HEALTH AND SPORT COMMITTEE

Wednesday 25 March 2009

Session 3

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HEALTH AND SPORT COMMITTEE
10th Meeting 2009, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

Jackie Baillie (Dumbarton) (Lab)
*Helen Eadie (Dunfermline East) (Lab)
Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

COMMITTEE SUBSTITUTES

Joe FitzPatrick (Dundee West) (SNP)
Mr Frank McAveety (Glasgow Shettleston) (Lab)
Jamie McGrigor (Highlands and Islands) (Con)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

Dr Graham Bryce (NHS Greater Glasgow and Clyde)
Julie Burns (ChildLine)
Brian Cooklin (Stonelaw High School)
Mary Gallagher (East Renfrewshire Community Health and Care Partnership)
Dr Margaret Hannah (International Futures Forum and NHS Fife)
Joan Hoggan (Smithycroft Secondary School)
Rosemary Howe (West Lothian Council)
Kathryn Howieson (Home-Start West Lothian)
Susan Kayes (NHS Greater Glasgow and Clyde)
Jacqueline Kerr (NHS Greater Glasgow and Clyde)
Dr Elaine Lockhart (Royal Hospital for Sick Children, Glasgow)
David Milliken (Home-Start Scotland)
Heather Muir (Falkirk High School)
Benjamin Napier (ChildLine)
Graeme Rizza (Moray Council)
Ruth Stark (British Association of Social Workers)
Dr Philip Wilson (University of Glasgow)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

David Slater

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Wednesday 25 March 2009

[THE CONVENER *opened the meeting at 10:09*]

Child and Adolescent Mental Health Services Inquiry

The Convener (Christine Grahame): Good morning. I welcome everyone to the 10th meeting of the Health and Sport Committee in 2009. I remind members and witnesses to switch off their mobile phones and other electronic equipment. Apologies have been received from Jackie Baillie and Michael Matheson.

The first item of business is the committee"s child and adolescent mental health services inquiry. Members will recall that we agreed to begin the inquiry with a discussion about how young people who are potentially at risk of developing mental health problems are identified at an early stage.

Our witnesses represent a variety of professions and services that work with children. We have had biographies of them all. I would like everyone around the table to introduce themselves briefly, after which I will talk about how we will conduct the proceedings.

Brian Cooklin (Stonelaw High School): I am the headteacher of Stonelaw high school in Rutherglen and the immediate past president of School Leaders Scotland.

Jacqueline Kerr (NHS Greater Glasgow and Clyde): I am the health visitor and school nurse team leader for the Rutherglen and Cambuslang area, just outside Glasgow. I have a clinical and managerial remit and am also aligned to a learning community within the area.

Susan Kayes (NHS Greater Glasgow and Clyde): I, too, am a public health nurse team leader. I work with school-age and pre-school children.

Graeme Rizza (Moray Council): I am an area manager for children"s services with Moray Council. I am also incoming Scottish convener for the British Association of Social Workers.

Ruth Stark (British Association of Social Workers): I am a social worker. I work for the British Association of Social Workers and am also a safeguarder for children.

David Milliken (Home-Start Scotland): I am the Scottish director of Home-Start. We have 32 projects dotted around Scotland.

Kathryn Howieson (Home-Start West Lothian): I am senior co-ordinator with Home-Start West Lothian, which is a volunteer befriending scheme for families with very young children in West Lothian.

Joan Hoggan (Smithycroft Secondary School): I am a pastoral care teacher at Smithycroft secondary school in Glasgow, which is in an area of multiple deprivation.

Heather Muir (Falkirk High School): I am a head of house at Falkirk high school. That is just another name for a principal teacher of pastoral care.

Julie Burns (ChildLine): I am counselling supervisor at Childline, which is a national helpline for children to call about absolutely anything that worries them.

Benjamin Napier (ChildLine): I am the service manager with Childline. Until a year ago, I was a senior social worker on a children and families team in Edinburgh.

Rosemary Howe (West Lothian Council): I am group manager in social work in West Lothian Council and have responsibility for the early years service, particularly the sure start team.

The Convener: I thank everyone for their introductions. I know that the witnesses have been briefed on this, but I remind them that our investigation is in several parts. We are focusing today on how children and adolescents who are at risk of developing mental health problems are identified, how those problems should be prevented, what obstacles there are to identifying those children and adolescents and how those obstacles might be overcome—we are right at the beginning of the process. The witnesses may make remarks on other parts of the inquiry—they are highly experienced and their information is useful to the committee—but those questions will be the prime focus today.

I ask the witnesses to indicate to me if they wish to speak. The committee members will intervene as little as possible because we want to hear the witnesses" interaction with one another. If somebody says something with which a witness disagrees or to which they wish to add information, they should feel free to come in. I say to witnesses who have not given evidence before that it is a relaxed procedure. We would be delighted to tap into the witnesses" wealth of experience in this highly important inquiry.

I ask someone to kick off by discussing how hard it is to identify children whose mental wellbeing is potentially at risk.

Benjamin Napier: Perhaps that is where a service such as ChildLine is valuable. As a freephone helpline service, it is accessible to all children—it is available seven days a week and 24 hours a day. There are no barriers to what young people can contact such a service about. There are no parameters and no assessment is required beforehand; young people can phone up to talk to us about whatever problem they feel they may have.

Such a service provides the opportunity for any child with mental health problems to be identified early. They can phone up and talk to one of our volunteer counsellors about anything that might trouble them. From that, we might be able to identify whether there is the potential for any further problems to develop. If so, we will offer support through telephone counselling or support the young person into another service that may be more appropriate to their needs.

Such a universal service that has no barriers to access and is available 24 hours a day probably allows a good opportunity for young people to make contact.

10:15

The Convener: Can you give us an idea of the numbers and age range of those who phone ChildLine?

Benjamin Napier: The numbers are significant. About one and half million young people in the UK called ChildLine last year. In Scotland, 33,500 children received the counselling service last year—that is not the total number of calls—and talked in depth with someone. That does not quite meet the call demand, because about 30 per cent of calls could not be processed through to a counsellor, although they may have needed to be. A base in Edinburgh opened in September last year as part of a process to increase the number of volunteers in Scotland who can answer calls.

On specific mental health problems, it is difficult to categorise that exactly because young people call us about a range of problems. Taking some of those together, we could say that they constitute a degree of mental health problems. Certainly, there has been an increase over the past five years in the number of children who phone us about anger, depression or suicide—problems at the more extreme end of mental health difficulties.

The Convener: I asked about age range, too.

Benjamin Napier: We tend to get more calls from those aged 12 to 15, although there are many calls from children under 10, too. The age range goes up to 19; we tend not to counsel children over that age.

Julie Burns: One factor that enables children to call ChildLine and speak about mental health problems is our confidentiality policy. Children access ChildLine because they know that what they say will not go any further.

Joan Hoggan: Our first line in identifying pupils with potential difficulties is the transition information. In our school, the principal support for learning teacher collects that by interviewing pupils in the primary schools and meeting class teachers and headteachers. She gleans information, such as who has suffered recent bereavement, who is exhibiting the kind of behavioural difficulties that might come from emotional problems and where there has been an acrimonious family split. Our school nurse also helps us to identify pupils who might be in need. She usually works with the learning community, so she will know families where there are difficulties and perhaps mental health problems, and be aware of a number of the youngsters coming up to secondary school.

Brian Cooklin: The important issue in identifying children with mental health problems is that we provide as many opportunities as possible for them to be identified or to self refer. Our major worry in school is that children slip through the net or that we do not find out about the problem until relatively late. It is important to understand that we have a patchwork quilt of different opportunities. In school, there are excellent pastoral care, pupil support or guidance systems—they will be under different titles—as a port of call. More important, however, is that the school nurse, or the school counsellor in my school—we currently have a pilot scheme—is another resource to which children can self refer.

Frankly, however, we cannot provide enough opportunities for children, because it is a question of where they will place their trust. We have worked closely with ChildLine, which has trained some of our pupils as peacemakers in the school to offer help to other children in the school. That is an important resource, but there is no package of resources. As far as children are concerned, the difficulty is that the resource situation is fragmented. They often have only limited access to services and resources and it is a hit-and-miss affair regarding what is available in any given school. It is just a matter of luck if a child happens to be in an area and school that has an array of opportunities. That is a major concern across Scotland.

David Milliken: We are in a slightly different position because we deal predominantly with families with children aged under five. The children are not as capable of identifying issues, particularly those to do with mental health, so it throws up some different issues. A lot of parents are depressed and are having difficulties with their children, so we work in a way that encourages the parents and the children to bond and establish a more successful relationship. By supporting the parents, we help to support the children and enable them to bond with their parents, which allows them to be more successful in later life—or at least limits the difficulties that they may face.

In terms of access to the service, we are fairly dependent on health visitors identifying families in which there are difficulties. We have some concerns about the health visiting profession in relation to the number of health visitors who are being trained and, therefore, its ability to refer families to us appropriately.

Heather Muir: Without a doubt, the first line of guidance in any secondary school is now in the format of having form tutors who build a positive relationship with the kids. The pastoral support is there in secondary schools, but when it comes to identifying children whose mental wellbeing is at risk, it is about trying to tap into resources. A wee bit more expertise might be needed and tutors have not necessarily had any training. When we are dealing with vulnerable young people—kids with anorexia, bulimia or depression—we want to tap into resources and bring in people who specialise in that area, but it very much depends on what is available at the time and how many kids in the authority have similar issues. We might find that the expertise is not available, depending on how many other kids are needing it.

Susan Kayes: I work as a public health nurse team leader in the Cambuslang and Rutherglen area. We are working within integrated children"s services, so I work with a range of other agencies. There is a lot of information sharing, but it is appropriate information sharing. For example, we work with senior social workers, education colleagues and drug counsellors. We also get information from accident and emergency departments and we link with general practitioners and nursery staff. A wealth of information is passed on to us about ranges of domestic violence and concerns about Asperger"s. One really good thing is that home visits will be instigated when children have a poor attendance record, and we can sometimes find that the parents or children are suffering from mental health problems. Working in an integrated setting has the real benefit of sharing information and knowledge on families and children.

Graeme Rizza: We seem to be seeing an ever-increasing number of chaotic families and children living in chaos, which results in the children"s behaviour being quite chaotic. The challenge for us is to differentiate between young people who are suffering from mental illness and children who are living in chaos. A lot of time is wasted and opportunities are lost, or at least delayed, as we try to work through what is chaos and what is mental illness.

Rosemary Howe: We need to go much further back in trying to prevent mental health problems from occurring. We know the importance, in the first few years of a child"s life, of their forming stable relationships or attachments and developing resilience. We need to place more emphasis on helping vulnerable parents to understand the importance of the first few years and develop much more robust parenting interventions for groups. In West Lothian, we have a particularly well-developed project for supporting teenagers not just when they have had their babies, but prior to that. We run a 12-week antenatal course, developed by sure start workers and midwives in conjunction with the young people, that focuses on what will make a difference for those teenagers and what their needs are. The course is very much about developing the teenagers" confidence in their ability to parent their child and to understand what their child"s needs are. The programme runs over 12 weeks, but the girls can attend more often—even for 24 weeks—if they like. They are also helped to develop peer support. The girls" increased confidence in knowing what their babies" needs are means that we are preventing mental health problems for those babies in their later lives. We also know that there is a high incidence of post-natal depression in teenage mums, so by providing support before birth and continuing that support after birth, we almost get two for the price of one.

