welcome Donna Bell's comments about an update on the 29 recommendations and where things have been superseded. We know that there has been a phenomenal amount of work during the pandemic and prior to it but, in direct response to Mr Hoy's question, we still have quite a long way to go, as the Audit Scotland blog has indicated.

Craig Hoy: My final question is perhaps for Alex Cumming. The Government has made £40 million available for CAMHS improvement work, based on the CAMHS service specification, to try to achieve a national standard of service. The referrals pathway was one of the key issues that were identified in the 29 recommendations. What are the most significant gaps that need to be addressed in the referrals pathway?

Alex Cumming: To go back to our original recommendations, we want a pathway or system that removes any inefficiencies. As Dr Morton has mentioned, a number of GPs are referring because they genuinely feel that cases meet the criteria, but they are rejected. I know from working with colleagues from CAMHS that they feel that bits of information are missing. That is all clogging up the system.

We recommended a multi-agency approach to ensure that we get input at an early stage. I know that some child and adolescent mental health services have set up opportunities for people in primary care to meet, have quick discussions about particular, complex cases, and see whether referrals are appropriate. We know that, again, that comes down to capacity, but we would still advocate that multi-agency approach for referral. If there is an opportunity and it is very clear that tier 1 or tier 2 services are appropriate, the question is: who is the navigator or link worker who can support the young person and their family to access the services so that there is—we hope—a positive outcome and the young person and their family do not feel let down? Much of it is about the expectations of the system and expectations within the system. The building blocks are there, but they are not necessarily fully implemented.

The Convener: Again, I want to try to nudge things on a little. I know that Willie Coffey wants to ask a number of questions.

Willie Coffey: Good morning, everyone. I will start with a question for Donna Bell about the 18-week standard. Will you clarify for me and constituents whom I represent what that means? When does the clock start ticking on the 18-week standard? Does it start ticking at the point at which a family has a meeting with someone to get a meeting with CAMHS? Is that the 18 weeks that we are targeting?

Donna Bell: The clock begins to tick at the point when a referral is made to CAMHS. That is not the only thing that might happen. One of the points that we have been trying to make is about breadth. A range of other things might happen for children and young people while they wait. However, I would like to bring in Alex Pirrie, who is the expert on the CAMHS specification and implementation, on the specifics of when the clock starts ticking and the process.

Willie Coffey: Alex, the standard says that treatment should start within 18 weeks. However, some parents say to me that they got a meeting

within 18 weeks, but a meeting is not treatment. What constitutes treatment?

Alex Pirrie: In Grampian, when treatment will start is a clinical judgment. We work with the choice and partnership approach in Grampian CAMHS. The initial assessment appointment could involve the first clinical assessment and possibly the start of treatment. At that point, clinical information and advice are given, and there is access to resources while the person waits for their next appointment with their allocated clinician, whether that is a psychologist or a nurse, for example. Things are done very much on a case-by-case, individual basis in light of what is relevant to the child or young person.

In Grampian, we used to stop the clock at the second appointment. When we dug a bit deeper and started to look at the clinical processes and those appointments, we found that, in some cases, the treatment for the child or young person started at the first appointment, when they agreed on the next steps and their care plan. For some children and young people and their families, we need to do a bit of homework in preparation for their next appointment. There is a very individualised approach but, for us, when the treatment starts is guided by the clinician, the child or young person, and their family. As I mentioned, in Grampian, the waits for the first appointment from the point of referral were six weeks. That could be when treatment starts, depending on the circumstances of the individual child or young person.

Willie Coffey: That is really interesting. I have read the comment about Grampian in the papers, which is really impressive. However, being seen within an average of six weeks is referred to, and parents say to me that being seen is not necessarily the same as treatment. I hoped to get from the panel clarification or a sense of what exactly we mean by "treatment". Some parents ask me about that. They say that having a meeting is not treatment, and they are still hoping and waiting for treatment along the line. There is a little bit of confusion there.

Does that explain the discrepancy that we are hearing about today? Dr Morton said that the period can be one to two years, and NHS Grampian says that the wait is an average of six weeks. Are we all talking about the same thing in relation to treatment happening for a young person? Are we talking about having a meeting or having treatment for a young person defined? Maybe Donna Bell could help with that.

Donna Bell: Treatment is defined in the national data definition standards for CAMHS, which are published by Public Health Scotland. What Alex Pirrie has said about what people think constitutes treatment is interesting. It might be more appropriate for her, as a clinician, to say a wee bit more about a clinical perspective on what the treatment is and what parents might feel. I think that that is what Mr Coffey is trying to get at. Is that fair?

