OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 28 October 2025

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 28 October 2025

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE

28th Meeting 2025, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Joe FitzPatrick (Dundee City West) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Patrick Harvie (Glasgow) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Tom Arthur (Minister for Social Care and Mental Wellbeing)
Gavin Gray (Scottish Government)
Stephen McLeod (Scottish Government)
Dr Lynne Taylor (Scottish Government)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 28 October 2025

[The Convener opened the meeting at 09:15]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 28th meeting in 2025 of the Health, Social Care and Sport Committee. I have received no apologies.

Agenda item 1 is a decision on whether to take items 4 and 5 in private. Do members agree to take those items in private?

Members *indicated agreement.*

ADHD and Autism Pathways and Support

09:16

The Convener: Our next agenda item is evidence taking from the Minister for Social Care and Mental Wellbeing as part of the committee's inquiry into attention deficit hyperactivity disorder and autism pathways and support. I welcome the minister, Tom Arthur, who is joined by Gavin Gray, deputy director, Stephen McLeod, professional adviser, and Lynne Taylor, professional adviser, all from the Scottish Government's mental health directorate.

I invite the minister to make an opening statement.

The Minister for Social Care and Mental Wellbeing (Tom Arthur): Good morning. I welcome the opportunity to speak to the committee and to contribute to its important inquiry.

Across the United Kingdom and globally, we are witnessing a significant and growing demand for neurodevelopmental support and diagnosis. That is not unique to Scotland—it is an emerging issue in many parts of the world. Increasing pressure is being placed on systems that were not designed to manage such a scale of demand.

The issue is complex. Neurodevelopmental needs span health, education and social care, and they are shaped by a wide range of factors. A traditional national health service waiting list approach is not sufficient. What is needed is a co-ordinated multi-agency response that focuses on timely, needs-based support and reflects the evolving nature of neurodevelopmental needs and the diversity of individual experiences. The Scottish Government is committed to improving access to timely, needs-based support for neurodivergent people.

For children and young people, our work is guided by the national neurodevelopmental specification, which promotes the provision of early, needs-led support through the getting it right for every child principles. However, rising demand has made implementation challenging. We have invested in pilots, digital tools and family support, and in our work to take forward recommendations to improve implementation, we are being supported by a newly established cross-sector task force.

For adults, we have accepted recommendations from the adult neurodevelopmental pathways pilot, and we continue to invest in support. Our autistic adult support fund and the work of the National

Autism Implementation Team are helping to reshape services and improve outcomes.

We also recognise the need for better data to inform planning and improvement. Work is under way with health boards and local authorities to get a clearer understanding of service demand and provision.

Finally, I want to stress the importance of finding consensus on the way forward. The committee's inquiry is a vital opportunity to do that, and I thank all the families, professionals and organisations that have shared their experiences and insights. I very much look forward to considering the recommendations that the committee makes as part of the outcome of the inquiry.

The Convener: Thank you, Mr Arthur. We will move straight to questions. I put on record the fact that I hold a bank nurse contract with NHS Greater Glasgow and Clyde.

An issue that has been raised consistently throughout the inquiry, in the written and the oral evidence that we have received, is that of waiting times for diagnosis, for children and for adults. While I am sure that committee members will have more to say about adults who are seeking a diagnosis, I want to ask specifically about children.

Over recess, I met a constituent whose child has been waiting several years for a diagnosis. They spoke very highly of the support that they have been receiving from their child's educational establishment and the third sector support that they have accessed. However, they feel that they are no further forward in gaining a diagnosis for their child, which they believe is vital for them as a family. I am sure that you and your officials are well aware of the waiting times issue. What is the Scottish Government doing to tackle that? How quickly can we expect waiting times to be reduced?

Tom Arthur: Your question raises an important point, convener. At the outset, I stress that I fully recognise the importance of assessment and diagnosis, not only for individuals but for families, in order to understand need and for reasons of identity and validation; in some circumstances, assessment and diagnosis are important with particular reference to medication in relation to ADHD. We want to provide a needs-led approach, recognising that, consistent with our national specification for children and young people, a diagnosis is not a prerequisite for accessing support—and nor should it be. As the committee has been told in evidence, particularly from professional organisations, although we have a needs-based approach on paper, the understanding, perception and experience are that a diagnosis is required to access support. That should not be the case.

We set out the national specification back in 2021 and undertook a joint review with the Convention of Scottish Local Authorities. I updated Parliament just prior to summer recess, when I announced the establishment of a joint task force, bringing together health and education and backed up by an additional £0.5 million of investment in this financial year. As I touched on in my opening statement, the task force is to take forward an approach that is consistent with GIRFEC and recognises that support should be available without a diagnosis. That approach also recognises the circumstances in which a neurodevelopmental condition can present itself and the needs that have to be met in those circumstances—for example in an educational setting—and that small adjustments are often all that are required to significantly improve an individual's circumstances. That is part of the work that we are doing.

As I said, it needs to be recognised that the level of demand, not only for children and young people but for adults, is such that the conventional NHS waiting list approach is not sufficient. The absolute priority is an approach that responds to need. Notwithstanding that, we continue to invest in our health and social care services, and we do so with the intention of ensuring that a diagnosis can be provided, where required, as part of a needs-based response.

The Convener: What is the Scottish Government doing to tackle waiting times for a diagnosis? I hear what you are saying about the needs-based approach and the supports that can be put in for families and individuals while they are waiting for a diagnosis, but the committee has heard evidence that, for a lot of families and individuals, access to a diagnosis is key.

Tom Arthur: The committee has heard about the variation throughout Scotland. In our engagement with health boards and local authorities, we are undertaking work to understand the data that they hold and get a clearer picture of where variation exists. That will help to inform our response. There is substantive investment to support the workforce, in relation to not only head count but training and professional development.

The point that I come back to is that although we are working to provide greater clarity and get a better sense of what data is available, we recognise that the level of demand is such that we must not lose sight of the needs-based approach.

Stephen McLeod (Scottish Government): The work of the task force is the answer to your question, convener. The implementation gap in relation to the national neurodevelopmental specification was identified in the review, and the task force has been given a number of short-term, medium-term and longer-term actions.

There are opportunities to improve the neurodevelopmental assessment pathway for children and young people, for example. Mr Arthur has touched on the data, which is not good. We have a really poor understanding of the needs of children and young people and their experience of service response.

I am most optimistic about the opportunity to use the information that we gather routinely—particularly from universal services such as health visiting and education, but also from elsewhere, such as general practitioners—and to use that data better, by digitising it and contributing it to any future professional assessments. That is our big opportunity, rather than starting again with professional assessments that do not carry any information for the families or universal services.

The Convener: We will come on to data specifically a bit later on in the session, so I will leave it there and move to Sandesh Gulhane.

Sandesh Gulhane (Glasgow) (Con): I declare an interest as a practising NHS general practitioner.

Good morning, minister. You spoke about better data. There were 42,000 children and 23,000 adults waiting for an assessment as of March 2025, and we are talking about waits of years, not a few weeks. Children are becoming adults and going to the back of the queue again. You spoke of a needs-based approach, and you were twice asked by the convener for a timeframe for when the waiting lists will come down. I will give you a third opportunity to answer the question directly. What is the timeframe that we are looking at to reduce the waiting lists?