We need more services, and they must be non-stigmatising. Key to our work is that any teenager can come to our courses. It is not the case that we stigmatise people or identify someone—who probably already has low self-esteem—as particularly vulnerable and needing to be referred; that can just reduce their confidence even further.

Jacqueline Kerr: I work as a health visitor and lead a team of health visitors and school nurses, so I think that it is worth letting people know that health visitors have regular contact in the early weeks after birth. We have weekly contact for the first six weeks and we use our post-natal depression tool twice—at around six weeks and then at around three to four months. We have quite a lot of contact in those first three to four months. In that period, the health visitor will decide which families should be taken in her intensive case load and which should be in her additional and core case loads. The intensive case load is the biggest part of the health visitor"s work because it includes cases involving child protection issues, chaotic families and families with conflicts.

The difficulty is that health visitors have really big case loads—they deal with many child protection cases, which can often overtake much of their other work—so, after a period of time, they are really reliant on parents to make contact if any problems arise. Health visitors tend to work with those families with intensive needs. Certainly, information on children from those families who are more vulnerable and more likely to develop mental health problems will be passed on to the school nurse. We have good links to ensure that, once the child is five, the information is passed on to the school nurse so that she is alerted and can follow through on any issues with the family. However, because health visitors have such large case loads, they cannot see lots of children regularly and must focus their work on families with intensive and additional needs.

The Convener: I am sure that committee members will ask you to develop some of those points further.

Kathryn Howieson: I agree with both previous speakers that it is absolutely crucial that we support parents before they have their children and when the children are very tiny.

The families that we support come mainly—99.9 per cent of them, I would say—from referrals from health visitors. The majority of those families have some type of depressive illness, such as PND, bereavement, sadness, grief, anxiety and all sorts of things. Parental depression is a massive issue and has a massive effect on parents" ability to parent or raise their children. It also has an effect on the child"s early years, which are crucial.

Home-Start is in a unique position, in that our volunteers, who are parents themselves, are trained and carefully selected to be matched with those parents. The volunteers can offer reassurance, advice and signposting and are there for as long as the parent needs them to be there. The volunteers are in a unique position to be able to help parents in an informal, non-stigmatising and non-threatening way, which is absolutely invaluable. We work with other agencies in order to identify when things might be taking a turn for the worse or going wrong such that extra support is needed. We can signpost those parents on to other organisations, such as sure start and other agencies.

I should also say that some kind of counselling service for parents is badly needed. In West Lothian, we could do with a lot more individual and generic counselling for parents.

10:30

Joan Hoggan: From the secondary school perspective, I endorse all the previous remarks. We might see teenage boys who have real problems with impulsiveness and anger management as a fairly typical group. There are often family splits in their histories. Often, there was domestic violence when they were young. Their emotions have become confused; their fear and anger have got mixed up. That can be identified, but they may not suffer from a mental illness. However, they may become abusive partners because of their lack of understanding of their emotions.

We have found that resources such as emotional literacy groups work quite well for such youngsters, but there is not enough group work, which is more user friendly than one-to-one work for teenage boys. Some teenage boys can cope with working with a school counsellor, but for others, speaking about their feelings is too verbal, too difficult and too girly.

Brian Cooklin: Perhaps I part company a little bit with Joan Hoggan on that last comment. I am not convinced that the emotional literacy approach is working. I flag that up because sometimes we are keen to find solutions to problems and we may therefore grasp at straws. There is no evidence that emotional literacy programmes necessarily address what we want them to address.

We must bear it in mind that we are dealing with a wide range of mental health issues. So far, we have rightly focused on the parental aspect, but parental depression, for example, often throws up other issues. Children can become the main carers for their depressed parents and will then have to cope with stresses. Young people can be under stress because of exams or parental expectations about how they want them to do in exams, for example, and that stress may manifest itself as another mental health issue.

I agree with what has been said about teenage boys. We have had and currently have a high teenage male suicide rate in Scotland, which schools and health bodies have tried to address. A significant amount of work has been done in conjunction with countries such as Australia, where a similar problem exists. People there are dealing with the problem by trying to raise awareness.

Training is a critical issue. It would be helpful if we could incorporate in initial teacher training an understanding of mental health issues and a child"s development. At my age and with my long experience, I have heard that said and have said it myself often enough, but I have not often seen the desire coming to fruition. More cross-sectoral and joint training would be even more helpful so that people would understand what social work, health and education services could do other than act separately and then come together to share thoughts in meetings. We often say that, but I have not seen such training happen.

Ruth Stark: I want to raise three issues. First, as social workers, we often deal with the most distressed and distressing children, because the systems lead them to our care. Every social worker who works with children and young people will be aware of substance abuse, which has not yet been mentioned. Young people find substance abuse to be a way to kill the pain, whether that comes from emotional distress, psychiatric illness or whatever. The use of substances to kill such pain is a really big issue for us to work on with children and young people.

The second issue is that some children really do need specialist services. I have safeguarded for a child who was diagnosed with Asperger"s syndrome. In her teenage years, she developed schizophrenia, which can be associated with that in adolescence. She had to go to Newcastle for help. I thought then of the poor resources around for children and young people who need very specialist services. Provision in Scotland is too haphazard. We have no overall scheme to meet the needs of those young people.

The third issue arises from what I have said and picks up on something that Graeme Rizza said. Distressed and distressing children whom we work with are often in chaotic circumstances. Very often, health services and special units will tell us that they cannot offer any treatment for a young person until they are settled, but when they are settled, we have done the work. It is a bit of a chicken-and-egg situation. We might refer a child for specialist resources, but there is sometimes a reluctance among the specialists to pick up the case at the time when the young person actually needs their help and when we as professionals need guidance from them. Those are three big issues.

The Convener: I know that a lot of committee members are itching to ask supplementary questions. If members could make them crisp, I may allow a whole lot of them. We will see how it goes. The witnesses will all get in again.

Mary Scanlon (Highlands and Islands) (Con): I do not really have a supplementary question. The submission from the University of Glasgow section of psychological medicine states that there

> "may indeed be critical and/or sensitive periods for social and emotional development after which the opportunity for change may be lost."

That is my concern; I know that I have raised it before. On health visiting, there is a lot of good practice in the organisations represented here—West Lothian is held up as the best example in Scotland for so many things—but I know that that is not the case for all Scotland. Although some people around the table might say that they have a great service in their area, I am quite frustrated because I know that that is not the case in Highland.

My granddaughter, who is now 2, got her MMR at 15 months. At that point, the family were told that she was to come back for her next health visitor check when she is 5. That is not right at all.

I also have three friends who work in nurseries. I asked them what their connection was with health visitors and what they should do if they felt that there was a problem with a child. I was told that there was a phone number on the wall but that in 10 years they had never seen a health visitor in the nursery. Although there is excellent practice in Lanarkshire, you should not assume that that is the case everywhere. Health visiting has fallen by the wayside. I was very much at one with what Rosemary Howe said.

Some children are dismissed from school because they are disruptive because they have attention deficit disorder or attention deficit hyperactivity disorder. When they are dismissed from school, they do not even get home tutoring. They cannot get help and support unless they are in school. It is horrible; we are simply not supporting people.

So many people have mentioned parental depression. Many parents are depressed because they do not know how to discipline their child. That might include middle-class parents—middle-class people do not have all the answers—who need a bit of help and support and advice from health visitors but do not get it. They do not get a decent night"s sleep and they do not know how to discipline their child, which often leads to marital break-up. I am not saying that that is the only problem.

I think that Susan Kayes said that parents know who to contact if there is a problem. Forgive me, but, let us be honest, some of the people involved in the very high-profile cases that have been in the news recently were not going to phone up the health visitor and say, "I"ve got a bit of problem. Can you come and give me support and advice?" Given that it has been in the news, I cite the case of Brandon Muir.

The services are great when a child is 12. If the services are that good—the Falkirk one sounds good—why are 33,500 children phoning ChildLine? That is what has angered me this morning. ChildLine is a wonderful service, but the large numbers who are phoning it are an acknowledgement that some children"s problems are not being picked up elsewhere. The problem is between the ages of zero and five. That is where we are missing the opportunities.

I have got that off my chest. I will leave it out there.

The Convener: I am glad that you got that off your chest, but I am trying to work out how to manage my list. I have written down the many topics that you covered. I invite Richard Simpson to ask his question now.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I will be brief. We need to start with early intervention and identification. We dealt with the secondary bit then came to the primary bit, but we need to focus a little on the very early stuff. The Scottish needs assessment programme group"s report says that 10 per cent of children suffer from a mental health problem, which is different from psychological distress, which the report says 33 per cent of girls were reported in 1999 to have experienced in their childhood.

Are we picking up the predictive factors—the risk factors? Before or by the time that every child reaches nursery school, do we list all the risk factors, such as a learning disability, epilepsy, a history of physical, emotional or sexual abuse or of neglect, witnessing domestic violence and a family history of mental illness? That list is not exhaustive.

If we do not identify children in that group at a very early stage, we will not pick them up and, as Mary Scanlon said, they will become disruptive in school. Such children are being identified as having an illness, although I am not sure about autistic spectrum disorder and ADHD, because the diagnosis seems to have expanded and I am not convinced that we are diagnosing conditions properly. I suspect that we are in the expansion phase and that we will shortly enter the contraction phase, when we will return to a much tighter diagnosis. However, that does not alter the fact that children who are labelled as having ASD or ADHD have problems—they are disruptive or unable to concentrate and they are a problem in school and end up being excluded.

My question is simple: are we doing enough to identify parental and childhood stuff early, so that we can focus our always-limited early years resources on the group concerned?

Ian McKee (Lothians) (SNP): I look forward to hearing the answers to the questions; I have learned much from what has been said already.

I have a specific question that I am interested in being answered. The Sexual Offences (Scotland) Bill, which is progressing through Parliament, will criminalise for the first time girls who are aged between 13 and 16 who engage in consensual sex. The bill will protect people who give such children advice if they do so for a child"s emotional welfare or to avoid pregnancy. I know from my experience as a general practitioner that precocious sexual activity presents as part of many mental health problems. Are the witnesses, who operate in the field, reassured by the fact that the bill will provide cover for people who give genuine advice? Are any problems likely? I have heard mixed reports from people to whom I have spoken.

Ross Finnie (West of Scotland) (LD): I hope that one element will be developed a little more. I am not surprised that many have mentioned the importance of parenting, which is a recurring theme. Sadly, it is also something that we as politicians tend to grab and which becomes a headline for a fortnight and perhaps part of an election campaign, after which it disappears.

I hope that those who have talked about parenting, or others, will be more specific. We talk in vague terms about helping with parenting. When I was a local councillor, efforts to do that were made in the Greenock and Port Glasgow area but, to be frank, they did not succeed. We never grasped what we wanted to do. We had a general idea but no one, not even some of our social workers—I say that with respect—said what we should do. That happened many years ago. Parenting is important and links in with the very early intervention to which Richard Simpson referred.

The Convener: Members have raised a range of issues, which I am trying to keep neatly in topics for reference when we produce our report and take further evidence. I thank Richard Simpson for making a distinction—I hope that I describe it properly—between a mental health diagnosis and psychological distress that might relate to parenting or a diagnostic mental illness. We accept that distinction.

Let us will start with the broadest topic, which is parenting, picking up on Mary Scanlon"s point that class differences could be involved. Perhaps the witnesses could deal with that first. I realise that that might be quite difficult, but after we have dealt with parenting we will move on to everything else that people have raised. There may be some crossover with the role of health visitors, which Mary Scanlon also touched on, which is fine, but the main topic now is parenting and how we are dealing with the issues that have been raised around the table. How much of a role does parenting play, and what assistance should Government consider providing?