Willie Coffey: Yes. If we are all talking about the same thing, why is there still such a discrepancy across Scotland three years on from the Audit Scotland and Accounts Commission report? Families are waiting for one to two years in some parts of Scotland, whereas people are turning things round within six weeks in another part of Scotland. What on earth is going on? What can we do to try to bring things into line with the Grampian experience perhaps?

The Convener: I do not think that Alex Pirrie from NHS Grampian has been put on the spot by Donna Bell. I think that she has indicated in the chat box that she wants to come back in. I ask Alex Pirrie to respond to Willie Coffey's questions from her perspective.

Alex Pirrie: The first thing to highlight is that children and young people can be referred to CAMHS for a range of reasons, such as anxiety, a neurodevelopmental assessment, depression or an eating disorder, and the type of treatment depends on the particular mental health problem of the individual child or young person. The treatment plan might be a psychological therapy, or there could be a need to start the young person on medication, for example. It depends on the circumstances. That is what I was getting at.

Expectations are possibly an issue, as well. I am seeing an increase in parental expectations about how quickly their child can be fixed and whether they can be given medication. We have to bear in mind that the parents have been through a very difficult time during the pandemic, as well, and they are managing the risks and challenges of their children's mental health problems.

The treatment is based on the reason for referral and what is going on for the individual child or young person. It could be a psychological therapy, medication or a group, for example. That is what I mean when I say that the treatment is very much defined on an individualised basis. There is not a one-size-fits-all approach because, at the end of the day, we are dealing with people.

10:15

Willie Coffey: My final point is that paragraph 7 of the Auditor General's blog tells us that the number of people waiting more than a year for the treatment has trebled in the past 12 months. That is a worry, but could it be a marker of the pandemic? That is a bit inconsistent with the Grampian experience, and I am not entirely certain that I understand why. Such a discrepancy

probably merits further investigation when the committee has time. Could anyone offer a reason why there should be such a difference between the great performance in Grampian and the performance elsewhere in Scotland, if the trend is as the Auditor General says? Could you offer a possible explanation?

Stephen Boyle: I am probably best to defer to the experts and the clinicians around the table for further insight. What we sought to do through the blog is to raise the profile again of children and young people's mental health, and to signal, as we do at the end of the report, that this is not the end of our interest in it. It is our intention to undertake some further audit work on this along with the Accounts Commission. I am sure that the committee will also be interested. We are also very keen to follow through on Donna Bell's contribution about the progress against the original recommendations. When it comes to an analysis of the difference between Grampian and the rest of Scotland, we are extremely interested in the factors that have led to that, and it remains our intention to undertake further audit work in this area.

Willie Coffey: I will leave it at that, convener, and allow other colleagues to come in. Thank you to the panel for trying to answer those queries from me.

The Convener: You will be delighted to hear that I have a couple of participants who want to give a brief response to the questions that you are asking. I know that Alex Pirrie wants to come back in again, I think for the third time in this little session. I want to invite Martin McKay to come in, because we have spoken quite a bit about the NHS Grampian experience, on how the service is delivered on the ground and how it is navigated. I will invite Martin to reflect on that, and then I will bring in Alex Pirrie, and I think that Donna Bell wants to come back in briefly as well.

Martin McKay: Mr Coffey's point is well made, and I think that the earlier discussions about education and communication are important. As a mental health nurse with 30 years' service, I find that it is difficult for people in our role when people try to understand, "What are you doing for me? What will you do for me? What will you do for my family member?", because it is not a job where you can take an X-ray and show someone where it is broken. Sometimes that is the first barrier that you have to get through. I think that if Mr Coffey, who is working around these levels, is unclear about that, the individual and their family will be unclear if it is their first contact.

In my lead-up to this committee session, I spoke to colleagues from the education sector. Reflecting on some of the discussions earlier about the training aspects, I think that there are some good examples out there of how our staff members in education are being assisted and trained to understand and support children in their care. When you think about it, apart from their own family, education is where the children and young adults will spend most of their time—hopefully. Good work has been done to keep them in education, so the information and support that the staff can give to the children and young adults and their families is vital as well.