Tom Arthur: As I said in my opening statement, a traditional NHS waiting times approach is not sufficient. The Royal College of Psychiatrists in Scotland published a paper—it was specific to adult cases—at the start of the work. It spoke about the increase in demand that we have seen in recent years as being unprecedented and unforeseen, and it said that the mental health system in Scotland cannot cope with it. Indeed, no mental health system in the world can meet that level of demand, and this is a global phenomenon. We see it elsewhere in the United Kingdom and internationally.

We have to rethink our entire approach. It has to be a whole-system, whole-society and needs-based approach. I recognise the importance that is placed on assessment and diagnosis, and I recognise their clinical value, particularly with regard to access to medication in the case of ADHD. However, I also recognise—this is particularly important—that a stepped care approach that is needs based can ultimately be the most effective and most impactful way to ensure that people are supported and that their needs are met.

Given the level of demand and the increase that we have seen, even just in the past five years, the traditional waiting times approach, with that particular paradigm and model, will not be sufficient. That is why I have to be frank with the committee and echo the points that have been made by professional bodies about the need to rethink and have a whole-system and whole-society approach.

Sandesh Gulhane: When do we expect to see the needs-based approach?

Tom Arthur: We have the national specification for children and young people. We conducted the implementation review jointly with COSLA and updated the Parliament in June about that. The cross-sector task force has been established; it met for the first time earlier this month. There will be an additional £500,000 of investment this year, and, as Stephen McLeod has set out, the task force will have short-term, medium-term and long-term actions that aim to improve the experience of children and young people.

With regard to adults, we previously accepted the recommendations of the pathways report that was conducted by the National Autism Implementation Team, and we are working with health boards and partners to ensure that those are delivered.

On being able to have a clearer understanding of the picture, on-going engagement about data is taking place with health boards and local authorities. I appreciate that the convener said that we will touch on that later.

Sandesh Gulhane: There is a high prevalence of neurodivergent young people and adults engaging with the criminal justice system. What steps are being taken to strengthen the co-ordination and collaboration between health service and criminal justice agencies for those people?

Tom Arthur: The need for collaboration across sectors is a really important point. It is particularly important for children and young people with regards to educational settings and the responsibilities that are placed on local authorities as education authorities.

My clear expectation is that there will be joined-up and comprehensive working that takes account of people’s neurodivergent needs. That should be part of the fully integrated response that we would expect in meeting anyone’s needs, whether they are in an educational setting or interacting with the criminal justice system. The key principle has to be meeting needs and responding proportionately in doing so.

09:30

Sandesh Gulhane: My final question is on the criminal justice system. We know that young people and adults with untreated ADHD are at an increased risk of developing substance misuse disorders, which is particularly relevant in Scotland. What steps are being taken to strengthen collaboration to ensure that those co-occurring disorders are addressed in a timely manner?

Tom Arthur: That is an important point. There is the risk not just of substance misuse but of poorer mental health. That speaks to the point about a needs-based approach and the earliest intervention. For children and young people, there is an opportunity for that to take place in an educational setting. With that needs-based approach, there can be a process of escalation of steps to ensure that those needs are met, and that can include assessment and diagnosis.

Having that integrated approach is essential, and having that early intervention is extremely important for prevention. That is fully recognised and reflected in the national specification.

Emma Harper (South Scotland) (SNP): Good morning. Sandesh Gulhane touched on the issues involving criminal justice, health and assessment, and you spoke in your opening statement about the collaboration that is required between health, education and social care. We have had members' business debates about eating disorders, which are also linked with neurodevelopmental conditions. I recently met the Dumfries and Galloway Ehlers-Danlos group, which identified the issue of co-existing and co-occurring conditions such as dyslexia and ADHD. I am thinking about eating disorders such as avoidant/restrictive food intake disorder. It is all very complex, which is why, I assume, there needs to be collaboration, co-working and all that engagement. I just want to highlight the complexity of everything.

Tom Arthur: Absolutely—you make a very powerful and profound point, Ms Harper. We have to bear in mind the complexity and the need to respond to individual need. We speak of neurodevelopmental conditions as existing on a spectrum, and they will manifest and present in different ways. As such, the response to that will differ based on the individual circumstances. You also recognise the possible interaction with other conditions and the fact that, for people who have a neurodevelopmental condition, there can be elevated risks of other conditions. Those things reflect the need for an integrated approach and—I repeat—a needs-based approach. That is very much reflected in the national specification.

Dr Lynne Taylor (Scottish Government): I am a clinical consultant psychologist by background, and I know that you have heard from colleagues from multidisciplinary backgrounds.

Emma Harper raises an important point. The complexity of how an individual presents is often affected by their environment, their physical symptoms and their past experiences. In relation to children and young people, trauma and adverse childhood experiences can have an impact on how someone presents in their individual world and in society, which means that there is complexity.

You raise a good point about ARFID, which involves restrictive eating and hyperfocus. Neurodevelopmental conditions can cause people to develop problems with eating and other things such as anxiety. For example, in relation to special interests, I have quite often in my clinical practice had individuals referred for obsessive compulsive disorder because they have presented in that way, but, through further needs-led assessment and individual formulations that describe individual stories of strengths and weaknesses, which is the needs-led approach that Mr Arthur talks about, we can gather a picture of the whole person and the whole individual.

Taking a needs-led approach does not mean that an assessment does not lead on to diagnosis. It may, but, for some individuals, having an understanding of the symptoms that they are experiencing and of their complexity in their individual experiences at different points in time can be a validating and helpful experience in terms of outcomes, support and the treatment pathways that they can access.

Patrick Harvie (Glasgow) (Green): I do not know whether any colleagues wish to ask a supplementary question before I—

The Convener: No—Emma Harper's question was a supplementary.

Patrick Harvie: Okay. I beg your pardon.

I wish to move on to discuss the role of the private sector—and a few other members have questions on this theme, too. There are quite a few dimensions to discuss. We have heard concerns from some of the professional bodies about quality, about whether services are being provided to a recognised and agreed standard, and about whether there is too much emphasis on single-condition assessments, which could miss other aspects of a person's situation.

From the point of view of individuals looking to access services, we have heard about the unfairness in the fact that private sector services will often be very much available to people who are well resourced, while others cannot access them or, in some cases, find themselves going into debt in order to access them. People may also have a frustration that, even if they have accessed a private diagnosis, it does not necessarily lead to access to the treatment that they want through the NHS.

There are also concerns from the third sector's point of view about "private" being thought of as covering everything that is non-NHS. Although the third sector may be in a position to provide services on a not-for-profit basis—which, ethically, most of us would be more comfortable with—and although third sector organisations may often work in a way that is rooted within the lived experience of people who have greater familiarity with the issues, that does not necessarily come with stable funding, which can leave organisations feeling taken advantage of in terms of what they can deliver.

Thinking about all of those aspects, what, in short, do you think should be the role of the private sector or of non-NHS provision? Do you want that to be expanded? Do you want such provision to be brought into the NHS, so that the NHS is providing for people's needs and people do not have to resort to the private sector? Where should things be going?

Tom Arthur: Thank you for your question. You have summarised a lot of the issues and the complexity. One particular issue that has been raised with the committee, which has probably been raised by our constituents with all of us in our capacity as MSPs, concerns what is described as shared care, whereby someone obtains a diagnosis in the private sector and then finds that they are unable to obtain their prescription via the NHS. The committee will be familiar with the range of reasons for that and with some of the concerns that have been raised around assurance, quality and confidence. If I recall correctly, the committee took evidence on the potential for online assessments by providers outwith Scotland. I appreciate that the committee is familiar with the range of concerns that have been raised, and I recognise the point that is being made about why individuals are seeking diagnoses from the private sector, which was touched on at the outset in response to a question from the convener regarding the current length of waits in certain parts of Scotland.