10:45

Heather Muir: We have talked about resources. Mary Scanlon mentioned, for example, that there are more resources for 12-year-olds and that the Falkirk example is great. Personally, I do not think that there are enough resources for 12-year-olds, and neither are there enough resources for parents.

As pastoral staff, we are in the job because we want to help young people—that is what the heart of our job should be—but I have had parents coming to me for help. For example, when a young boy died tragically in a road accident, the whole family, including the boy”s two younger brothers who were at the school, needed support. At that time, nobody other than me knew the kids and had a genuine interest in the family, and I could not tap into resources to help any of them. I found myself searching on the internet to see what else was out there. I got in touch with organisations such as Cruse Bereavement Care, but the waiting list was so long that the family had to wait a year to get any help. That is just one example of a really vulnerable family. Personally, I do not think that the resources are available—

The Convener: Can you clarify whether there was a waiting list for Cruse or a waiting list per se?

Heather Muir: It was for Cruse. I found myself thinking, “Surely there must be something else. I must be missing something.” I could not find any support for the young people. That is just one example out of many.

We love our jobs—I do not want this to sound like a moan about having too much to do. Supporting young people should be at the heart of our job, but other things take over that are not fundamental to the health and wellbeing of the young people whom we should be supporting, which is frustrating.

There has been an increase in raising awareness of mental health issues, which is fundamental to enabling young people to say that they have a concern or that they need to speak to somebody, and that has played a huge part in encouraging young people to disclose their concerns. In social education, a lot of time is now spent on learning that a person”s mental health is just as important as their physical health. A lot more has been done on that over the past three years, which I hope will have a positive impact.

There is still frustration, though, at the fact that whether we can help a young person who is in front of us and needs help is pot luck, based on our resources, our contacts and whether we have got in there before somebody else. That is wrong when we are talking about the health and wellbeing of a young person.

The Convener: Thank you. That was useful, but I would like to hear about parenting. I appreciate that your example involved a whole family, and I know that this is difficult, but I would like to nail things down about the need to provide assistance earlier. That would tie in with the early risk factors that Richard Simpson mentioned.

Susan Kayes: There are ways of assisting staff in undertaking a range of work to promote good parenting, such as baby massage to promote a close bond between the mum and the child, which is crucial. We also have a first-time parents group. When someone becomes a parent for the first time, they might not find themselves in the idealised situation that they imagined. The group addresses real and practical issues about how to raise and care for a child and child development.

The vulnerability of teenage mums has been mentioned. We have a teenage mums group, which provides kind of a two-tier hit. We support vulnerable young mums who are often known to social work services. The group has a good record of preventing children from being taken into care, which is another risk factor for the children of teenage mums.

Lanarkshire NHS Board has introduced a first steps worker programme, which allows workers to work with children with additional or intensive needs who are part of the health visitor case load. They discuss with parents how to create routines in the family home, how to play and interact appropriately with their child, and how to develop their child. They also work closely with the family centre on a range of issues, such as teaching people how to cook. A vast range of work is being done on parenting. We try hard to target the most vulnerable people, but there are always people who do not engage as well we would like them to.

Ruth Stark: I have two points. First, social work skills are not being used effectively in the community, because we are too bogged down in bureaucracy. That issue is being dealt with in other places, but the committee”s support in emphasising it would be helpful. Social workers are trained to be there for families that are going through a bereavement process, and we should be allowed to do that work, but it is difficult for us to find the time for it. It is important for us to be released from bureaucracy.

The Convener: What bureaucracy would you like us to ditch?

Ruth Stark: The report writing. There are often eight different sets of assessments and reports for children, such as reports by education departments, social work departments and health departments. If a child is away at a residential school or a care home, there is another set of reports. There is huge duplication of work—the process needs to be streamlined. We know that we must tackle the issue as a profession. I hope that we are in the process of doing so.

My second point relates to some of the difficulties that Mary Scanlon and Richard Simpson highlighted. We are talking about two different types of family, and we must be careful to distinguish between them. Some families and children seek help, but in other cases, such as that of Brandon Muir, we must get beyond the door. Being a social worker who must knock on people"s doors in order to get access is a skilled job. We should support people to do that. We must have services for those who seek them, but we must also have services for those who do not readily knock on our door.

The Convener: What inhibits you getting beyond the door? An ex-social worker gave a graphic description on the radio—I do not know whether you heard it—of the difficulty in accessing a home in which the mother was a drug addict. A chap was there, too, but a two-year-old answered the door. What statutory restrictions do you face?

Ruth Stark: They are enormous. I have stood outside a door with a policeman, trying to get access to a family. We had to get a warrant and so on. Fortunately, there was a piece of burning toast, which was a fire hazard, on the other side of the door, so we had to go in. We were worried that we would find a dead child and a dead mother on the other side of the door.

There are inhibitions in our work. We must proceed legally—we cannot enter people"s houses without sanction from a court—but there are times when we find ourselves in very difficult circumstances, just because we are trying to make contact. We do not want to be seen as those nasty people from social work; we want to establish relationships with people so that we can continue working with them. However, dealing with situations in which the door is closed and we are left wondering about what is happening on the other side is sometimes difficult.

Joan Hoggan: I endorse Ruth Stark"s comments. Parental non-co-operation can be one of the real obstacles to young people getting specialist help when they need it. A referral for a possible specific difficulty may be made to child and adolescent mental health services by a GP, a school or a school nurse. An appointment will be offered, and if it is not kept another will be offered. However, if the parent does not support the young person to go to the clinic, there is a cut-off point. The clinics are already hugely overstretched; the waiting list is very long, perhaps a year and four months, unless a person is suicidal or self-harming.

Shame, embarrassment and guilt can all prevent parents from seeking help and can prevent children from speaking out freely. Children who are experiencing abuse are in a very ambivalent position: they feel loyalty and love towards their parents, but also distress and confusion. Such conflicting emotions can lead to mental health difficulties.

Ironically, knowledge of child protection procedures might be a deterrent. All sorts of myths are flung around; for example, parents might threaten their children that they will be taken into care. Often, the heart of young people"s mental health problems is never reached because they are afraid of confiding in people. It might be easier for them to confide in a confidential setting such as ChildLine, but young people might not go any further if they are afraid of possible consequences for their family.

The Convener: Thank you. Did Kathryn Jamieson want to contribute? I am sorry—Kathryn Harrison. Howieson. I am sorry, I cannot read the clerk"s handwriting.

Kathryn Howieson: Do not worry—I can change my name. I do not mind.

I want to make a point about parenting. We have been talking about services for parents and early years services. The majority of parents who access our service for help are mothers. In the families that we support, it would be lovely to be able to engage the father in the family, and to support him if he needed or wanted that. I sometimes find it very frustrating that we are not able to talk to the father. In West Lothian, we offer some support to the fathers of very young children, but—correct me if I am wrong—often when we say “parents” in discussions such as this one, we are really talking about mothers. Where are all the young fathers in our discussions? They, too, need help, support, encouragement and advice. They need education about being a male parent.

Graeme Rizza: I very much agree with those points about absent fathers.

One of the fastest-growing groups that we are working with—or, rather, that we are coming in contact with—is drug-using parents, especially drug-using young parents. That point has begun to be acknowledged in some press coverage following the Brandon Muir case. We need to take a more robust approach to access, and we need a greater understanding of what drug abuse means and what it means to be a drug-abusing parent. We need to examine the extent of the problem.

As Ruth Stark suggested, there are two categories—the engaging parents and the non-engaging parents. Parenting and chaotic drug use do not mix. We need to be more robust about our access to children with non-engaging parents when there is clear evidence of drug use.

Brian Cooklin: Graeme Rizza is quite right to raise the difficulty of getting a handle on the size of the problem. So far, we have only scratched the surface. We do not know the half of it.

I have a lot of experience of parents sitting in my office—both male and female, because schools often work with both the father and the mother, if they are there—and saying to me, “I am sorry, Mr Cooklin, but I can”t cope.” They then ask whether there is anything that I can do with their son or daughter. It is a plea for help, but it is also an indication that the support networks that used to be available, in families and communities, are no longer available.

We are focusing on the negative, but I often think that we need to turn the issue on its head and ask, “Where are things working and why are they working?” I was interested to read research about a part of Harlem in New York where the average age of grandmothers is 28 and no male role models are available at all. The focus of the research was on the children who succeeded. There had been a great deal of research on the children who had failed, but research was done on those who had managed to survive that situation. I cannot summarise an entire research paper, but it boiled down to two things: first, the fact that the children who survived and succeeded had at least one adult somewhere who had taken a committed interest in them; and secondly, those children had built up resilience. Since I read that a number of years ago, I have committed myself to trying to build up resilience for children. It is not easy, but it is the approach that we need to take.

Parenting can be completely chaotic and dysfunctional. In the case of one child I dealt with, the most stable situation that she had been in was being looked after by the parents of her mother”s last boyfriend. However, I had to report that to social work, because those people were not related to her. Another child came to me in trouble and admitted when I questioned him that his parents hated him and that he stayed with an aunt on a Monday, a gran on a Tuesday and a neighbour on a Wednesday—the boy was never in the same house two nights running. However, we did not know that because, on the face of it—at the parents evening and so on—everything about the parents looked okay. That is why I agree with Graeme Rizza”s point about identifying the scale of the problem that we are trying to deal with.

11:00

Jacqueline Kerr: On the topic of substance misuse, we are seeing many more children being looked after by their grandparents. It has become a huge part of our work. I have got families in which the mother and gran are addicts, and it is the great-gran, who is in her late 70s, who is looking after young children in difficult circumstances. Those children”s parents, who are drug misusers, often come in and out of their lives, causing havoc and chaos. There is not enough support for those great-grandparents.

I want to pick up on a point that Mary Scanlon raised. Health visiting has changed considerably since the advent of Hall 4. Our surveillance system has changed. Previously, we used to assess children at six weeks, eight months—

The Convener: Will you tell us what Hall 4 is?

Jacqueline Kerr: Sorry. Hall 4 is a report—”Health for All Children 4”—about child health surveillance and how we assess children. After Hall 4, we had to change the way in which children were assessed. Prior to Hall 4—up until four years ago—children were assessed formally at six weeks, eight months, 22 months, 36 months and pre-school. All children had all of those formal assessments.

After Hall 4, it was decided that we would work more intensively with families in the very early weeks, and that every child would have a six-week assessment. Only the children in our additional and intensive case load would have a two-year assessment. After that, there would be no formal assessment. That is practised throughout Scotland. Many health visitors have been unhappy with that, because they now rely on parents coming to them or to their GPs with problems, and their work is much more focused on those intensive cases. There are many other families in which children will probably develop problems, but if the parents do not realise that there are problems, the health visitor will not be alerted and will be unable to offer help and support. Most children now have nursery places from about three years old, so we are relying on nurseries to alert the health visitor.

The Convener: When I had my family—which was many years ago, as you can guess—it was quite useful for the health visitor to come in and give you confidence. That was an important role—”You”re doing this right.” No matter your age, with a first child you are in a bit of a tizzy.