I will go back to some of the points that Alex Cumming made earlier. I am very interested in the project that he spoke about to do with how to support rejected referrals. My education colleagues indicated to me that one of their great concerns is how to support children when a referral has been rejected, the effect that that has on the child and their family and the impact that it has on staff who are trying to support them through that if they have to make referrals again and again. I think that those supports, the primary care aspects and how we deliver them, are important. Mr Coffey spoke about investment and, as I said at the outset of the meeting and as others have mentioned, there is scope here to build new roles to plug those gaps.

On what you invited me to speak about, I have experience of working in the service review in CAMHS in Grampian, which Alex will remember as well as I do. It was a very long, complicated and complex review, but we believe, and I think that the data shows, that it has delivered results. In my role working in service redesign in NHS Grampian as a staff-side partnership representative, I always look at the gaps in service, the risks and the negative aspects, because you cannot ignore them; they inform you where the service is not working. I have had this discussion in Grampian in recent weeks about the funding. It is not a negative approach. It is sensible and it will deliver information about where the service needs to improve. I have worked in adult mental health for over 20 years, and in that time my ward was the adult ward that held the remit for CAMHS admissions at tier 4. It is always a hard thing to have young adults admitted to adult wards. I always wanted to look at how we got there and how we could have stopped it.

The important thing for us in the next five, 10, 15 and 20 years is to look at what other roles would improve the connections and fill the gaps between parts of the service to have earlier support and earlier impact on the mental health of children and young adults. As my GP colleague stated, if we do not have early intervention and effective early intervention, this will continue into adult life. The transition points are very important areas that we need to look at, looking at the whole service across Scotland, because the gaps and points where things fall down and where people fall

through the net are where we have to focus on improvement. If we keep doing the same thing and throwing money at the same thing, we will get the same results. We do not have the number of clinicians that we need. We cannot train them quickly enough, and we do not get them into service quickly enough. We need to look at building other effective roles that will improve the outcomes for the people who access this service. It is sensible to look at where we fail, because that is where we need to improve.

The Convener: Thanks, Martin. I know that several other panellists wanted to come in on this point, but I think that you are all likely to be in the scope of some of the questions that Colin Beattie is about to ask. Do not feel that you need to strictly only answer the question that Colin asks if you want to go back and make any points that you think are important to make in relation to that conversation with Willie Coffey about how things are working on the ground.

Colin Beattie: Auditor General, you have so far escaped a bit of questioning, so I have a couple of questions for you. As has been pointed out, in paragraph 7 you say that the number of people waiting for treatment has trebled over the past 12 months, yet at the same time the number of referrals to CAMHS has gone down by 17 per cent. How do you equate these figures?

Stephen Boyle: It is probably two things, which I partly touched on in the response to Mr Hoy. We rightly caveat the drop in referrals with people's appetite for and access to services at the height of the pandemic, and we make reference to school closures and the extent to which children and young people were able to access GP services, acknowledging all that Dr Morton has said about the on-going work of GPs and recognising fairly that the use of Near Me increased significantly during the course of the pandemic. We think that that is a key component. The trebling of the wait times is probably another component of the pandemic—we have heard already this morning about the pandemic exacerbating mental illness in children and young people and about the difficult circumstances that Scotland's children and young people, particularly those from our more deprived communities, would have found in the home to do with their access to education and concerns about the mental health of adults in the home. All of those factors contributed to a groundswell of demand for services and had an effect on the ability to cope. We think that those two things are relevant, but we understand that there is something in the contradiction that you make.

Colin Beattie: I will follow up on that in a second, but if CAMHS referrals are down 17 per cent and three times as many people are waiting for referrals over a year, does that imply that CAMHS capacity has reduced during the pandemic? Is that a core issue?

Stephen Boyle: It is hard to be definitive and support that with concrete data. The need for more data is one of the themes in our report.

Martin McKay makes an interesting point about the sense of capacity that exists within the system among the widely varied partners that contribute to service provision and the analysis of the availability of services across the piece and the number of people who are working, recognising all the challenges that we know about the availability of psychiatry services and more. What does the future workforce look like for the provision of mental health services? I think that colleagues will be available to expand on that, but absolutely that capacity is no doubt a factor behind some of the numbers that we put in our blog.

Colin Beattie: I have a second question for you. In paragraph 13, you say, "Geography matters too." How do you make that link when NHS Grampian has over a three-year period significantly increased its capacity, and even NHS Tayside has made some significant improvements from a low level? Those are a couple of NHS boards that have been on our naughty step in the past. How does that link? You seem to be implying, by saying that geography matters and so forth, that it is more difficult to be effective if you have a spread population, yet Grampian, and to a lesser extent Tayside, have spread populations.