We are focusing on rethinking the system and moving away from the paradigm of an NHS waiting list approach to one that is ultimately based on needs, recognising not only the importance that is placed on assessment and diagnosis but the fact that significant help can and, indeed, should be provided. In many cases, needs can be addressed without a diagnosis. If we can achieve that shift, it is potentially a way of helping to ensure that people receive support. They may find that that initial support meets their needs and that, consequently, there is no requirement for a diagnosis—which can have an impact on demand overall.

I want to caveat that by being absolutely explicit that I recognise the importance that is placed on diagnosis and that what I am saying should in no way be misconstrued as meaning that I do not. However, ultimately, there is a need to focus on meeting needs, because, as you touched on, Mr Harvie, a diagnosis is, in many cases, not necessarily going to lead to any other interventions. I appreciate the points around certainty, identity and validation. However, in many circumstances, diagnosis does not, outwith the question of medication, lead to any additional service or support being provided that cannot be provided without a diagnosis. That is part of it.

The points around shared care have been raised with me on more than one occasion in the chamber. We have been engaging with the Royal College of General Practitioners Scotland to gain more of an understanding of the issue, and we are doing a bit of work on it. I want to ensure that every individual who requires the support of our national health service in any way can receive the support, help and care that they require from that service without the need to go private. That is what I want to see.

My focus is on ensuring that our system is responding to the needs of individuals. Recognising the unprecedented increase in demand, I want those needs to be met within our existing health and social care system and in our educational settings. To respond to your question directly, Mr Harvie, I am not here to advocate for an expansive and increased role for the independent sector. However, recognising that individuals are able to exercise their right to use that sector, and recognising the challenges that have emerged around shared care, we are having that engagement.

Patrick Harvie: Can I just tease out what you are saying a little bit? You say that you want people to be able to access the support that they need through the NHS without having to resort to going private, but previously you made a distinction between support and diagnosis. Diagnosis might lead to treatment—to a prescription—but support is something different. Support is valuable, but diagnosis and support are two different things. Are you saying that you want everyone to be able to access not only support in the broadest sense, but also diagnosis and, if appropriate, treatment through the NHS?

Tom Arthur: Of course I want to ensure that every individual who requires diagnosis and treatment through the NHS is able to access that.

That is the founding principle of our national health service—

Patrick Harvie: Given the scale of the demand that you have described, can that be delivered? Or should the Government be looking to provide, for example, more sustainable funding for third sector services that are run on a not-for-profit basis, which could help to expand capacity in a way that is specialised and perhaps more relatable?

Tom Arthur: The role of the third sector is hugely important. I know that the committee had an evidence session with many of the organisations that have worked and engaged with the Government over the years. Whether it is the funding that we provide to Scottish Autism for the autism advice line, the autistic adult support fund or the additional resource that we are providing this year—

Patrick Harvie: Forgive me, but I am going to pick up again on the difference between those wider support services and diagnosis and treatment. Do you see a role for the third sector or other parts of the non-NHS sector—

Tom Arthur: Yes, they play a—

Patrick Harvie: —in meeting the need for diagnosis and treatment, as opposed to wider support?

Tom Arthur: I know that this is not your intention at all, Mr Harvie, but the term “treatment” is almost suggestive of the fact that something is to be cured or remedied. I know that that is not—

Patrick Harvie: No, but I mean that medication needs to be prescribed.

Tom Arthur: It is in specific cases, consistent with clinical guidelines. For many people with a neurodivergent condition, support can be provided through very minor and straightforward environmental adjustments and peer support.

Patrick Harvie: Absolutely.

Tom Arthur: On those particular points, the role that the third sector plays is vital, and it does tremendous work. I recognise some of the challenges that have been articulated to the committee and in relation to some of the decisions—

Patrick Harvie: I am not seeking to take away from the value and importance of that at all. However, we have heard a significant number of voices say that diagnosis is hugely important for a range of reasons, including access to prescription medication in certain circumstances. I am not yet hearing from the Government how it intends to meet what you, yourself, are describing as a substantial demand that is currently unmet.

09:45

Tom Arthur: As I tried to say in my opening statement, part of the answer has to be about moving away from that paradigm of the traditional NHS waiting list approach. I appreciate that the committee took evidence from the Royal College of Psychiatrists in Scotland on the paper that it published at the start of the month on adult neurodevelopmental services. It made the point that the system in Scotland cannot meet the need and that, thinking about what would be needed to do so, no system in the world could meet the level of demand that there now is.

There has to be a focus on meeting need. In a stepped care approach that is consistent with what is in the national neurodevelopmental specification for children and young people and with GIRFEC, it is important to have that focus on meeting need. I recognise that, as part of meeting need, assessment and diagnosis can play an important role, but diagnosis is not and should not be a prerequisite for obtaining support. As Stephen McLeod touched on, there is a challenge at the moment in relation to implementation, which is why we established the cross-sector task force and why we are putting in the additional investment.

Stephen McLeod: Perhaps I can give an example. I understand your question, Mr Harvie. Our view is that, if we gathered in a more systematic and structured way the information that is currently routinely collected—particularly for children and young people—and had better ways to share that information with the consent of the families, the assessment and diagnostic pathway for some people would be much more efficient. We would use the resources that we already have in place.

That touches on the estimates, which colleagues have talked about, of the numbers of people on waiting lists—the 42,000 children and 23,000 adults. We are not 100 per cent sure what those numbers mean. We know that, in children’s services, lots of universal contacts and supports are provided to families. That information could travel with a family or young person and contribute to the assessment and to any diagnostic outcome in a way that is much more efficient than the traditional NHS waiting times approach.

We have to move away from the approach in which there is a stand-alone offer whereby we start all the information gathering from scratch, without any of the continuity of context for the young person coming with it. That is the single biggest change that we could make to the way in which we approach this.

Patrick Harvie: I know that other members want to come in on this theme. My last question is this: by what time—what date—do you think that moving to the different model that you have described is going to make a substantial difference to people who are currently left waiting or feeling forced to go to private providers if they have the money to do so?

Tom Arthur: Work is already under way. The policy framework for children and young people—the national specification—is in place. We recognise that there is an implementation gap, hence the work that I have referred to. That is under way and I want it to move at pace. We are working with health boards on the implementation of the findings of the pathways report.

I made reference to the paper by the Royal College of Psychiatrists in Scotland, and we are giving serious consideration to that. I reiterate a point that I have made in the chamber: we welcome that paper. It makes an important contribution to the discussion, and there is much in it that is worthy of serious consideration. I give the committee the undertaking that this is an absolute priority for me and that we are going to be working at pace to make as much progress as possible—hence the additional investment that we have committed to in this financial year.

Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP): Good morning, minister and your officials.

I want to explore that area a bit further—I thank Patrick Harvie for starting us off. I am thinking specifically about an individual constituent of mine: a young person who has had no access to any waiting list, despite repeated referrals by his GP. He finds himself in a situation in which he does not have the co-occurring mental health issues that are required in order to access, in Ayrshire and Arran, the services that are set out in the national specification. His family have the means to seek a private diagnosis, but his local GP practice has a blanket ban on undertaking any such shared care arrangements.