Helen Eadie (Dunfermline East) (Lab): I think that we received 76 submissions to our consultation exercise, which the Scottish Parliament information centre used to create a helpful briefing paper for us. All the responses echoed what you have been saying about harsh and unsympathetic treatment by parents. The SPICe briefing highlighted an interesting American scheme:

> “The Nurse Family Partnership is an American example of a successful prenatal and postnatal home-visiting programme which involves two years of home visits and is currently delivered in 23 states to approximately 13,000 low-income, first-time mothers. Several evaluations have reported benefits for newborns including a 46% difference in reports of child maltreatment and improved health and social outcomes for the children also extend up to the age of 15. The programme is now also being piloted in Germany, the Netherlands and in England”.

The briefing is exceptionally good, because it also gives many examples of good practice from

Germany, Sweden, Northern Ireland and Wales. We ought to consider those examples in the course of our inquiry. Are others around the table aware of examples of good practice from around the world that they would like to be piloted in Scotland? Obviously, that is something that will form part of our recommendations.

The Convener: Before we come to that, I would like to rattle through the list of other questions to see whether we have missed anything.

I think that we have dealt with the question of health visitors. The answers on that were helpful. The issue of exclusions was mentioned with regard to sin bins for children and how that sort of thing can mean that people have given up on those children. We might want to talk about that some more. The problem of who to contact was raised—I think that Mary Scanlon pointed out that people are not clear about who to contact, even if they are not hiding anything. Someone might want to pick up on that. We have dealt with the risk factors to some extent. Have we covered that to a sufficient extent, Richard?

Dr Simpson: I think so, yes. The other important issue was substance abuse. We have partly dealt with that. When I left the Parliament in 2003 and went to Glasgow, no one in the drug services there was specifically identifying children in families with drug problems. It was not being recorded in our case notes at all. Glasgow has probably got the best connectivity between social work and health visiting in the country but, at that time, the specialist service and social work had no connection. However, the situation has improved enormously since then.

We know that there are around 50,000 children in families with drug problems and probably 70,000 to 80,000 children in families with alcohol problems. Given that there is a considerable overlap between those two groups, there might be around 100,000 children who are living in families that are substantially chaotic and for whom there really are no co-ordinated services.

Sorry, I am making a speech.

The Convener: I am delighted that you chose to do so. I think that we will ask whether there could be an improvement in the data that are available to the Parliament—the committees and the individual members—and the Government, against the background of children who do not want to tell. That is one of the issues that you raised.

On the Sexual Offences (Scotland) Bill, I will raise the point about protection for agencies that deal with even consensual sex between 14 and 16-year-olds. Do we feel that sufficient protection is in place?

Ian McKee: I think that the bill might cause children to be inhibited about going to guidance teachers or other teachers for advice. Recently, *The Scotsman* reported a case in which a 16-year-old talked to his teacher about something, and the teacher had to report him to the police, and the issue ended up in court. That will put other children off—

The Convener: You said that, in your experience in this area over many years, there was a connection between mental wellbeing and precocious sexual activity.

Ian McKee: Yes, absolutely.

The Convener: Anyone can talk about any of those areas, including the issue of good practice, which Helen Eadie raised. If there was one thing that you could ask us to do, what would it be? I know that it is unfair to ask you to make only one suggestion, of course.

Benjamin Napier: We have talked a lot today about identifying problems at an early stage and about access to services and barriers to services. Front-line services are responsible for the delivery of those services; they cannot be solely responsible for the identification of the problems as well. We need to acknowledge the responsibility of the community and the family in that regard. That has been lost in our society to an extent. There needs to be a greater emphasis on encouraging families and people in communities to take greater responsibility for their neighbours and young people around them.

Government ministers and the media have contributed to the problem, to an extent—they have certainly allowed the situation to continue—because they bay for the blood of front-line professionals whom they see as being responsible for making the mistakes in some of the cases that you talked about earlier. However, every one of the children in those cases had extended families and neighbours in the community around them. Those people could have taken responsibility for identifying problems and offering support.

You mentioned that health visitors used to offer people support about the things that they were doing right, convener. To some extent, people in our communities could be doing that for their neighbours or younger family members. It does not always have to come down to front-line services. The more we expect the responsibility to lie with the front-line services, the more we move away from encouraging people in our communities to take on that responsibility and the less likely we are to try to educate them about how they can do so.

On the issue of barriers, you are correct to say that things such as the Sexual Offences (Scotland) Bill might make people fearful about what the consequences will be if they approach services. People who might want to refer a family to services might be fearful about the consequences for themselves, and people who are accessing services might be fearful about whether, for example, other agencies will be involved.

The sharing of information between agencies can also act as a barrier because some people are scared that if they approach a service, social workers might come to their house or other agencies might get information about them.

There are no clear answers to the questions in this area. All that we can say is that agencies have to continue to be imaginative about how they approach their services. They cannot stick to criteria in deciding which people will be referred to them and which families they will work with. They need to continue to challenge the service that they provide to determine whether it is meeting the needs of the people in the community. They also need to think about whether they can break down some of the barriers that exist in order to deliver services to some of the people who might otherwise not receive them because they do not fit into a certain category.

On education, it is disheartening to hear that, when people go on the internet to refer something to services, they are not getting access because of waiting lists. However, people in schools, health visitors and other people who deliver services to families have core skills that would enable them to deliver bereavement counselling and so on. People in those agencies should take a little time to train a group of other professionals who can then go out and deliver those services. We do not need to hit the gold standard of service all the time; we simply need to use enough of people"s core skills to ensure that they can help families a little bit.

The Convener: That was helpful.

Ruth Stark: On the Sexual Offences (Scotland) Bill, I would say that anything that criminalises people under the age of 16 is inappropriate. The United Nations Committee on the Rights of the Child has criticised Scotland about other aspects of the way in which we label our young people. I do not think that it helps to criminalise young people at an age when they are struggling with sexual emotions and relationships. At that point, they need to be given access to help rather than being stigmatised.

I cannot remember the second thing that I was going to talk about.

The Convener: It will come back to you.

For the record, I should clarify that you are talking about not criminalising consensual sexual activity between people under the age of 16. Obviously, as we all know, if it is not consensual, it is a criminal offence.

Ruth Stark: Yes.

The Convener: You can come in again later in the discussion when you have remembered what you were going to say. That happens to me all the time, as the committee members well know.

11:15

Heather Muir: I, too, want to touch on the issue of sexual health. When an underage person discloses information to a teacher about their sexual activity, that teacher has to follow child protection procedures. As teachers and as people who want to support kids" health and wellbeing, we are put in a difficult and frustrating position; after all, because we have on-going daily contact with these kids, we might well be the closest to them.

We are also quite vocal in trying to ensure that kids do not put themselves in a certain position without being aware of it. We can tell kids about the resources that are available and talk to them about issues such as sexual health and substance abuse—as we do with first years—but, even in social education, we have a responsibility to let them know that teachers are different from other agencies and to make clear what will happen if they disclose personal information that we think shows that they are at risk.

The Convener: In what way are you very different from other agencies? I do not quite follow your point.

Heather Muir: If a young person wants to disclose that they have had unprotected sex or express concern about their sexual health, they can go for advice and support to their GP, the family planning clinic, Caledonian Youth or other places without necessarily being afraid that their parents or social work will be contacted. However, if a young person tells me that, for example, they did something at a party that they should not have done, child protection procedures instantly kick in.

The Convener: So you have a statutory obligation.

Heather Muir: We have a statutory obligation to contact social work, which might tell us that we have to contact the parents. That puts us in a difficult position. A young person might have done something that they regret or have had a difficult experience but, even though we are quite often the only ones to have daily contact with them and to support them within and outwith school, we cannot discuss the matter with them because of our statutory obligations.

Ian McKee: So you say to that young person, “Don”t tell me anything more.”

Heather Muir: If they disclose anything to us, we need to follow child protection procedures. When we talk about sexual health, substance abuse and their care and wellbeing, we have to tell pupils from first year onwards that teachers are quite different from other agencies. We have had cases in which a young person has disclosed something and sought assistance, help, advice and support, only to find to their horror that we have had to share that information with others. Kids can ask for general advice on an issue, as long as it is clear that they themselves are not in that position. Even though we might need to provide one-to-one support to young people, we might not necessarily know what has happened.

The Convener: It would be unfair of me to ask you to speak on behalf of the profession on whether that should be changed. Nevertheless, you have raised an interesting point.

Brian Cooklin: Heather Muir has highlighted a difficulty that many teachers face regularly and which is partly to do with the different protocols in operation. The school nurse, for example, might advocate that we do something to reduce the incidence of sexually transmitted diseases or tackle the issue of teenage pregnancies. In suggesting, for example, that condoms or the morning-after pill be offered to any child who asks for it, they are rightly operating under their own protocols. However, such suggestions immediately ring alarm bells in schools, because our role is always in loco parentis; in other words, we can do nothing without parental consent. We cannot have a situation in which parents do not know that those kinds of things are going on at school—unless, of course, everyone has agreed to and bought into it, which is difficult in a school of any size.

The issue is difficult. After all, we are focusing on people with concerns. Given that, in my experience, most young people who are involved in consensual sex have no knowledge of or concerns about what this or that act says, what the crime is or anything else, I say with all due respect that I do not think that any act or amendment will affect their behaviour in any way. As a result, I do not think that the agencies need to be worried. Sometimes we create artificial situations for ourselves, looking over our shoulder constantly, when really we should remain focused on the people who are in front of us and what we can do to help them in their situation.

There is a completely different social attitude among young people. They are concerned about the issue and have wandered into situations and been taken advantage of, but they are a perfectly knowledgeable group who understand what they are doing and see nothing wrong with it—that is the way in which they live their lives. They are connected through the internet, which allows them to meet up on a regular basis to have such experiences. That is their attitude. We must be conscious of the fact that their outlook is entirely different from our focus.

I must respond to the point that Mary Scanlon made about school exclusions, as I am probably responsible for more exclusions than anyone else present. I know no headteacher or senior manager in a school who would readily exclude someone who has a condition or mental issues. Headteachers do everything in their power to prevent matters getting to that stage. However, there are competing forces. If a teacher is teaching 20 or 30 children and one child is kicking off on a regular basis, no one else is getting taught. The issue is what to do about that. Various steps can be taken. Pass-out cards can be issued, the child can be taken to a quiet area, or they can be moved to another class or within the class. We do not say automatically that the child must be excluded but, at the end of the day, people”s patience will wear thin. Parents will say that they are fed up with their child coming home saying that they cannot do any work because of another child”s behaviour. That issue must be addressed.

The situation is not helped by the fact that efficiency savings have led to reductions in staffing and behaviour support. That makes it more difficult for us to deploy more strategies to help the children concerned. Exclusion is a last, not a first, resort, but we must bear in mind that headteachers have the rest of the children and staff to consider in such situations.

The Convener: I was a teacher many years ago—I taught for 12 years at secondary level. You have long experience in the area. I understand the point that you make about support and so on, but is behaviour generally in schools more difficult to deal with now because of the issues about which we have heard, such as the breakdown of families and poor parenting? Are you dealing with greater difficulties than I experienced before I retired from teaching at 40?

Brian Cooklin: I am an eternal optimist. Sometimes the problem in teaching is that we always look at the past through rose-tinted spectacles. Somehow, children were always much better behaved 20 or 30 years ago. The full range of behaviours is exhibited, as has always been the case. However, the circumstances have changed. There is a higher level of low-level bad behaviour in classes, which has a drip-drip effect. We deal constantly with the same issues—children not having done any work, not being ready for work, not being interested in working and looking for any excuse not to get started. That sort of behaviour is more prevalent now, but I would not categorise or describe it as much worse than the behaviour that we faced previously. We have to tackle some individual cases that are much worse but, as a general rule—it is always dangerous to generalise—I do not think that behaviour is worse than it was in the past.