Stephen Boyle: We set out in the exhibit one factor around wait times, and we have touched already this morning on the progress that Grampian has made and the exploration behind some of the factors, and on the similar progress that Tayside has made. We would also note—and Government colleagues may wish to comment further on this—that that is not a universal picture. There are still some boards and areas in Scotland that are not experiencing that level of progress. I think that there are seven health boards in Scotland that are receiving additional support for services to generate some of the improvements that are necessary.

I think that you are making a point about equity, Mr Beattie—that, regardless of where somebody lives in Scotland, people should have access to the right level of services, whether direct and face to face or using technology, when they need it, where they need it, truly equitably. I was very interested to hear Alex Cumming's contribution about the number of minutes away from services people are. There are clearly factors in geography that are worth further exploration beyond today's discussion.

10:30

Colin Beattie: Okay. We have established that CAMHS referrals have dropped by 17 per cent, and the suggestion is that that is possibly due to school closures and limited access to GPs, rather than a reduction in overall demand. To what extent is there an unknown backlog of cases that are not yet being seen by CAMHS? I put that to Alex Cumming first.

Alex Cumming: I can speak only anecdotally—colleagues around the room might be able to give a better answer.

Dr Morton has mentioned that, across the board through the pandemic, lots of different services—CAMHS as well as others—have had to reduce intake and change their delivery mode. Things are starting to recover, so we are starting to see increased referrals.

My apologies, but I cannot give the concrete answer that you might be looking for. Anecdotally, it makes sense that, as we recover from the pandemic, there will be a wave of mental health problems across our communities and CAMHS will see an increase in the number of referrals.

Colin Beattie: Caroline Amos, do you have anything to input?

Caroline Amos: The focus for us in education is on positive mental health and wellbeing, and that is what we as schools have been trying to do. That is the focus of a whole-school approach that sits within a whole-system approach, which ensures that we are considerate of children and young people's wellbeing, and that we are working in partnership, collegiately and co-operatively with the other services around us.

Anecdotally, I, too, can see that there has been significant distress and challenge for some children and young people in North Ayrshire. We can see that coming through in the use of our service, in the use of the educational psychology service and in the conversations that we are having in schools and with other partners, services and agencies.

In education, we are looking at it in two ways. First, we are considering how we can support those who are experiencing challenges and signpost them to other services as required. Secondly, we are focusing specifically on ensuring their wellbeing and making sure that the activities and the curriculum that we deliver focus on positivity, resilience and nurture.

Colin Beattie: Perhaps Catriona Morton could come in.

Dr Morton: I do not know if my mic is—

Colin Beattie: It comes on automatically.

Dr Morton: Oh—right. I can speak loudly in any case.

I come back to the issue of equity. I wonder whether part of this is about definition. I agree with the comments made earlier that a detailed consultation and assessment can also be therapeutic and the start of therapy. However, we would then need everybody across Scotland to use that definition of the start of treatment. We cannot have different definitions.

On the other hand, an initial consultation might be an assessment that says, "This person has very, very severe anxiety and needs to see a psychologist", but definitive treatment might then be six months down the line if there is a six-month wait for a psychologist. I am just making that figure up—I have no idea what the waiting time is. Therefore, we need standard definitions.

Some of the feedback that I have had from GPs in Grampian and Tayside has not been as optimistic as what we have heard. In Grampian, they say

"waiting lists are long and parents and patients often are left to fend for themselves".

I received a text from a GP that I will quickly read out. The GP is talking about her soon-to-be 13-year-old daughter who is the patient. The GP has given me permission to share this. She said that her daughter

"has been on the CAMHS waiting list for over 2 years. In this time her anxiety has progressively worsened and has become critical in the past 2 months to the extent that she can barely leave the house. She has been to school on less than 6 days since the start of term. School have been contacting CAMHS almost twice weekly asking for her to be urgently seen. Our GP has written again asking for her to be seen urgently but she has no appointment. The impact on children and their families cannot be overstated."

I wanted to read that out because when we talk about a two-year waiting list, that is what that means. People do not get on a waiting list easily, as we have heard. Referral is set at a high bar, and the bar is also high to then be not rejected and to be put on a waiting list.

Colin Beattie: Martin, perhaps you might have some input here.

Martin McKay: Sorry, in what context?

Colin Beattie: My original question was about whether there is an unknown backlog of cases that are not yet evident.