How does the Government envisage a system in which that type of situation can be addressed in a way that I think the Royal College of Psychiatrists has set out in its paper, which talks about the fact that no one agency or model will be able to do all the work that we need it to do? In some situations, we have seemingly blanket bans in GP practices not to undertake any shared care. That is not based on an individual or clinical assessment of the patient—the practice is just not entertaining that, yet the patient is not meeting the practice's referral thresholds to get on to a list. That leaves some young people who are essentially hidden in the system and whose needs are not being met. How do we address that type of situation?

Tom Arthur: What should happen is what is set out in the national specification. Stephen McLeod made some points about how we can work effectively to utilise the data that is gathered from the innumerable interactions that are already taking place in the system, such as in educational settings. How we more effectively utilise data is a challenge to public bodies and to Government, which is why we have had the engagement with health boards and local authorities and why we are working to consider not just the data that is available but how it can be more effectively applied.

The cross-sector task force is working on improving the implementation of the national specification. The work has been committed to and is under way, specifically to respond to the circumstances that you have articulated, where a young person is not necessarily receiving the support in their local area that they should be receiving.

We are working to respond in a way that recognises the complexity and is also consistent with much of what the Royal College of Psychiatrists has said, while recognising that there is no one particular model and that there will be a multitude of different approaches, as well as the different circumstances that people find themselves in, the different settings and the particular needs of the individual. That is where we are at: the policy and the framework are there, but there is a question about implementation, hence the joint review on implementation, the subsequent establishment of the task force and the additional investment. Stephen McLeod might have something to add.

Stephen McLeod: This is specific to local authority areas. The children's services planning arrangements and the relationships between different children's services are the key for children and young people. As you and your colleagues will know, those can vary from local authority area to local authority area. The Government is specifying the standards that need to be reached, but the implementation challenge is local. I know that my colleagues in Ayrshire and Arran have three sets of relationships to negotiate and are trying to have partnership working arrangements with education colleagues in particular to develop the pathways that support the neurodevelopmental specification. However, that will vary from area to area, depending on local circumstances.

I am most optimistic about the chance of local solutions, particularly when headteachers are involved in the discussions. In my experience, headteachers understand the needs of their schools and can make decisions about the changes that they need to make to most closely meet the needs of children and young people. There is a macro and a micro level. At this stage, we probably know less about the micro level than we would like.

Elena Whitham: In the specific instance that I mentioned, the school has been proactive and supportive of the family and it has put information forward to support the need for an assessment.

I have one other question about shared care. At our previous evidence session, we heard certain comments and the phrase "wild west" was used. I felt compelled to come back in at the end of that session to ask about the value of private providers, especially when they are based in Scotland, regulated by Healthcare Improvement Scotland and partnered with many local areas to deliver assessments. Is there a value in that sector if it is based in Scotland, is conducting online assessments and is subject to all the same checks and balances as any other practitioner in Scotland that might be rooted in the NHS?

Tom Arthur: I recognise the importance that many people will place on the independent sector. Those who have the means to do so may choose to exercise their right to utilise it.

When it comes to the interaction with the NHS, those decisions are ultimately clinical decisions to be taken by the clinician who is in charge of the patient's care. That is a well-established and well-understood principle. However, where there can be variation with regard to, as we have described, the shared care arrangements in different parts of Scotland, we are engaging with the Royal College of General Practitioners to deepen understanding of the issue and consider potential options or responses to the situation. I stress that I recognise the primacy of the decision making of the relevant clinician.

David Torrance (Kirkcaldy) (SNP): Good morning. How does the Scottish Government ensure that national specifications are implemented at the local level?

Tom Arthur: That gets to the heart of the challenges that we have been discussing this morning. The process of developing a national specification is a collaborative endeavour. In the case of the national specification for children and young people, we recognised that there were challenges around implementation and consistency—hence the joint review and the establishment of the task force. That work will go forward with the aim of ensuring that the experience of individuals engaging with services is consistent with what is set out in the national specification.

That is beyond the engagement that regularly takes place between Government and local partners. The task force is doing specific, dedicated work and had its first meeting earlier this month.

David Torrance: How can NHS boards be supported to move towards improved pathways and assessments while dealing with long and increasing waiting lists? We were told in a previous evidence session that good practice does not travel well. As you know, there are 32 local authorities and different NHS boards. How can we improve that good practice?

Tom Arthur: That is an important point. We in Government certainly try to support boards and local partners to take forward best practice. The National Autism Implementation Team published the pathways report a couple of years ago. The Government accepted the recommendations from that and has been working with health boards to support implementation of those recommendations, but I recognise that there is currently variation. Recognising the day-to-day operational role that health boards have, we are committed to continuing to work constructively with boards to achieve the level of national consistency that people across Scotland expect.

Do any officials want to come in?

Stephen McLeod: As part of the development of the national specification for children and young people, we commissioned five tests of change. We understand a lot more now than we did then about the answer to your question, which is, in effect, about what works locally and what the challenges are. It is a combination of things. Local leadership and commitment to delivering the change are essential. The resources that are required are not always people and money, but infrastructure resources, good practice and tools that have been effective elsewhere.

The final thing is the scrutiny. It is always helpful for local areas when ministers and committees, including local government committees, as well as others are interested. The reports from the task force on the tests of change progress were effective in encouraging and informing politicians and getting more support for further roll-out of the very small tests of change. Some areas have taken those lessons and have done much more with them.

David Torrance: How will the cross-sector task force's progress be measured and evaluated, and how will the use of the existing money and additional funding be evaluated?

Tom Arthur: The review set out a range of actions in the short, medium and long term that will provide a means of assessing progress, and the task force is taking forward that work.

On the additional resource that was committed to, I hope to be in a position relatively soon to set out how that will be deployed. I undertake to keep the Parliament informed of the progress that is made.

As I said earlier, the task force met for the first time earlier this month. I am happy to continue to engage with the Parliament to ensure that it is kept up to date as and when outputs are articulated.

10:00

Brian Whittle (South Scotland) (Con): Good morning to you, minister, and to your officials. You will not be surprised to hear that I want to talk about early intervention and prevention of harm. How will early intervention and harm prevention be built into neurodevelopmental services for assessment and support for both children and adults?

Tom Arthur: That is such an important point. As the committee will be aware from the work that it has undertaken, there is a significant increase in demand among adults, which could be for a multitude of reasons. Perhaps their child was assessed, prompting thought and reflection about their own circumstances in life, which ultimately led them to take a decision to seek assessment and diagnosis.

From engagement, encounters, conversations and reading testimony, I have found that, when someone has such reflections later in life—perhaps in their 40s—the evidence speaks very powerfully about what the difference would have been if they had had an intervention, a diagnosis or more awareness at a much earlier age. As I say, that is powerful, and it speaks to the importance of children and young people in the approach that we have set out in the national neurodevelopmental specification and in being consistent with GIRFEC.

We are taking every opportunity to identify need at the earliest stage. As you have said very clearly, you are a passionate advocate for prevention, and we know that recognising need and responding to it at the earliest stage is of vital importance. That is reflected in GIRFEC and in the national specification. The point that Stephen McLeod set out earlier on how we can more effectively use the data that is already in the system is important. That will be reflected in the work of the task force in addressing the implementation challenges that we have seen. Perhaps Stephen has something to add.

Stephen McLeod: In 2019, we did some work with the previous task force, which was the children and young people's mental health task force. The University of Birmingham did a study that found that three quarters of mental health problems in adults are identifiable in childhood. In addition, Professor Guldberg and Professor Minnis provided evidence to us that showed that, possibly, about half of the children and young people who require neurodevelopmental support could be identified by around the age of eight.

It speaks to Brian Whittle's question that, if we got better at identifying and supporting families at a much earlier stage, we could shift the whole life course of presentations in the way that the minister has described. It is not that there will not be later presentations, but we could get ahead of it for some people and support children and families prior to the transition to adulthood. That is a great ambition. There is also potential for change at the public health level.

Brian Whittle: I have a specific interest in the issue. I have coached people with autism and fetal alcohol spectrum disorder—not ADHD but FASD. The minister has talked about a whole-system approach, which I whole-heartedly agree with. The structure from coaching, the outlet for energy and the ability to mix with others in such an environment is a positive thing, in general, especially in one's youth.

However, Covid took all that away. It had a very poor impact on the mental health of the squad that I coached in general but, very specifically, the impact on those who were neurodivergent was miles worse, and the way in which their lives were impacted was considerably worrying.

When we talk about a whole-system approach and the prevention of harm, I am interested in the opportunity for kids in general, but specifically those with neurodivergence, to participate. I raised that issue with autism and ADHD third sector organisations and the Royal College of Psychiatrists in Scotland; to be honest, I expected a major pushback, but they were very supportive of the approach and agreed that, as well as the fact that we are better at diagnosing, one of the reasons why we are seeing such a large increase in the number of presentations is that we have taken away a lot of that opportunity. That was a long-winded way of asking how you are working with other departments and other portfolios in the Government to deliver on that whole-system, whole-health approach.

Tom Arthur: The whole-system approach is why the task force is jointly chaired with representation from those in health and education. However, in certain respects, it goes beyond only a whole-system approach to a whole-society approach.

Cultural change is difficult, but having to move to a more accepting and neuro-affirmative culture in society is going to be important as well, and certainly a lot of progress has been made. There were a number of drivers behind the significant increase in demand, including a widening of the diagnostic criteria, which reflects a more developed and nuanced understanding of neurodevelopmental conditions. There has also been a tremendous amount of work to raise awareness and tackle stigma. That, again, has made an environment in which people are much more willing to come forward with regard to themselves and their children. That is positive, and it reflects the societal shift that is taking place.

The specific point about the system, which comes back to the point that Stephen McLeod set out, is about how we utilise our existing resources more effectively. When we think about all the ways in which children and young people are interacting with the state, whether that is in an educational setting or a healthcare setting, it is about ensuring that that work is coherent and holistically centred around the needs of the individual. That is reflected in the national specification and it is reflected in GIRFEC.

I came back to that point to reiterate why there is dual representation from health and education in the work on implementation and in the joint task force.

Brian Whittle: I know that you buy into this, but the population health framework is about how we make sure that there is an opportunity for neurodivergent people to integrate and participate, and the reality is that that opportunity has reduced. I am almost reverse engineering it based on what happened during Covid, because we have seen what happens when that support is withdrawn. What if we went in the opposite direction and produced a public health framework that says that people will be able to integrate and that there will be an opportunity for them to participate, not just in sports but in any kind of activity at all? What are you going to do to ensure that that reverse engineering is done? It is not enough to say that you understand it; it has to be done.

Tom Arthur: If we consider the statutory framework that our education authorities operate under, we see that an inclusive approach in which needs are assessed and support is provided based on those needs is already in statute. There are requirements for that in the way in which our education system operates. The challenge has been implementation, and that is at the forefront of my mind. It is important to have statutory obligations, but what matters is what the experience of the individual is when they interact with a particular service, which, in the case that you described, is an educational setting. That is why we are doing the work on the implementation review and the joint task force.

That reflects the need to address the points that you made, Mr Whittle, but I also recognise that we cannot look at support for people who are seeking assessment or support for a new developmental condition in isolation from wider society. The impact of the pandemic has been profound and it has affected people in different ways. However, significant cultural shifts are taking place in society, too.

I know that the committee will have given consideration to our changing mobile phone and social media habits in its broader deliberations on mental health. I know that that is just one factor, but it is having a profound impact on society, particularly on people with neurodevelopmental conditions. Some of that impact will be positive—those aspects can be used to create awareness and prompt people to seek more information and support. However, some of it might be less positive. I realise that those dynamics apply across a range of aspects of society.

I take the point that, when considering our approach, we should not just take a whole-system approach to neurodevelopmental needs; we have to see things in the round, at a population health level. We are taking specific steps to improve implementation of the existing standards, and we recognise the broader population health aspects, too.

Brian Whittle: I will press the issue. We are witnessing the increasingly devastating effect of isolation on neurodivergent people. It is unbelievably important for people to be part of something, and we have heard evidence that communities can be built online, so it is not all bad. As a Government, how are you making sure that all portfolios recognise the importance of tackling isolation?

Tom Arthur: I come back to the point about the work of the task force and of the joint review. COSLA and the Scottish Government are working in partnership with local authorities on the review, and the task force is being jointly chaired by those in the health and education sectors. That is in recognition of the fact that the issue cannot be siloed. It cannot simply be that one particular department responds, nor can it simply be that the Scottish Government responds. There must be a whole-system response, with local government, local partners and health boards all having a vital role to play.

Mr Harvie mentioned the third sector. It has a profoundly positive impact, particularly when it comes to peer support and helping to tackle isolation and provide opportunities for engagement and socialising.

We recognise that a range of different partners can provide support. We need to work together in a co-ordinated fashion to ensure that needs are being met.

Emma Harper: I have a quick question that will pick up on your comments on stigma and helping to support people in the work environment. When I was an NHS educator, we used Turas, which is a digital training platform from NHS Education for Scotland. NES created and delivered a foundations of neurodiversity-affirming practice webinar in 2023. That is recommended for all health and social care staff, but the organisation does not seem to be tracking whether that has been delivered or what numbers have received the training. It is fair enough to recommend that as a starting point for all staff, but does that mean that it is being delivered to all staff?

The training is a great way of creating a neuro-affirming work environment so that people who are clinical educators—as I was—can understand what works best for people who might be autistic or might have ADHD. Is there a way of finding out how that training is being delivered by health boards?

Tom Arthur: It is really important to recognise that that resource is available. I add that it is available at three levels, so there is an opportunity to develop knowledge and expertise further. On the uptake and utilisation of the training, I do not have any data or statistics to hand, but I am happy to take the question away.

I mentioned data, which is very much focused on the number of individuals who are seeking assessment. However, the point about the uptake of that training resource is useful. I appreciate that the committee might think about that when considering its recommendations but, as an output from this meeting, I am happy to take that away and discuss it with officials, because it is an important point.

10:15

Paul Sweeney (Glasgow) (Lab): We have heard from various stakeholders that support, information and resources are highly variable, particularly for neurodivergent people who are waiting for a diagnosis. To judge by the experiences that we have heard about, that seems to be a bit of a doom loop. We know that support should be available without the need for a diagnosis but, in practice, someone cannot get support without a diagnosis. We know that, for example, education authorities often use diagnosis as a gate-keeping tool in order to ration resources in the context of funding constraints.

How does the minister propose that we address that doom loop, which is a fundamental problem that repeatedly comes up as an issue? How do we open up a much wider discussion on the lack of support for neurodivergent people across the NHS? At the very least, we should be signposting people to the relevant support while they are waiting for a formal diagnosis.

Tom Arthur: My clear expectation is that anyone who is waiting for assessment should be sensitively signposted to support that is available. I reiterate the point that diagnosis is not, and should not be, a prerequisite for support. Education and local authorities should not be using the need for a diagnosis as a way to gate keep access to services. They have clear obligations—there are statutes—on meeting people's needs and ensuring that services are delivered consistently in line with the principles that are set out.

Having said that, I recognise that the evidence that the committee has taken is as you have articulated, which comes back to the point about implementation. I will not rehearse my previous points on the review and the joint task force, but those are the principal ways in which we are responding to the issue.

Paul Sweeney: The organisation child heads of psychology services in Scotland made the interesting point that there are areas of good practice. In its submission, it identified NHS Lanarkshire and NHS Lothian as having

> "developed a bank of digital resources offered to those waiting to be seen, however this is not the case across the country".

Do you share the view that a once-for-Scotland standard should be adopted? Do you agree that there should be rigorous benchmarking against good practice and that approaches should be brought under a national standard?

Tom Arthur: We have a national neurodevelopmental specification for children and young people, and I expect to see a consistent approach. In our work with health boards, my strong desire is that we achieve consistency.

In saying that, I recognise that there is variation to respond to the needs and assets of different communities in different parts of Scotland, and that is particularly important when working with local partners. Variation can be important, but that is in the context of how a service is delivered and what assets are utilised to meet what should be a consistent national standard, because that is what people ultimately expect.

I recognise that there is variation at the moment. In partnership with local government and health boards, we are working to reduce that. We have a clear policy framework that sets out what the standard should be. The question now is one of implementation and our being able to achieve that.

Paul Sweeney: Will you elaborate on your point about how we ensure that that is delivered? What mechanisms are at your disposal in the civil service to benchmark, assess and hold accountable authorities for not complying with standards?

Tom Arthur: I have to operate within the constitutional and legislative framework that exists with regard to the autonomy of local authorities, of which, ultimately, Parliament is the custodian. Although it is entirely a matter for Parliament and individual committees to determine what topics and matters they wish to pursue, I recognise that committees such as this one—I say this as a former member of the committee—can play an extremely important role in the scrutiny of individual health boards and health and social care partnerships, for example.

My responsibility is ultimately one of collaboration, and the consensus that we are building through having national standards is ensuring that delivery on the ground. Where there are challenges, we are working collaboratively and in partnership with the relevant body to seek to remedy them. Does Stephen McLeod want to add anything?

Stephen McLeod: We have talked a lot about the task force, but I am looking at the list of short, medium and long-term actions, which picks up some of Mr Sweeney's questions. For example, we have talked about the data being poor, and one of the longer-term actions of the task force is to agree on the data points and understand the support arrangements in each area.

There is also the sharing of good practice. Many of our colleagues out there would want to share good practice, and they would want to know who is doing things well and whether they can use tools that have been developed. Another commitment of the task force is to gather that information and make it more available digitally for areas that want to build on good practice elsewhere.

At the end of the day, we have to have better data on outcomes for children, young people and families, so that all the statutory bodies and players in this game can be accountable. Until that data is routinely available, it will be difficult to ensure accountability.

Paul Sweeney: Is there a balance to be struck around the clinical nature of diagnostic pathways? Are there examples from around the world of alternatives that could offer a better structure for Scotland?

Tom Arthur: The committee has heard evidence about using multidisciplinary teams and taking a partnership approach. I come back to the important point that Stephen McLeod made about using the data that we already have in the system and the range of opportunities to develop an understanding of an individual's needs. We need to utilise that more fully, particularly in the context of children and young people.

On international examples, I come back to the comments contained in the paper from the Royal College of Psychiatrists in Scotland, which recognised that this is an international phenomenon, with a significant increase in demand. If I recall correctly, in the RCPS's words, no system in the world could realistically respond to the level of demand.

We are certainly open to examples of good practice, but the work of the National Autism Implementation Team and the national specification take the correct approach that policy in Scotland should have a needs-based focus. The issue now is implementation. In looking for other approaches that we can add to that, as I touched on earlier, we very much welcome the paper from the Royal College of Psychiatrists in Scotland and will give careful and detailed consideration to its proposals.

Paul Sweeney: Are you aiming to get a clear picture of what the national baseline should be and of how each local authority or integration joint board is performing against that national baseline? Is that your ultimate goal as minister?

Tom Arthur: To answer the question in the spirit in which it was asked, I will say yes. However, I caveat that with what I said in my opening statement about conceiving of this in a traditional NHS waiting times paradigm. To ensure that there is broader consistency across Scotland and in people's experiences, we need to continue to work towards achieving a clear picture of the national baseline. I know that the committee has heard of examples of good practice. The challenge is to ensure that that good practice travels better than it perhaps does at the moment.

Carol Mochan (South Scotland) (Lab): I will ask about the workforce and training. When a previous health minister gave evidence to the Equalities, Human Rights and Civil Justice Committee in 2024, they recognised that we need to consider the issue across NHS boards. Are you encouraging NHS boards to develop their workforces together, particularly given the lack of certain professionals and the training that people need?

Tom Arthur: In response to a question from Emma Harper, we referred to the resources that are available. If I recall correctly, NAIT participated in the development of those resources, which operate at three levels.

Resource is in place. I committed to consider further Emma Harper's point, which was about the utilisation of resources and our ability to assess the impact that they are having. It is a valid point, and I will be keen to see whether it features in the committee's report. Does anyone want to add anything about workforce development?

Gavin Gray (Scottish Government): In the wider context, we published the health and social care service renewal framework earlier this year. In relation to the issues that are being dealt with in the inquiry, as the committee will be well aware, there are other challenges throughout the health system. Different approaches to addressing that could include working with health boards to get better planning, based on the evidence, and develop different operating models.

We also need a different workforce approach. That has been a theme in a lot of the evidence, but we could increase the use of digital resources in considering how workforces can look different. Delivery of that sits with the health boards, IJBs and others. The question is how we create the framework that supports those conversations and helps boards to deliver that.

We will be looking at a lot of those issues in that context and working with boards to think about what different workforce models could look like. There is a lot around the professional mixes. Psychologists, allied health professionals and others have an important role in that, so we will work with boards on implementing different models, recognising the points that the minister made about the need for a different approach.

Carol Mochan: The sustainability of funding has been raised with the committee and, I am sure, with other members. Does the minister feel that, in the long term, we have security of funding for the work? We are taking a long-term look at how we can change and improve services. Is there any thinking around not only maintaining funding but providing additional sustainable funding to change the models?

Tom Arthur: I have two points to make. First, Gavin Gray touched on the service renewal framework. There is a particular focus on prevention, which will prompt detailed consideration of current funding arrangements and whether areas are prioritised to ensure that the focus on prevention is realised throughout the health and social care system.

I can give a specific example. I touched on the additional resource this year of £500,000 for supporting services, which was part of the package that I announced to Parliament at the end of June. I hope to be in a position shortly to set out further details on the utilisation of that funding. That is an example of what is taking place in-year. It builds on existing funding that was provided previously, as well as the funding that is provided through the autistic adult support fund.

There is a range of funding streams. Part of that involves the wider settlements that are available to health boards and local government for delivering on their statutory responsibilities, but there is also specific targeted funding. I recognise the importance of certainty and predictability of funding and the need to ensure that funding matches the preventative agenda that we are setting out.

10:30

Carol Mochan: I have one last question; I know that we are tight for time. The link between health and education is so important in this area. How do you feel that the work to implement the autism in schools action plan is going?

Tom Arthur: The link between health and education is vital. That is why it is so important, in taking forward the action that is set out in the implementation review, that the task force that has been established has representation and co-chairing from both health and education. That very much recognises the absolute importance of having a joined-up approach in that area specifically, notwithstanding my exchange of comments with Mr Whittle about the need for broader engagement. We cannot have a siloed approach.

That speaks to the point about consideration of data, which is not just specifically about health boards but about understanding the position in local government and posing the challenge to ourselves collectively about how we can more effectively utilise the data that is there and is being generated. The challenge is how we can more effectively utilise that data to ensure that we are meeting people’s needs.

Brian Whittle: On the workforce, I spoke to the Royal College of Psychiatrists in Scotland and I heard that a lot of the burden is falling on psychiatrists, even though it should not. They are not the ideal people to diagnose neurodivergence, but the burden is falling on them. The college says that the number of psychiatrists is on the decline. That will obviously add even more pressure on the system and on psychiatry. How are we developing a system in which, first, the burden does not fall on psychiatrists and, secondly, there is enough employment to deal with the increase in pressure?

Tom Arthur: Work has been undertaken in relation to the workforce. The Royal College of Psychiatrists makes a profound point in the paper that it has published. That speaks to the need for a stepped care approach that is based on need and looking at the opportunities for early intervention.

There will of course be cases where engagement with a psychiatrist is appropriate and that is consistent with meeting an individual’s need. However, there will also be many cases where needs can be met and support can be provided without the involvement of a psychiatrist in the way that is perhaps occurring too frequently at the moment. I recognise that and I also recognise the point that has been articulated by the royal college about the impact that it is having on the sustainability of the existing workforce.

Gavin Gray might want to add something and speak a bit more broadly on the workforce point.

Gavin Gray: We have been undertaking a bit of work with the royal college and with psychiatrists not just on the numbers—we have been increasing the number of training places, so we are expecting some of those increases to run through the service—but on a whole suite of different issues around how we can work with psychiatry more effectively, the working conditions and so on. We published a report earlier this year and we are now working with the college on the implementation of all of that—we are working really closely with it to engage on some of those issues.

We are looking at a lot of things around service design. Lynne Taylor might want to say something about how we use other professions and how we make sure that we have psychiatrists doing things so that they can really add value and that we have the right staff and the right workforce implementation. We are working with the health boards to make sure that they are thinking about that as they renew, revise or transform their services.

Dr Taylor: What is helpful to consider in all of this is that a lot of the points that we have raised are around the multidisciplinary support that is required to provide a whole-system response to individuals. If we take psychology, for example, we have 14 applicants for every training place in Scotland, so there is not a shortage of workforce supply for all professional groups. You will have heard from other professionals, such as allied health professionals, who have significant skills to add. We have also heard about the support that our valued colleagues in the third sector can give to help in this area.

Emma Harper raised an important point about training. I was just checking the NAIT recommendations that we have for NES, and the training framework describes four practice levels for our workforce. For example, trauma-informed training transcends disciplines; that is about how the skills that people need depend on the contact that they have with the different clinical or population groups that they are supporting. We have staff who are at the skill levels of informed and enhanced and those who are specialists.

It is important to think about how we provide training and support for the whole workforce so that we can provide that whole-system and multidisciplinary response and use the skills of the wider professional groups that can add significant value to this space.

Elena Whitham: I would like to spend a wee bit of time thinking about data. This morning, we have heard a lot about data gaps and the work that is being done to understand those in every local area. I understand the robustness of the child and adolescent mental health services waiting times data and how that is assessed and presented by Public Health Scotland. I am interested in understanding—and I think that the committee would benefit from understanding—the impact that the national specification implementation and the focus on CAMHS waiting times has on neurodevelopmental waiting lists and what that looks like at the local level. That is very different from the CAMHS waiting lists as we understand them. It would be helpful if you could set out for us, as you understand it, what impact that has had on CAMHS neuro waiting lists.

Tom Arthur: I thank you for that important question, Ms Whitham, and for clarifying the distinction. I am conscious that, in the past, there might have been some conflation between CAMHS and ND. CAMHS is a specialist service for children, adolescents and young people with acute mental health conditions. Neurodevelopmental conditions, as we understand them, are not mental illnesses or mental health conditions.

When there is comorbidity with neurodevelopmental conditions and mental health conditions, if CAMHS is the clinically appropriate pathway, we would expect an individual to be included as part of the measurement, while also recognising that the majority of children and young people who engage with mental health services do so at the community level. That is an important point to make.

We have also touched on a degree of complexity in the interaction between the way in which assessment support can potentially be provided for children and young people who have a neurodevelopmental condition and the statutory responsibilities of education authorities to provide support, including additional support for learning, within the educational setting. That speaks to the point that Stephen McLeod made, which has been touched on a few times, about bringing to bear the data that already exists in the system so that we utilise it effectively to make sure that needs are being met.

Stephen McLeod: This takes me back to a period when the neurodevelopmental specification was a policy response to what we found when we asked why CAMHS was not delivering the national referral-to-treatment target. I think from the phrasing of her question that Elena Whitham understands that. Essentially, this is about unmet need and, as Mr Arthur has described, we need a response that is different from the traditional NHS waiting times response.

Under GIRFEC, support is provided universally and requests for assistance should then be made to draw other professionals towards that support and meet the needs of the child or young person and their family. It is a very different way of measuring what good looks like. That is the challenge for us, because it goes from a school and local authority level up to a national level.

I do not think that the approach that we have taken in CAMHS, as Mr Arthur has described, is the right one to measure success with the neurodevelopmental specification, but I was very pleased that we led on its development, because a group of young people were being referred to the wrong place—they had quite different needs, which were not being addressed.

Elena Whitham: Following on from that, it would be helpful to understand the impact on lists of implementing the national specification. We have heard from organisations and individuals in their written submissions that, once that was implemented, their young person—or they themselves—came off a list but did not go on to any other list. There is a direct impact for people on the ground that we do not yet have the data to understand. Is the work that you are doing as part of the task force—with boards and local authorities and their partnerships in schools—about understanding what implementation looks like on the ground for individuals in each of those areas? What does that data tell us about what the need is?

Tom Arthur: That is it in a nutshell—we are working to assess and understand the level of need and to ensure that we meet it. With the exception of situations where there is a comorbidity, CAMHS is not the appropriate pathway for a neurodevelopmental condition.

So that there is no doubt, I reiterate that I fully recognise the importance that is placed on assessment and diagnosis for a range of reasons, but there is a real opportunity for need to be met without diagnosis. Diagnosis should not be a requirement for needs being met, notwithstanding the points that the committee has taken in evidence and raised today about concerns that diagnosis has been used by authorities as a gate-keeping tool. That should not be the case. Needs should be met.

The point about the exercise that has been undertaken with health boards and local government is for us to utilise the data that is available so that we have a fuller picture of need. That can help us to ensure that the national specification is implemented and that need is met.

Elena Whitham: Where it becomes tricky for individuals at a local level is the fact that, for some people, it will be CAMHS that does the assessments once they get there. That feels a bit confusing. It will be confusing for someone whose child has come off the list that it is perhaps still CAMHS that eventually delivers that service.

Tom Arthur: Yes, but, again, in the development of our understanding, it has become very clear that there is a clear distinction between a mental health condition and a neurodevelopmental condition. They are distinct. A neurodevelopmental condition is not a mental illness or a mental health condition, but someone who has a neurodevelopmental condition, who also has a mental health condition, should be able to access mental health support in the way that anyone else would be able to. It is important that there is that point of clarity. As I touched on in my earlier remarks, there has been some conflict in the past, and that probably reflects the fact that there is evolving and developing knowledge and understanding as well.

Stephen McLeod: One of the outcomes that the task force needs to deliver is the clarity that people are looking for at a local level. I take Ms Whitham's point that some professionals in CAMHS actually work in the emerging neurodevelopmental pathways, which raises the question whether people understand that locally. As Lynne Taylor touched on earlier, other professions—such as AHPs and educational psychologists, who are a fantastic resource—could be trained to do that and are more available. Is that clearly understood locally? The answer is probably no, but the task force is working to help areas take a framework—we have called it a pathway—and implement that locally. Of course, that would need a communications plan, as well as work with partners so that families understand who they should ask for the right help.

10:45

Elena Whitham: My final question on data is on whether the Scottish Government would commit not only to collecting and publishing data on neurodevelopmental waiting times but to understanding the need in that respect. I am thinking of missing data sets such as gendered data and information on co-occurring conditions that it might be useful for, say, a GP to understand. They might have a patient who has been diagnosed as being autistic or as having ADHD, so they might ask, "What other things should I, as their general practitioner, be looking at? What other conditions are they presenting with?"

It is all about understanding what data we do not have. For example, we do not publish sexdisaggregated data in this space, and I think that we really need to start looking at that. Is the Scottish Government looking at that data issue as something that the task force could address?

Tom Arthur: When it comes to the work that we are taking forward on understanding data, I want to consider the opportunities for presenting it. I should caveat that with my previous points about the paradigm in this respect and thinking of CAMHS referrals in a traditional NHS waiting list context. Given the complexities and the range of interactions involved, that is probably not appropriate. Therefore, I do not want to make a commitment to the committee with regard to a particular mode or form of presenting data.

That said, I certainly recognise the strong parliamentary and public interest in ensuring the fullest availability of the information that is held, and I appreciate the work that the committee has undertaken and its engagement with health boards ahead of this inquiry in order to present figures that I think are important and which illustrate the scale of existing demand. Therefore, without committing to a specific form or mode of presentation, I want to assure the committee that, in respect of the work that is being undertaken, I am giving full consideration to how more robust, reflective and clear data can be presented and shared and ultimately, deployed and utilised to ensure that need is met.

Elena Whitham: Thank you.

Sandesh Gulhane: Following on from Elena Whitham's questions, I note that it has been reported that NHS Grampian does not have the ability to separate out neurodevelopmental cases from its CAMHS data and, as a result, it could not provide the current length of its waiting list, even if it wanted to. I have also been told by colleagues that NHS Lanarkshire's data, which was published in *The Herald*, is actually incorrect and that, when you call the board, you find that the waiting time is actually two years more than the two that had been stated. What is the Scottish Government doing to ensure that such basic data is being collected and published in a transparent way?

Tom Arthur: I am conscious of the points that have been raised and the comprehensive briefing that was provided by the Scottish Parliament information centre just before the inquiry was launched. Ultimately, health boards are responsible for such operational matters in their day-to-day work, but this speaks fundamentally to my point about the challenges that we have right now with data. Of course, this is not just an issue that we are considering in health boards; it is also an issue in local authorities and educational settings, and it speaks to the level of complexity that we are talking about and why a traditional NHS waiting times approach to publishing lists would not—

Sandesh Gulhane: Forgive me, minister, but my specific question was about NHS boards, which should have this data.

Tom Arthur: My point is that that is why we are having that level of engagement with health boards. We have previously written to all health boards about data, and we are collating and assessing what they have provided.

The important issue for me is ensuring that, in undertaking that work, we are utilising data that has already been generated, and any further data that has to be collected for the specific purpose of addressing need. That is the work that we are taking forward. I stress that I recognise the importance that has been placed on data and the variation that exists, which is why we are working with health boards to understand the data that they do hold and which can help inform any further action that we would want to take with regard to any national collection of data.

Joe FitzPatrick (Dundee City West) (SNP): Minister, in June, in the chamber, you re-emphasised the previous minister's commitment with regard to the Government taking forward legislation in this area. Can you give us an update on where that legislation is sitting and when we can expect to see draft provisions? That would be helpful to the committee.

Tom Arthur: I recognise the importance being placed on the proposed learning disabilities, autism and neurodivergence bill. I will not reiterate the points that my predecessor made with regard to the rationale for the decision that was taken, but I assure the committee that it is commanding my full attention and that I am engaging closely with officials on it. I cannot commit to any specific time, but the undertaking given by my predecessor to publish draft provisions still holds and is one that I will honour.

Joe FitzPatrick: It would be useful to the committee to get an update as things progress. Indeed, that would be helpful not just for us but for other folk with a personal interest in the matter.

One of the arguments for taking a bit more time over the bill than had been expected was that that would ensure the meaningful involvement of people who are most affected—that is, people with autism, ADHD or learning disabilities. How is that going? Are you managing to get that meaningful engagement? Are there plans to continue it?

Tom Arthur: Yes, I will undertake specific engagement with the panels that were established, but this is also a feature of my wider engagement with a range of organisations representing all the interests that would be affected by the bill. It has featured as a matter for discussion very frequently, and I want to assure the committee that I am actively engaging with people with lived experience on this as part of wider conversations pertaining to my portfolio. Moreover, further specific engagement is planned ahead of the publication of any draft provisions.

Joe FitzPatrick: That is very much appreciated. I was about to come back in when you mentioned organisations, but you then made it clear that you are including people with lived and personal experience. I think that that is very important, and it will be appreciated by the committee.

The Convener: I thank the minister and his officials for their attendance and evidence, and I suspend the meeting briefly.

10:51

Meeting suspended.

10:58

On resuming—

Subordinate Legislation

National Health Service Superannuation and Pension Schemes (Miscellaneous Amendment) (Scotland) Regulations 2025 (SSI 2025/259)

The Convener: Agenda item 3 is consideration of two negative instruments. Scottish statutory instrument 2025/259 makes changes to the salary earnings bandings of the employee contribution tables from 1 April 2025 to ensure that the tiering of pay bands remains in line with annual increases in the pay of members of the schemes. The instrument also delivers a number of other policy changes, as well as making a series of technical and miscellaneous amendments to the national health service pension schemes.

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 30 September and made no recommendations in relation to it, although it welcomed the fact that the instrument corrects errors that that committee had previously identified in a 2023 instrument. No motion recommending annulment has so far been lodged in relation to the instrument.

I put on the record that I am a member of the NHS superannuation and pension schemes.

If members have no comments, I propose that the committee does not make any recommendations in relation to the instrument. Are members content to note the instrument?

Members *indicated agreement.*

Sports Grounds and Sporting Events (Designation) (Scotland) Amendment Order 2025 (SSI 2025/262)

The Convener: SSI 2025/262 amends the list of designated sports grounds in schedule 1 to the Sports Grounds and Sporting Events (Designation) (Scotland) Order 2014 to reflect promotion to and relegation from the relevant levels of the Scottish football pyramid and any relevant stadium name changes. This is in the context of police powers in relation to alcohol-related and other controls at football matches.

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 30 September and made no recommendations in relation to it. No motion recommending annulment has so far been received in relation to the instrument.

If members have no comments, I propose that the committee does not make any recommendations in relation to the instrument. Are members content to note the instrument?

Members *indicated agreement.*

The Convener: Thank you. At our next meeting, on Tuesday 4 November, the committee will commence stage 2 proceedings on the Assisted Dying for Terminally Ill Adults (Scotland) Bill.

That concludes the public part of today's meeting.

11:01

Meeting continued in private until 11:38.

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