The Convener: After we have heard from Julie Burns and Ruth Stark, I will wind up the session by putting the sharp question that Helen Eadie asked. I will ask everyone to refer us to an example of good practice.

Julie Burns: My point follows on from the teachers" comments about what enables a child to talk or prevents them from talking. Because of ChildLine"s high confidentiality threshold, which we discussed earlier, children speak to us. They often check our confidentiality policy with us. Once they have done so, many of them tell us strongly—in their own voices—how trapped they feel with their distress. They are not sure where they can go with that level of distress, and they do not feel that they have any choices.

Children often tell us about how much responsibility they take for the adults around them. When they know that the family is struggling and there is a lot of chaos, the children take responsibility for that. They feel either that it is their fault or that it will overburden parents or carers whom the children see as already struggling.

Such feelings of being trapped have an incredible effect on children"s mental health and wellbeing. A distinction was made earlier between having a mental illness and being psychologically distressed, but there is obviously a continuum. Children tell us that, because they do not know where to go, problems often get noticed only when they start to self-harm or abuse substances to block out pain and distress that they have felt for some time.

Ruth Stark: I have remembered what I wanted to say earlier regarding what we can learn from other countries. How social work services are perceived in this country is important. Speaking as a safeguarder rather than a social worker, when I go into a children"s hearing and get asked to report on what is in the best interests of a child with a heroin-abusing parent or parents, I need to consider the timescale for the parent to go through the process of withdrawing from drugs, often by means of a methadone script, and recovering. That can take five or 10 years, but the child does not have that length of time for their development.

The process in this country is that a child in such a situation who will not return to their parents" care within two, three or five years is placed for adoption, which means that they lose contact with their birth family. However, things are done differently in Sweden, where such children are placed with foster parents, supported properly with finance and encouraged to maintain contact with their parents wherever possible, up to the age of 18 and sometimes to 21. We need to consider that system because adoption creates an artificial separation for many of our children that does not help them in the long term. We have no long-term research to back up what we do. We must invest in such research to find out what is in the best interests of children whose birth parents cannot look after them during their formative years, which is a difficult situation.

The Convener: That was helpful. I will take that as your good-practice example. I will work my way round the table briefly, starting with Graeme Rizza. Do you have a comment to make on best practice elsewhere? I bounced that on you, so perhaps people should just self-nominate. I want to wind up the discussion by giving you all one bite at this.

Rosemary Howe: It is important to help parents to access parenting support services in a range of ways. For example, West Lothian Council has a website—parenting West Lothian—that gives a range of information on parenting topics as well as the facility for parents to e-mail us with requests for information on specific aspects of children"s behaviour. It takes a comprehensive, co-ordinated approach to trying to meet the needs of parents who have difficulties at all levels. There is a basic, short-term parenting programme that any parent can sign up for; a medium-term programme for parents who are experiencing difficulties; and a more intensive parenting programme called mellow parenting, which has been quite successful with parents who have children on the child protection register.

The Convener: Does anybody else want to comment before I close the discussion? As soon as I say that, hands always go up.

Joan Hoggan: I suggest stable funding for voluntary organisations that are highly rated by their partner agencies, so that they do not constantly have to bid for funding. For us, that might mean Barnardo"s, which offers mentors and group work, or young carers organisations that work with young people in distress. There needs to be consistent funding for school counselling services throughout Scotland, because they are one of our most valuable resources. We also need to train a huge number of art and music therapists to work with youngsters who cannot verbalise all their emotional difficulties but who might, given other routes to expression, be able to make some progress.

11:30

Kathryn Howieson: We place an extremely high value on the experience of parenting and raising children by recruiting and training volunteers who must be parents and have had that experience. Sometimes society does not value that experience and the skills that are learned from it highly enough, or as highly as we in Home-Start do.

Brian Cooklin: I echo the point about school counselling. I cannot stress enough the importance of the need for access to school counselling in every school—that is a top priority. In addition, the ability of integrated children"s services—involving people such as home-school partnership workers—to make the connections with families is an invaluable resource that I do not want to disappear. I am making a plea for those two areas, because they are Scottish initiatives. We do not need to look abroad for ideas—in fact, people abroad often come to us for ideas. It is important that we recognise what works, and that we ensure that if something works, it is available to all children.

Susan Kayes: There have been many policies from the Scottish Government, and there has been a transformation in the way in which health services work with education services and social work services to support families. The structures have been put in place—the Education (Additional Support for Learning) (Scotland) Act 2004, the "It"s everyone"s job to make sure I"m alright" report and the getting it right for every child programme—to help us all to work together to support children and families.

The Convener: Mr Rizza, are you indicating that you want to speak? You will have to do more than wiggling your glasses as Dr Simpson is doing.

Graeme Rizza: To go back to the drug issue, we currently spend a lot of time in this country to-ing and fro-ing in the early stages, with the result that children can be in and out of care half a dozen times with half a dozen sets of carers. There are a couple of American models—and I do not jump there quickly or easily—that suggest that we should take the bull by the horns, by removing the children in the first instance in many cases, and then working closely and specifically with the parents to deal with the drug problem before we return the children.

The Convener: Is there a name for those American models? Perhaps you can write to us afterwards and give us something specific to which we can refer.

Graeme Rizza: Yes, I can do that.

The Convener: Thank you. Mr Milliken?

David Milliken: Sadly I do not make a lot of overseas trips for investigative purposes—

The Convener: Neither does the committee, by the way—let us get that on the record.

David Milliken: I was not suggesting that you do.

The Convener: Stirling was one of our major trips.

David Milliken: I will not produce any major examples from overseas, but I will make a plea. It is fairly well recognised, and we have identified this morning, that the early years are crucial in children"s development. It is fairly well settled, and everybody knows, that tertiary education receives significantly greater resources than secondary and primary education, which in turn receives significantly more resources than early years services. However, it is also fairly well settled that the return on the investment in the early years is significantly greater. I make a plea to take account of that and to examine the resources that are provided to early years services.

The Convener: I thank everyone for their evidence and close this part of the meeting. We have dipped into the goody bag, so there is tea and coffee available for you all—it is a generous Parliament. We will have a five or six-minute break before the next panel of witnesses arrives.

11:34

Meeting suspended.

11:47

On resuming—

The Convener: I reconvene the meeting. We are back in public session with our second group of witnesses. Dr Graham Bryce is a consultant child and adolescent psychiatrist at NHS Greater Glasgow and Clyde and the former chair of the Scottish needs assessment programme core working group on child and adolescent mental health, which is also known as SNAP. Our other witnesses are also former members of SNAP. Mary Gallagher is operations manager, children and families, at East Renfrewshire community health and care partnership; Dr Margaret Hannah is acting director of public health at NHS Fife; Dr Elaine Lockhart is a consultant psychiatrist for children and young people at the Royal hospital for sick children in Glasgow; and Dr Philip Wilson is a general practitioner and senior research fellow in general practice and primary care at the University of Glasgow.

Have there been any good or bad changes since your report in 2003? What has happened? You may wish to comment on the evidence that we have just received—that would be helpful.

Dr Graham Bryce (NHS Greater Glasgow and Clyde): I will kick off. One clear change that has happened since 2003 is that we now have a policy for children"s and young people"s mental health in Scotland in "The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care". The heartening thing for this group of witnesses is the extent to which that policy built on our needs assessment work. We can be proud of our policy framework because it is founded on evidence and an assessment of need and is informed by the experience of children, young people and people who work with children with mental health difficulties. That is a positive achievement.

We have seen some shifts along the lines that SNAP suggested—in education culture, for example. As members heard earlier, there is much more attention to and concentration on schools being places in which to promote the wellbeing of children and young people. I am not saying that that is a result of SNAP"s work; rather, it is a welcome parallel development.

I will finish with a disappointment. One of the things that we have not seen is a step-up in the capacity to embark on mental health improvement work with children and young people throughout Scotland in a way that is proportionate to the level of need that SNAP identified.

Mary Gallagher (East Renfrewshire Community Health and Care Partnership): From a local authority perspective, I echo a lot of what Graham Bryce has said. My work is essentially in social work, but I work in children"s services across the board, with colleagues in education and health in particular. The SNAP report and subsequent framework have promoted a greater understanding of mental health and wellbeing issues for children and young people and the fact that everybody has a role in providing support and in identifying and addressing the issues. There are still capacity issues when children and young people need specialist services.

There is still a lack of confidence among the wider group of professionals who work with children and young people to tackle the issues—we heard some of that this morning. I am thinking, for example, of the school teacher feeling that there is a need for a specialist resource to help a child to deal with a bereavement. At a time of crisis, children need to get help where they are and from people whom they know and trust. There is often too much of a tendency to refer children and to look for external resources and services. To take that several steps down the road, let us consider some of the major inquiries into child deaths and the range and number of professionals who were involved in all those cases. They did not help or succeed in protecting the child. There is too much of a rush to seek a range of specialist services for every issue that is identified. We should strengthen capacity and the confidence of the professionals who work directly with children in promoting children"s wellbeing and resilience.

The Convener: Will you develop the phrase "strengthen capacity"?

Mary Gallagher: Brian Cooklin made a point about training this morning. In all the professional training, there has to be a greater emphasis on the fact that the job of any professional who works with children in health, education or social work is very broad and that an holistic approach has to be taken. Teachers cannot expect to stand there and teach French or maths and deal only with that; they must have a wider awareness of the issues facing young people and some of the effects of them. They must have some capacity to recognise the early signs of psychological distress that leads to subsequent mental health problems. There is a need to look at putting more on the training agenda about children"s health and wellbeing and professionals" role in that. The idea of cross-profession training and bringing professionals together has to be explored. I know that some of that has been happening, but it has probably not been happening enough.

Dr Philip Wilson (University of Glasgow): In the style of Graham Bryce, I will start with the good things that we have seen, and I will start my answer with my academic hat on. First, there has been an enormous blossoming in the evidence base on ways of identifying early in life the children who are going to follow a problematic and painful trajectory. Secondly, there has been a big increase in the evidence base on what works to stop the bad things happening. At a policy level, there has been substantial movement towards an emphasis on the very early years. We should be thinking most about and putting most resources into the under-threes.

The bad news is that catastrophic damage has been wrought to the health visiting profession. The number of health visitors has declined, and the morale of the profession is the lowest that it has ever been—and the importance of its work should mean that its morale is high. Part of the reason for the decline in morale and the loss of numbers is that there have been some unfortunate policy developments.

The review of nursing in the community is perhaps one of the main problems. It provides for a policy whereby the health visiting profession will be abolished altogether and replaced by a generic community nurse. The policy driver was the increasing number of elderly people with multiple morbidity, but children were completely forgotten in the review of nursing in the community. That has led to no health visitors being trained in NHS Highland, for example, because of the belief that the health visiting profession will no longer exist. Until recently, that also applied in the Lothian, Tayside and Borders areas. That is one bad development.

The review of health visiting in Glasgow suggested that, because of the laudable aims of protecting the work that health visitors do with children and of allowing health visitors to spend more time with more vulnerable families, health visitors should be moved into social-work-led teams. That sounds okay but, in reality, it would create major problems if the front-line approach made by parents who needed help was to a social work team, because of the stigma in social work.

The "Health for All Children 4" report, which was published in 2004, has been mentioned. That uses an evidence base that is now dated and does not have much regard for the mental wellbeing of very young children. Many managers in health boards and community health partnerships have interpreted its recommendations literally to mean that a decision on whether a family needs help can be made in the first few weeks of a child"s life—other witnesses mentioned that—and decisions about whether a family requires core, additional or intensive services are now made by the time that a child is two, three or four months old. We have strong evidence that that is far too early. The Hall 4 recommendation that we can stop bothering to contact families after two, three or four months is a dangerous development.

It is unfortunate that child neglect has not been part of the policy forum as much as it might. All the news seems to be about child abuse—we hear a lot about child murder whenever it happens—but much evidence shows that children who are emotionally neglected do worse than children who are abused, as long as those children survive. That fact has not filtered into policy making, but perhaps we will have more time to talk about that later.

The Convener: We will return to that.

Dr Elaine Lockhart (Royal Hospital for Sick Children, Glasgow): You asked about changes since the SNAP report was produced. We have much more data on who works in specialist services and what their training needs are. Training has been developed and really good resources are available. For new entrants to services, for example, good resources are available on the internet, such as the handsonScotland toolkit, which is accessible for children, young people and front-line workers with children and young people.

As the committee has heard, the SNAP process pulled together people who work with children and young people across services and agencies. Tremendous commitment and enthusiasm were shown for the work. That led to the framework, which spelled out how promotion, prevention and care can be delivered in mental health services for children and young people. However, as someone who works in those services, I have been frustrated at seeing no change in the development of services and no increased or enhanced resources in specialist teams. The framework asks us to develop training for front-line staff. As Mary Gallagher says, many people could deliver care to children and young people in schools, but they need training and support to do that. We in specialist services struggle with the hard end—severe and complex difficulty—and cannot contribute to the promotion and prevention work.

The development of networks also came from the SNAP process. People throughout agencies and services are more connected locally, and all of us who work with children and young people are trying to get away from operating only in our own professional areas. However, I am aware of little progress on joint training—that could be developed.

It was encouraging to hear the earlier comments about focusing on intervention as early as people would like it—all the way through from antenatal care. We need to put a lot of our energy and resources into that.

12:00

Dr Margaret Hannah (International Futures Forum and NHS Fife): Thank you for the invitation. I make my comments as the former vice-chair of SNAP and a member of International Futures Forum. NHS Fife has kindly allowed me to come here to give evidence, but what I am about to say is not its official policy. Good things have happened locally as a result of SNAP, and I will also provide a global perspective on the issue.

Locally, between public health and our child and adolescent mental health service, we set up the Playfield institute to provide training and information and to bring together the research that is needed to drive forward the SNAP agenda. It was made clear from the outset that the SNAP report provided the impetus for the work in Fife. We have started to address locally many of the issues that Elaine Lockhart and Mary Gallagher mentioned, and that work could be one of the examples of good practice that you requested earlier.

Recently, the Kirkcaldy and Levenmouth community health partnership published a report entitled "In Our Shoes: Self Identified Health Needs of Young People". One of my reasons for coming to today"s meeting was to say that, although we have an example of good practice, we are not necessarily reaching all the young people in Fife whom we want to reach. The report states:

> "one participant in a Levenmouth group indicated that his parents had said they expected him to be in jail within five years. This was echoed by a participant in a Kirkcaldy group. A further participant in the same group suggested that they expected them to be dead."

Parental aspirations for children in certain pockets of Fife are somewhat dire.

The question of aspiration—what youngsters are growing into, where they are going and the world that they will inhabit—is genuinely international and global. We have the credit crunch and all the ramifications of what is happening globally on the economic front, but human society faces many other major challenges. Our young people are picking up on that and asking themselves, "What is my place in the world of the future?"

Since the publication of the SNAP report, I have been working with the International Futures Forum. From my work with the forum, I have learned that all societies around the world, especially those that are modernising rapidly, face the problem that I have described. I can leave with the clerk a copy of short article on the issue that I wrote for the *Holyrood* magazine back in 2006. No matter how good our professional response is to the issue, it will not reach all the need that exists. Problems are deeper and more culturally determined than any of those who were involved in SNAP had previously imagined.

I have led on a piece of work for the International Futures Forum to develop a set of resources called kitbag. The aim is to parcel up resources in a format that can be readily distributed to people who have no chance of getting access to the professional help that they need, so that they can start to do inner work themselves. It is about learning our way into a new world and acquiring a new set of capacities—not the traditional subjects that are taught at school, but life skills and the psychological capacity to deal with the mental demands of modern life.

The Convener: I have a feeling that there is a thesis somewhere in those comments. That is a rather large question for us to address at the moment, so we will be more pragmatic.

Mary Scanlon: I was pleased that Dr Wilson mentioned NHS Highland because his comments confirmed the experience that I described earlier. I put on record that some feisty health visitors in Thurso pursued a policy of non-co-operation, just short of a strike, with NHS Highland because they thought that the review of nursing in the community was rubbish. They were so committed to health visiting and to what they had come into the profession to do that they refused to co-operate with the board.

Dr Simpson: Health visitors in Dunoon did the same.

Mary Scanlon: There are some feisty health visitors throughout Scotland.

My main point relates to the action framework. Mary Gallagher mentioned training, but the framework also said that the SNAP report found that mental health services for children and young people were "patchy" and that specialist services were "under very heavy pressure". It is not just about having a policy—we have an awful lot of policies—but about how that policy works and whether it works consistently throughout Scotland. That is what I am trying to understand.

The Government report, "Delivering for Child and Adolescent Mental Health Services", states:

> "CAMHS data standards are incomplete without information on outcome measures."

I go on to read that the SNAP group is working away to get those outcome measures. It formed a working group in November 2008, but it seems to be having so many problems trying to get some sort of data standards and measures that the group is awaiting a decision on progressing that work. There may be a policy, but we do not seem able to come forward with outcomes or even the basic data standards. That concerns me.

The Convener: And the question is?

Mary Scanlon: The question is: why did the group not manage to get data standards in November 2008? Why is it still awaiting a decision on progressing the work, and what is happening about data standards? We keep talking about best practice; there is best practice, but there is also pretty awful practice as well. I am hanging on in the hope that there will be an outcome arrangement throughout Scotland—a set of standards that people can aspire to, which would help to bring those who are not following best practice up to a certain level of service.

The Convener: Dr Bryce is at the starting gate.

Dr Bryce: I can speak a little about that. I am now a member of the CAMHS core group, which you have probably heard about. It offers advice to the Scottish Government about children and young people"s mental health.

There are two issues. First, the issue of how best to measure mental health outcomes for children is far from settled. That is not unique to Scotland: a lot of work is happening on that throughout the United Kingdom, and one illustration would be the CAMHS outcome research consortium. A number of centres in Scotland are participating in that process, which is an attempt to develop a system that asks whether, when a child has had help from a specialist service, they are better off afterwards. That is work in progress.

Secondly, I have a related reference to November 2008. You probably know about the Information Services Division. Part of its work is to try to standardise the data that is collected, so that the same things are measured in Argyll and Highland, for example, and the boards therefore have comparable data. ISD did some work to clarify definitions related to CAMHS. The work concluded in 2008, and ISD indicated that there might be some follow-on work on outcomes. I think that it was asked to do that work in November 2008, and we are waiting to hear whether and when ISD will take that forward.

Mary Scanlon: I did not want to know just about people who had been identified and given support; I was hoping that the outcomes might measure the identification of children and how issues that relate to children under three or five or whatever are picked up.

Dr Bryce: That is a much wider and, in a sense, equally important issue. One thing that SNAP did was to encourage us all to raise our eyes and look at a further horizon. The initial request for SNAP came about because the Scottish Executive, as it was then called, was concerned about mental health services toiling. When we began the work on SNAP, it quickly became obvious that, although mental health services are important, still underresourced and struggling, they are not the whole picture and not the answer to the problem. That is why one of the main recommendations of the SNAP working group concerned promotion, prevention and care.

As Richard Simpson said earlier, we now know that, by examining risk factors, we can identify many of the children who are at the highest risk at an extremely early stage. However, we do not have a system to do that work that we then use to filter children into the appropriate level of help. The opportunity exists to create such a system because we have more or less the knowledge that we need to do it, but at the moment we lack the wherewithal. We have not made it happen yet.

Dr Wilson: There has been no data collection on early childhood mental health in the community as a whole. The only piece of information relevant to mental health for all children under five that is being collected nationally is whether they can smile at the age of six weeks. That is the only such information that the Information Services Division has.

There have been some moves on data collection in Glasgow. Graham Bryce and I have been involved in developing an evidence-based parenting support framework for the city, which involves the systematic collection of information about children”s emotional wellbeing. We have proposed that a structured parenting questionnaire be offered to all parents to assess their difficulties in parenting and that a structured tool for assessing parental mental wellbeing be administered when a child is 13 months old. At the moment, the postnatal depression information is recorded—it is not collected nationally but we have it locally. We propose an extension of that so that there is another assessment at 13 months.

At a slightly later age, information will be collected from two other strong indicators. One is a measure of child behaviour at two and a half years. There is strong evidence that children who have problematic behaviour at that age are highly likely to end up with major problems later in life—in fact, some work in the United States suggests that it is possible to predict at the age of three as many as 70 per cent of the children who will end up as in-patients in mental hospital or in prison.

The final indicator, which is also a strong indicator of later mental health problems, is information about language. One problematic aspect of the decline of health visiting is that we have stopped collecting information about child language. We know that 70 per cent of children who do not have the capacity to put two words together meaningfully or do not have 50 words at the age of two and a half will go on to have a mental health diagnosis aged seven. Almost all of those children will require major input from health, education, social work and criminal justice services.

We have some robust early indicators of mental health but we seem to have stopped collecting information, so an opportunity is being lost and we now identify those children only when they start school and cannot cope. We propose to reintroduce, at least as a pilot, systematic collection of those data in Glasgow.

Dr Hannah: In the assessment of a child”s mental health need, we must always be careful not to consider only the individual child because the child is in a social context and in relationships, particularly with parents if they are still present. Over and above the use of indicators in the individual, one can anticipate that many children of mothers who have mental health problems are more likely to suffer from such problems themselves. I would caution against looking at the pathology only in the child. In the field of children and young people”s mental health, we can miss a trick or two if we individualise the pathology.

12:15

The Convener: Is the parental questionnaire that Dr Wilson mentioned voluntary? Parents might not want to fill it in.

Dr Wilson: The questionnaire is being tried on a pilot basis. We do not know how keen parents will be to fill it in—

The Convener: When did the pilot start?

Dr Wilson: The pilot is about to start.

The Convener: So when will it start?

Dr Wilson: Within the next couple of months. The pilot is taking place just in one CHCP.

The Convener: Will the questionnaire be piloted just in one school or over the whole of Glasgow?

Dr Wilson: It will be piloted only in the west Glasgow community health and care partnership.

The Convener: I have one final question. Will the parental questionnaire be used in primary or secondary settings?

Dr Wilson: The proposal is that there will be a universal contact with all families first when the child is 13 months and then when the child is two and a half years. That is a new development that will be piloted and evaluated.

The Convener: Thank you.

I will take questions from Helen Eadie followed by Ian McKee, Richard Simpson and Ross Finnie.

Helen Eadie: Some responses to our call for evidence argued that greater emphasis should be placed on community-based specialist services, as hospital-based settings can be a barrier to access, especially for hard-to-reach groups. One suggestion—more information on this is given in our briefing paper that gives examples from other parts of the world—was that we should look at what happens in New Zealand, where mental health services are delivered primarily by community-based multidisciplinary teams. Does anyone in the panel want to comment on that?

Our briefing paper points out that one specialist—a lady called Vicki Degotardi—has criticised other systems. It is argued that multidisciplinary teams are the best way to move forward, provided that the work is done under the close supervision of a psychiatrist. However, one problem that I foresee with that suggestion is that one of the psychiatrists that I know told me that she was the only psychiatrist dealing with a population of about 70,000 people. That perturbs me. If we adopted the set-up that has been suggested, how would it be organised? Is there a shortage of psychiatrists, psychologists and other specialists in Scotland?

In addition to responding to that question, will the panel comment on whether facilities should be community based or hospital based? Convener, I also have another couple of small questions.

The Convener: We need to move on, so what are your other small questions?

Helen Eadie: My other small question is for Dr Wilson. Will he expand on what he said about emotional neglect? I thought that that was very interesting.

Finally, what advice would the panel give us on the data that should be collected? Often, we collect only the data that has always been collected. Do we collect data that we should not collect, and should some data be collected nationally?

The Convener: The questions are on three issues: community-based services, emotional neglect, and whether we collect the wrong data. Perhaps members of the panel can self-select in answering those.

Dr Lockhart: I will answer the question about community-based versus hospital-based services. In Glasgow—this will vary across the country—we have community-based multidisciplinary teams that work across the city as well as hospital-based specialty teams. However, people sometimes make the mistake of assuming that, because the clinic is based somewhere in the community, the people must be doing community work. Sometimes, those might just be mini-clinics. Also, public transport issues can mean that families can find it more difficult to travel to a community-based service that is located within their quarter of the city than to one that is located in a centralised spot.

Another difficulty with community-based services is that the multidisciplinary teams for child and adolescent psychiatry are quite small. If one or two people are on maternity leave or sick leave, the team can fall below critical mass. That is a challenge for any service that has been dissipated around the city.

It is interesting that Helen Eadie mentioned New Zealand. In Auckland, the services are all housed in one building, which facilitates a lot of creative working between teams to provide different services to the city. There are pros and cons to the different systems.

Dr Bryce: I am a little bit perplexed by some of the evidence that Helen Eadie has heard, because I had thought that this policy area was very clear and that we had been making progress. When people were considering mental health services for children and adolescents, a clear decision came out of SNAP that such services should be community oriented, and that decision was reflected in policy. The number of children who receive mental health services by coming into hospital is infinitesimally small. The vast majority visit particular bases, are seen, and then go away again.

Another initiative, which was influenced by developments in Australia, has been to shift the centre of gravity—to shift the point of contact with people who have experience and training in mental health services away from the clinic and out into the more ordinary settings, such as schools and primary care centres, where children and young people are. Over the past few years, there has been growth in the number of primary mental health workers.

The development is not moving as fast as any of us had hoped that it would, but the direction of travel is clear and goes along with the aspiration of your correspondents.

Dr Wilson: One of the most effective things that a member of a CAMHS team can do is to offer support and supervision to someone like me, in primary care, or to a health visitor who is visiting families. Examples of that exist. Mention has been made of shifting the centre of gravity, and liaison, consultancy and supervision are important functions to develop.

A promising and encouraging development in Glasgow has been the introduction of the Solihull approach to infant mental health, which is about expert support for workers such as midwives, health visitors and GPs in the work that they do in the emotional sphere.

The Convener: I think that Dr Wilson spoke about emotional neglect between mothers and children as young 15 months.

Dr Wilson: Last year, a major piece of work in the *American Journal of Public Health* considered about 1,200 children who had been involved with child protection services in four states in the United States of America. The work showed that the only strong predictor for later childhood mental ill health was whether the child had been neglected before the age of two. Abuse before or after the age of two, or neglect after the age of two, did not seem to have any consistent relationship with later childhood mental health. Early neglect is one of the biggest influences. That neglect can take many forms, and the one that has been given most attention is neglect by parents whose drug and alcohol problems mean that they are so preoccupied that they cannot connect with the child. However, many other examples exist. Some mothers with post-natal depression can find it very difficult to connect to the child. That is not always so, but sometimes it is. The lack of an early relationship, and the lack of early and secure attachment, are powerful predictors of mental ill health. The issue should be seriously considered. There has not been much of a policy push or a service push in that direction.

In the work by David Olds, which was mentioned earlier, the American equivalent of a health visitor made more than 30 visits to families from the middle part of the mother”s pregnancy to when the child turned two, targeting the development of the mother, the development of the relationship between child and mother and the development of the child. That might be more intensive than the number of visits made by UK health visitors on a universal basis, although they might often make that number on a targeted basis.

The group of women who were targeted was fairly loose—they were teenage mothers, mothers living in poor areas or unmarried mothers—and they were either offered or not offered the service. The children in the visited group were by the age of 15 half as likely to have psychological problems, half as likely to have been involved with the criminal justice system and half as likely to have had sexual relationships. Indeed, as far as early sexual activity is concerned, it is worth pointing out that the only work that has had a major impact on teenage sexual behaviour has been the work by David Olds, which ended when the children were two. By the time they were 15, the children who had been visited frequently by the health visitor before the age of two had had less than half the number of sexual partners.

The Convener: What is that piece of work?

Dr Wilson: It is the 15-year follow-up of a randomised trial by David Olds. I will send you all the information.

The Convener: Please do. We would like to take a full look at it.

Helen Eadie: Is that work being piloted in Glasgow and Lothian at the moment?

Dr Wilson: There was a diluted version of it in Glasgow called starting well, but for a variety of reasons it did not work well. A version called the nurse family partnership is being piloted in Lothian, and some pilots have been introduced in England.

There are still question marks over whether the nurse family partnership will be any better than good-quality health visiting. After all, there are no health visitors in the US. The nurse family partnership trial compared the effects of 30 visits to mothers with the effects of nothing at all. However, in areas with a reasonable, competent and well-trained health visiting workforce, health visitors might be very smart at working out which families to get in touch with. Indeed, the targeting that they do—in other words, working out which families need the help and spending quite a bit of time with them—might work perfectly well already.

Dr Bryce: I hope that I will have the opportunity at some point to say a bit more about working with older young people. Our experience—and, indeed, the emphasis of the report—is that this should not be an either/or.

I want to dwell for a moment on neglect, which links to an issue that was raised in the earlier evidence session and was covered in the evidence from Glasgow University that Phil Wilson and I were involved in submitting. That submission highlights the issue of critical periods and the time beyond which any harm that is done to the development of children"s brains as a result of neglectful relationships is irreversible. The problem is that in Scotland we do not have a universally used, systematic and robust form of assessing those matters. When social workers, for whom I have for the most part endless admiration, try to assess children who in their early days have been neglected and have come to the attention of child protection or have been put into foster care, they are trying to be guided by the best practice that is available. However, their efforts are confounded by the lack of a robust framework.

You have already heard about work that has been done in America. Another piece of work that was done in New Orleans and which we in Glasgow are examining indicated that a very intensive and systematic intervention with young children in foster care could change outcomes. Although one of its effects was that more children stayed in care, those who went home fared better. In other words, fewer high-risk children were returned to parents who would not be able to look after them well. We have to work on that in Scotland, because we have not got it right. That is certainly reflected in some of the difficulties that we hear about regularly in the press.

12:30

Helen Eadie: Why is the relationship between the general practitioner and the health visitor—as opposed to a social work team—so critical?

Dr Wilson: General practitioners and health visitors are pretty much the only people who see all families with children under three. Generally speaking, other agencies are not involved. Obviously, critical events in social development are taking place in those families. The health visitor and GP professions need attention in that regard.

Until very recently, the normal model involved a health visitor and a GP being based in the same premises; in other words, the health visitor would be attached to the GP. Their knowledge was complementary. It is likely that the GP would know a family"s history, and they would certainly know about mental health and substance use problems. They would receive all the information about the broader family if it was registered with the practice and get information from accident and emergency departments. The health visitor would visit families and do the child health surveillance and would know about the home conditions. Those two sets of information are complementary.

I will give an example of what can happen when there is a good relationship between a health visitor and a GP, although I will change the details of the case slightly. Not long ago, I received a slip from an accident and emergency department that said that a two-year-old child had attended it with a minor head injury. I was involved in the prescription of methadone for the child"s mother. I thought that she was doing fine, but I knew that she had a new partner. Therefore, I said to the health visitor that perhaps she should pop round to where they lived to check that things were okay. She did so and things were okay. The child is simply rather boisterous and bumps his head a lot. There were no problems at all, and that was the end of the matter.

Whether I would have picked up the phone to call the social work department is a moot point. Unfortunately, a threshold is crossed when that is done. The terribly sad thing is that because social workers have not of necessity been able to do preventive work, social work has an unfortunate reputation among most families as a sort of policing function. In the case in question, social workers doing preventive work would not have been welcome, so I would have hesitated to phone them to check the situation. I might have tried to find a way for me to visit, but I had a really good close working relationship with the health visitor. I know that GPs in NHS Lanarkshire, for example, never see health visitors.

Such day-to-day informal and continuous working relationships provide an incredibly powerful service. GPs and health visitors provide universal, non-stigmatising services. Both professions are linked to social work services and to education services in some cases. There are problems in all professional relationships, but the relationship between the health visitor and the GP works incredibly well by and large. The health visitor has a health identity, is involved in the health service and has a clear badge. That is important.

David Olds showed through a comparative trial of nurse-delivered home visitation services versus paraprofessional-delivered home visitation services that the nurses" outcomes were miles better. There were two reasons for that. First, the nurses were allowed into people"s homes; people who were not nurses were not allowed into people"s homes. Secondly, for some reason, nurses seemed to be able to deliver the interventions better. There is something quite magical about a universal nursing service that allows families to trust nurses and let them into their houses. If people have a clear health identity rather than an identity that is more related to statutory services, they can do wonderful things. However, that situation is in danger if there is only some sort of multi-agency team.

Mary Gallagher: I would like to respond on the issue of fear of social workers. We welcome the support of the Scottish Parliament and ministers with regard to recent tragic child deaths that have been reported in the media, but a big part of the problem is the media presentation of social work. It is difficult for the social work profession to promote a positive media image because of the confidential nature of our work, which we cannot report on. A huge amount of work is needed on the media image of social work, but we need support for that.

The Convener: I agree to an extent with what you say about the media, but the perception exists in any event that social workers come to criticise, whereas health visitors come to be helpful. It may not be correct, but there is a perception that the health visitor is on people"s side, whereas the social worker may not be seen to be on their side. That perception has not appeared recently, but has been at large in our culture for a long time.

Helen Eadie: Convener, you did not deal with the question on data.

The Convener: We will come back to that. We can sweep up at the end. It is 12.36 and I am trying to finish by 1 o"clock because I know that members have commitments.

Ian McKee: Following on from what has been said, I want first to say how much I agree with Dr Wilson"s comments, which are very important. The importance of core training and people on the ground actually doing something has been mentioned occasionally in the discussion. Helen Eadie and I had the pleasure of visiting Lochgilphead and talking to a CAMHS team there. However, there were only four in the team, covering a vast area that included 20 inhabited islands. It was obvious that they could not cope with the situation on their own.

Some time ago, when I was in general practice in an urban area, the CAMHS team seemed incredibly remote. We referred people to the team, but unless they had something that the team was interested in, such as an eating disorder, it took months and months for them to be seen. Perhaps people have begun to discuss the role of primary mental health care workers since my time, when the community mental health service was just like a hospital service that happened to be in a slightly more inconvenient position, as Dr Wilson said. It was not linked up with what was happening on the ground.

How can we use the specialist knowledge of the CAMHS team to empower just about everyone in a local area so that they can cope with problems as they arise? Have we got the right approach, or can we do more through not just GPs and nurses but receptionists, teachers and other people with whom young people come into contact when their mental health problems first become obvious?

Dr Bryce: One of the things that we learned in the SNAP survey was that people who were not mental health specialists were ready and willing to learn more. As has been described, they were commonly aware of children and young people in difficulty and tried to support them, but they were looking for help either to do that better themselves or because they felt that they had reached the end of what they could do.

When the SNAP report came out, we were very engaged with the specialist services, which were very willing to engage in that activity, although there might have been some exceptions to that general rule. However, the confounding issue is capacity. As Ian McKee described, CAMHS teams are typically small. I noticed that in his written submission, Dr Rob Wrate compared Moray with an equivalent area in Norway, which has three times the number of CAMHS specialists. Our own work, using some workforce models, suggests that we have no more than half the specialist workforce that we need across Scotland.

The SNAP report said that, as the workforce situation improves, people should increasingly orientate themselves towards outreach work—the primary mental health work. Fife is one place where people have really grasped that by actively trying to link up. There are examples of that happening everywhere, but it is still patchy because services are so thin on the ground.

Dr Hannah: It is interesting to see what, apart from the SNAP report, turned things around in Fife. Playfield house provided the in-patient service in Fife—we had about 12 beds there—but we simply could not staff it because we did not have enough specialist staff available. It was not a lack of funding; it was more a matter of vacancies and people drifting away from the service because it was generally seen not to be valued. We had a crisis moment when Playfield house had to close, but the Playfield institute was established as a result of that crisis. We knew that we could not go back to the Playfield house model; instead, we established multidisciplinary teams to provide more intensive support in people"s homes. Now, we rarely need to refer a child to a hospital-based service outside Fife.

As Graham Bryce said, the emphasis is on developing the capacity of all front-line staff to deal with the common problems that they will be presented with. At the Playfield institute, we set up the handsonScotland toolkit, which Elaine Lockhart mentioned. That is a web-based resource that anybody in Scotland can access. In fact, people from around the world are accessing it because they find it a useful resource that gives front-line staff the wherewithal to do their work.

Dr Lockhart: During the SNAP process, there was extensive surveying of people who worked with children in a range of settings. It was striking to note that, on the basis of the evidence that they gave us in which they described what they did, people who worked closely with children—for example, in schools or in primary care—delivered really good care. What they seemed to lack was confidence that the system was working and that they were doing what they should have been doing.

People do not require extensive training and intensive support from a specialist resource; people need to be freed up to have that relationship with local people in primary care, education or other agencies. It is not about skilling everyone up to the level of specialist mental health services.

Helen Eadie: On the issue of illness, Dr Hannah said that cases are rarely referred outwith Fife. However, if a psychiatrist is off sick for many weeks and there is no one to cover for them, what happens to the children? I am dealing with a case just now and there are no other professionals there to help.

Dr Hannah: I will have to take that up outside the inquiry. I am happy to take—

Helen Eadie: But the general issue about what happens when psychiatrists—

The Convener: Witnesses usually say that, if the member writes to them about a matter later, they will deal with it. That is your out, Dr Hannah.

Helen Eadie: There is a general question for all the witnesses if—

The Convener: I think that we are talking about the human resources that are out there.

Dr Hannah: Sure. It is a struggle with people coming into and leaving the service. As Elaine Lockhart said, people go on maternity leave or vacancies arise. We must try to marry up the resources that we have with the demand that exists out there. In some ways, it is a juggling act.

Helen Eadie: It is not right that people have to wait for many weeks.

The Convener: I want to move on. I think that Dr Lockhart and Dr Hannah made the point that the issue is not the number of people that you have, but your ability to use them—within limits—differently.

I feel that Ian McKee and Richard Simpson know more about the issues on the front line, so I want them to have more of a go at it. This is very much Richard Simpson"s field.

Dr Simpson: One of the things that we seem to have a problem with is how the primary care group—health visitors, social workers and general practitioners—are involved in universal as opposed to targeted care.

I find it disappointing that, after all the work that was done by people such as Goldberg to show that social work attachment to primary care is highly effective, we are still sitting in our silos or still talking about moving health visitors across to social work, although that is clearly the wrong way in which to go.

That is incredibly disappointing and counterproductive. The result of co-locating a drug team with social work was an enormous improvement to the quality of service that we offered chaotic families. That was a specialist service, not a general practitioner service, but that one move of co-locating the two teams was hugely effective. That was the other way round from the approach that was attempted in Glasgow, which in my view would have been hugely destructive. The witnesses might want to comment on that.

12:45

I have a question that moves us on to the teenage years, which is when mental health issues become much more evident. Perhaps early intervention has failed—for whatever reason, there are mental health problems. One of the examples in the comparative work from SPICe is Sweden, where there is a social and emotional training programme that is designed to promote good mental health in schools. The evaluation of the programme has demonstrated clear and positive effects on health. Dr Lockhart talked about teachers" confidence and having mental wellbeing in the educational setting as a specific goal of the curriculum for excellence. Should we promote such a programme? Are there other programmes that promote mental health and wellbeing that should be delivered by teachers in schools?

Dr Hannah: I do not know the names of the various programmes, but some are already in place in schools in Fife. I can get more details on that for you. One programme that I am interested in, which is running in Perth and Kinross, is a wellness programme for teachers, who become wellness champions for their schools. I believe that 24 teachers are going through the programme. It is challenging for them, because they are not simply learning a subject on top of all the other subjects that they learn and teach; instead, the programme is about how they live their lives.

That is the direction in which public health services are going—it is not so much about considering the illness, distress and obvious needs that are out there in isolation from what creates the thriving conditions for people really to enjoy life to the full. The teachers on the programme have individual coaching sessions in which they examine their work-life balance and start to achieve a more balanced way of living. I am trying to get the Playfield institute to do a write-up on the programme and evaluate it for Perth and Kinross Council, but that is a bit difficult because the programme is not in our patch. However, we are working on that.

Dr Wilson: I have a brief point in answer to Richard Simpson"s comment. Like him, I have been very disappointed in one change that has taken place in my professional lifetime of 20-odd years in general practice. A social worker used to come to our practice meetings every month or so, which gave us the opportunity to talk about problem cases and families and the social worker the opportunity to do preventive work under the auspices of the practice. That was a non-stigmatising service. However, from what I can gather, that approach has disappeared completely throughout Scotland, which is a terrible missed opportunity.

At a political level, another change that has taken place is the development of community health partnerships and community health and care partnerships. I have yet to find anybody who is not a manager of one of those organisations and who has anything good to say about that development. It seems that the involvement of general practice has been completely sidelined, so GPs are no longer listened to in service planning. In general, that does a disservice to the under-5s.

Dr Bryce: I will respond to the question about what we want to happen in schools. Again, I do not know the particular programme to which Dr Simpson referred, but it is fairly clear that we need deliberate and sustained efforts to address that agenda in schools.

Various approaches have been taken in Scotland, such as the pilot project in West Lothian, which I heard being praised earlier. Primary mental health workers were attached to all the schools—that connects to what Margaret Hannah said—and the project offered a range of programmes in each school. In every case, the workers first had to establish the legitimacy of their presence. They had to get teachers to be open to the possibility that it was reasonable to have people in the school to support and promote mental health and wellbeing.

One of the workers ran a programme called managing the monster within. He has spoken about how teachers signed up for it in large numbers only to discover that the monster within was actually their frustration and anger. My point is that the issue is about who we are and how we are disposed to working with one another—in the case of teachers, that means working with children.

We need to be clear that there is a locus in schools for deliberate programmes and efforts to sustain this work. There are now good examples in various parts of Scotland of the role that young people themselves can play. I saw a presentation a couple of months ago by, I think, Beattock school—it was somewhere down that way—about a system that had been put in place whereby the older young people offer peer support and a drop-in facility for the younger pupils. The presentation was delightful, and the system seems to work. It seems to go some way towards helping with the stigma, because it is run by the culture leaders in the school. We need to have that sort of thing in schools.

Ross Finnie: I have one final question for you. You will look at me and think that you could take all day to answer this.

The Convener: But you can"t.

Ross Finnie: I thought that, being a SNAP group, you could give a snap answer. We have the core of the SNAP group here, and here we are looking into CAMHS. As you will know—but you are too polite to say so—there is always a temptation for politicians who conduct such inquiries to come up with a new and original plan, which terrifies the life out of you. As Dr Wilson and Dr Simpson have pointed out, people with new and original plans have decided that the relationship between GPs, health visitors and social work should be torn up and rent asunder. We are not entirely clear, however, what the evidence base for that is; it is certainly not borne out by the evidence that we are hearing this morning.

Given that you were there at the time, and given that it is always healthier to build on what you have, rather than thinking about new and original plans, if you had to pick one area that the committee should concentrate its attention on in order to build on the work that you have produced, what would it be?

Dr Bryce: This is a "University Challenge" moment—"Bryce, Glasgow."

Ross Finnie: We hope that you are all part of the same university. That would be helpful.

Dr Bryce: The framework has to be implemented. In a sense, that means having it all ways. After examining the issue closely, we came up with a framework that encompasses promotion, prevention and care. We need all those elements. To emphasise one to the detriment of the others will not do. People might say that that will take a lot of time and resources, but so be it—this is about the mental health of our children. I think that the framework is good enough, as is the evidence base—although it is still growing. The problem is that we have not found a mechanism to drive the implementation of the policy reliably. That is what is most needed.

Dr Lockhart: I echo that. As Ross Finnie suggested, the idea that we or other people need to carry out another assessment programme and produce another report that gets translated into another policy fills us with horror. The framework covers all the issues that have been discussed this morning. It is a very comprehensive policy—it just needs to be implemented.

The Convener: We are not hot on bringing out new strategies—we do not like the word "strategy", and we have decided that there are too many strategies scattered around.

The committee is looking to find out what is happening on the ground and how things can be improved. Certain issues are already rising to the surface. The role of the health visitor is obviously a major one, and we have the role of the GP and the flexibility of the workforce to consider. Quite a few things have come up already, and this is only the first day of evidence taking.

Thank you all very much for your evidence.

Subordinate Legislation

National Health Service (Optical Charges and Payments) (Scotland) Amendment Regulations 2009 (SSI 2009/86)

National Health Service (General Dental Services) (Scotland) Amendment Regulations 2009 (SSI 2009/96)

12:55

The Convener: Item 2, our final item of business, is subordinate legislation. Before us are two negative instruments for our consideration. I am rattling on, because I know that members are interested in the ministerial statement that is to be made this afternoon.

The National Health Service (Optical Charges and Payments) (Scotland) Amendment Regulations 2009 (SSI 2009/86) increase the value of vouchers that are used to contribute to the cost of the supply, replacement and repair of optical appliances. The National Health Service (General Dental Services) (Scotland) Amendment Regulations 2009 (SSI 2009/96) amend the terms of service for dentists to increase from 36 to 48 months the length of time before a continuing care agreement or capitation arrangement lapses.

No comments have been received from members, and no motions to annul have been lodged. The Subordinate Legislation Committee did not draw the instruments to our attention. Is the committee agreed that it does not wish to make any recommendations in relation to the instruments?

Members *indicated agreement.*

Meeting closed at 12:56.

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