Martin McKay: I can speak from my experience of sitting on the national stakeholders group for mental health for Unison. At the start of the pandemic, the work that we were doing at national level on strategic policy and delivery changed to focus on the direct impact of the pandemic and how we would have to change the direction of the

delivery of services for the mental health and wellbeing of the nation.

We know the impact of trauma not just from mental health services but from all clinical services. We know that that impact begins to show only quite a way down the line. In 18 months to two years, a significant impact can just be beginning to show. During the 18 months of the pandemic, people have been dealing with whatever it is that they have had to deal with, and it is when their resilience levels disappear that the impact on people's mental health and wellbeing starts to show.

We have been expecting what many people have called a tsunami of ill health and of mental health and wellbeing issues. During the pandemic, we have seen the level of acute ill health in the number of admissions into hospital.

I know from my colleagues in community services—it is the same across the whole of Scotland—that they are dealing with more and more cases of people who have become unwell. We have found—we have data on this nationally—that we have had more and more new admissions on to case loads and into hospital of people who have never been known to mental health services before. That will be exactly the same for CAMHS. Unfortunately, those people might be facing delays in getting a referral or being put on a waiting list.

We knew that that was coming. We know that the impact—the wave—of the pandemic has not finished in terms of mental health referrals and hospital admissions, and that those will continue. Most of our services are at full capacity; most of our hospital beds are full. When the top end—tier 4 level—is full, the pressure expands through the rest of the sector out to our community teams, the third sector, colleagues in health and social care settings, and to staff working in education who are having to support children and young adults during the school day on a daily basis.

I do not apologise for painting a bleak picture because that is the information that I have on the ground. That is what I know from my work colleagues who work daily on the wards and in the communities, and that is what I hear from my colleagues in Unison branches, in health boards, in other sectors and from other employers across the country. We are at a significant point.

When I hear it mentioned that we are now in the post-pandemic phase, that does not equate to how our staff feel on the ground. Neither does it equate to how they are trying to support the patients they are dealing with and treating in hospital or in the community, or the clients they are supporting in other sectors. We are not in post anything. This is a tsunami wave that just keeps coming and is not slowing. The pressure is constant.

As I have said already, we need to look at how we use the funding that has come in differently to try to build resilience and early intervention in health and wellbeing, because otherwise we will be throwing money at the same gaps in services that we have always had and we will not change.

We do not have enough nurses, psychiatrists or psychologists. Furthermore, in remote rural areas, such as Grampian and the Highlands, we cannot recruit them. There are large areas across the country that have significant difficulty in attracting staff from the central belt, for example. However, even in that area, we still have a significant retiral rate in mental health services. Staff can retire early because of their pension status and service status, and because of changes to pensions and so on. The pressure in the service is making people change the way in which they think and they are leaving the service earlier than they had planned to. That is putting significant pressure on the top end of staff. We keep working to recruit more people at the front end but that is always a constant fight. Apologies for—

The Convener: Martin, time is running away from us, but you are making some extremely powerful and important points that I am pleased are now on the record. That will allow us to follow some of them up.

We are drawing towards the end of the evidence session. I ask any witnesses who want to come back in to keep any final remarks short if possible.

Colin, I do not know whether you have any further lines of inquiry.

Colin Beattie: I have one thing that I want to add. Martin McKay quite rightly mentioned money, which is the lifeblood of any service. The Scottish Government has earmarked £40 million for improvements to CAMHS. What should those improvements be?

Alex Cumming, maybe you are the right person to ask first.

Alex Cumming: I will go back to some of my previous points. I know that colleagues will have lots of other ideas as well. That is about how we ensure connections at referral and when a young person or their family are rejected. It is not fair for them to have to navigate the system themselves—we need to support them to do that.

Link workers across Scotland have had a positive impact. We know that, hopefully, there will be more mental health link worker-type roles coming as part of the Government commitment. However, there must also be something specific attached to CAMHS to improve the connections for young people and for families as part of that.

As Martin McKay said, it is about changing our focus slightly so that is not necessarily just on

clinicians. Yes, experienced practitioners must be involved, but I do not consider that it necessarily must be CAMHS that has those conversations and helps people navigate a very complex system that is changing all the time. Even the individuals around this room are saying that it is difficult to keep up with the changes. Therefore, as I mentioned at the start, we need to do more for the wider public.

Colin Beattie: Donna, do you have anything to add?

Donna Bell: There are a few areas where we want to focus. Some of the issues that have been raised today highlight the variation in both practice and funding across the country. One of the key issues for us is implementation of the CAMHS specification in a robust and reliable way across the country.

Mr Coffey mentioned specific issues around long waits, on which there is a real need to focus. We are working intensively with seven NHS board areas where the biggest challenges are being felt. That is another key area.

10:45

Improving community CAMHS is another important area, particularly in relation to the work that we are doing on the expansion for 18 to 25-year-olds and targeted groups.

Another area that the joint delivery board has focused on in particular is crisis response—out-of-hours assessment, and intensive and specialist CAMHS services that benefit children and young people with complex needs and their families, particularly in a home setting.

Those are the areas that I want to highlight.

Colin Beattie: Convener, I am conscious of time, so I will draw to a close.

The Convener: Thank you very much. I know that a couple of other people wanted to come in on that, but given that we are the Public Audit Committee, I want to use our final few minutes to have a quick look at the issue of the absence of data that has been highlighted in some of the work by the committee as well by Audit Scotland. I know Sharon Dowey has a question or two on that.

Sharon Dowey: The session 5 committee stated that the absence of basic data was a concern. I will read out some of the comments in that committee's 2019 report on children and young people's mental health. In relation to spending on CAMHS, the then Auditor General said that

"the numbers are so variable as not to be credible".

Audit Scotland said:

"We saw gaps and problems throughout the system in terms of how the money is accounted for and, critically, in terms of what difference any of it makes to children. We have made a series of recommendations in the report that those things need to be sharpened."

It also said:

"we understand that boards will choose which ones they want to measure, and that will make benchmarking very difficult."

There is a common theme here.

In her response to that report, the then Minister for Mental Health outlined work that the Scottish Government was progressing with NHS National Services Scotland to improve the quality and scope of the available data. Considering that the report is now two years old, to what extent has the work been progressed?

Donna Bell: Some progress has been made already—I have highlighted a couple of areas where we have made progress. We are working with Public Health Scotland, particularly on outcomes data and benchmarking. I am happy to come back to the committee with a more detailed response, because a significant amount of work has taken place.

Tracking the finance input and linking that to outcomes is one area where we need to do more work. I am fairly sure that we will be working with Audit Scotland on that over the next few months and on an on-going basis.

Sharon Dowey: Does anyone else want to come in?

The Convener: I do not think that anyone has indicated that they want to come in. As we have the Auditor General here, I think that it would be useful to get his reflections on where he thinks we are with data collection—not just data for data's sake, but data that tells us about outcomes.

Stephen Boyle: That would be exactly our conclusion, convener. Recognising Donna Bell's point and the role of Public Health Scotland in analysing why referral rejections have happened, our sense is that—as we have said, not just in this context but across a number of different themes—consistency and high-quality measurement and analysis of data are essential components of understanding how well public money is being spent and what outcomes have been achieved from that spending.

Our sense is that we are not yet in a position to be definitive about that, or that we have much in the way of concrete evidence to show that we have moved terribly far beyond where we were when we did our audit report in 2018 and your predecessor committee produced its report in 2019. Progress has still to happen and, as we

have heard this morning, there is some urgency around that.

The Convener: Thank you. That sense of urgency is absolutely right, because these children and young people are only that age once and we need to get it right now. We cannot come back in five years' time and decide that we should have done things differently. We need to try everything that we can to offer them and their families the support that they need.

I thank you all for the very useful and informative evidence that we have been given, which will allow us to consider our next steps. I am sorry that we ran out of time—I know that some people wanted to come back in. I simply say that, if you are so inclined, we would appreciate your submitting any written evidence to us through the clerks so that any of the points that you have been unable to make during this morning's round-table session will still be captured by the committee and be a matter of record. We will look closely at those points.

As I think the Auditor General did, I also thank Donna Bell, who gave a commitment to come back with some more information for us, in relation to both the data that Sharon Dowey asked for and the 29 recommendations made by SAMH and the NHS NSS Information Services Division in the 2018 publication "Rejected referrals to child and adolescent mental health services: audit". As members of the Public Audit Committee, we will find it very useful to understand what progress has been made in the pursuit of the recommendations in the Audit Scotland report.

I again thank you for your endurance this morning. It has been quite a long session, but I know that the committee has gained a great deal from it. I thank you for your time and your energy, and for the great deal of preparation that you will have undertaken before coming to the session.

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

10:52

Meeting continued in private until 11:33.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba