HEALTH AND SPORT COMMITTEE

Wednesday 22 April 2009

Session 3

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by RR Donnelley.

CONTENTS

Wednesday 22 April 2009

HEALTH AND SPORT COMMITTEE
12th 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:

Fiona Bonnar (Royal College of Nursing)
Gwyneth Bruce (College of Occupational Therapists)
Professor Mick Cooper (British Association for Counselling and Psychotherapy)
Karen Cromarty (British Association for Counselling and Psychotherapy)
Martin Egan (North Lanarkshire Council)
Martin Gemmell (British Psychological Society)
Professor James Law (Royal College of Speech and Language Therapists)
Dr Kathy Leighton (Royal College of Psychiatrists)
Brian Lister (Scottish Children’s Reporter Administration)
Elizabeth MacDonald (College of Occupational Therapists)
Linda Morrison (Aberdeenshire Council)
Anne Ritchie (West Dunbartonshire Council)
Dr Chris Wiles (British Psychological Society)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

David Slater

LOCATION

Committee Room 6

Scottish Parliament

Health and Sport Committee

Wednesday 22 April 2009

[THE CONVENER *opened the meeting at 10:03*]

Child and Adolescent Mental Health Services Inquiry

The Convener (Christine Grahame): Good morning. Welcome to the 12th meeting in 2009 of the Health and Sport Committee. I remind members, witnesses and members of the public to switch off mobile phones and other electronic equipment. No apologies have been received.

Item 1 on the agenda is our inquiry into child and adolescent mental health services. We will start by taking evidence from Linda Morrison, who is the strategic development manager for children's services at Aberdeenshire Council; Martin Egan, who is the service manager for children and family support at North Lanarkshire Council; and Anne Ritchie, who is the head of social work operations at West Dunbartonshire Council. We move straight to questions.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I would like first to ask a couple of technical questions.

The Convener: As long as you do not expect me to answer them.

Dr Simpson: No.

We have a new alphabet soup in the papers for today's meeting. Can Anne Ritchie from West Dunbartonshire Council tell us what scat and PAThs are, so that we can get those acronyms out of the way? They appear on page 1 of the council's written submission.

Anne Ritchie (West Dunbartonshire Council): I am afraid that I cannot tell you exactly what the acronyms stand for, but I can tell you what scat and PAThs are. I cannot find scat in the submission.

The Convener: Richard, where does scat appear?

Dr Simpson: It is on page 1.

Anne Ritchie: The term is pre-scat.

Dr Simpson: I am sorry—I did not get it quite right.

The Convener: Is there a post-scat? Let us settle down. Please tell us what the substance of the acronyms is.

Anne Ritchie: Pre-scat is the system for identifying children who may have additional needs at the point of transition from nursery to primary school.

Dr Simpson: In the next paragraph of the submission, there are references to circle time, pastoral care and, in between, PAThs.

Anne Ritchie: PAThs are another form of nurture group support in schools.

Dr Simpson: The submission also refers to LAAC—I presume that that still stands for looked-after children.

Anne Ritchie: LAAC stands for looked-after and accommodated children.

The Convener: Next time, we should get a general glossary.

Dr Simpson: It helps us to follow what is being said if terms are given in full the first time, with the acronym in brackets, but you have not done that.

Anne Ritchie: That will never happen again.

The Convener: You said that with such conviction and intensity.

Dr Simpson: On page 5 of its submission, under point 4, Aberdeenshire Council talks about

> "Embedding IAF and ensuring that <u>all</u> services and agencies are fully signed up".

What does IAF stand for?

Linda Morrison (Aberdeenshire Council): IAF stands for integrated assessment framework.

The Convener: That is explained on page 4 of the submission, under point 3. I have caught Richard Simpson out.

Dr Simpson: Good—I missed that. I am hesitant to ask my other question.

The Convener: Please, do not let me inhibit you—you are on a roll.

Dr Simpson: What is CSN?

The Convener: In which submission does it appear?

Dr Simpson: On page 5 of its submission, above the reference to IAF, Aberdeenshire Council states that action has been taken to

> "Link mental health workers in place across CSN networks."

Linda Morrison: CSN stands for community school networks.

Dr Simpson: Thank you, convener.

The Convener: Not at all—that was highly informative and entertaining.

Mary Scanlon (Highlands and Islands) (Con): I am pleased to say that I looked up "nosological" in the dictionary before coming here; I discovered that it refers to the classification of diseases. I am sure that Richard Simpson and Ian McKee knew that, but I did not.

My first question is directed at Aberdeenshire Council. I felt quite depressed—almost upset—after reading your written evidence. We were hoping to get a picture of what is being done, but the submission provides a picture of what should be done. On the first page, it says that children

> "should be offered a medical assessment".

It goes on to say that

> "There are a number of … tools available"

and states that

> "Attendance of local health professionals at multi-disciplinary meetings"

has proved helpful. It also states that

> "We can learn from … research".

I think we all knew that. It continues:

> "Early intervention … will have positive benefits"

and then suggests that

> "We ... need to get better at supporting children".

We are also told that

> "Social workers in North Aberdeenshire have a perception that access to … CAMHS has reduced."

Either it has reduced or it has not. The final point that I found quite upsetting and horrible is that even when children

> "have experienced lengthy periods in secure care due to extreme self-harming",

they are

> "not … eligible for … support from CAMHS".

I really do not know where to start, so I leave that open to you. I hope that you understand that your submission does not make good reading for a committee that has a remit for and commitment to children with mental health problems. Nothing in the submission made me feel good about the services.

Linda Morrison: I can certainly see where you are coming from. In Aberdeenshire, there are 62 per cent fewer CAMHS staff than the recommended number for the population. As a result, many of the services have been concentrated in the city of Aberdeen, although there is a corresponding deficit in the number of specialist CAMHS posts in the city.

NHS Grampian has promised that it will reinstate the posts that we had that gave advice to residential staff and foster carers. We think that it is important that we can, when there are reduced resources, get advice and consultation for the people who are caring for children who might not have a recognised illness but who have complex needs.

We have put a lot of time and resources into rolling out our integrated assessment framework, which is picking up children's needs at a much earlier stage and looking at what the universal services can do, appropriately referring children to more specialist services.

Access to specialist CAMHS services is an issue for us in Aberdeenshire.

The Convener: Can you develop the phrase "is an issue", please?

Linda Morrison: Access to the services is a difficulty.

The Convener: Can you develop that more specifically? What problems do you face?

Linda Morrison: There are fairly long waiting lists. Our particular interest is in looked-after children, but there are no specific CAMHS specialist teams in Aberdeenshire for looked-after children.

Mary Scanlon: So, my reading of the situation is fairly accurate: it is a very bleak picture.

Linda Morrison: At the end where children need the specialist service, we have difficulties. However, at the other end we work more closely together.

Mary Scanlon: You say that there are waiting lists. How long would the longest or the average waiting time be for a child?

Linda Morrison: I am sorry, but I must give you that information later.

Mary Scanlon: I have a final question. If it is difficult to access services, if the waiting lists and waiting times are long, if there are not the staff and if the social workers have a perception that we do not know to be true, how are the children identified? It is bad enough getting into services. How are the children's mental health issues—temporary or whatever—identified pre-school and in primary and secondary school?

Linda Morrison: I should clarify that children who have the most complex mental health illnesses are seen. Identification now happens through our integrated assessment framework, which involves health, education and social work working together.

We are putting a lot of emphasis on early intervention. Our integrated assessment framework has been rolled out across all of Aberdeenshire, with associated training. I will explain how it works. Whoever identifies an issue has responsibility for it until it is decided that someone else is more appropriate. They start off by considering what they can do within their own service, or perhaps what they could do more widely, and can then organise multi-agency meetings if more support is needed.

10:15

Mary Scanlon: I know that "integrated assessment framework" and "multi-agency" sound like jargon—such things can be either wonderful or awful. Are nursery staff trained to identify communication or other problems at the pre-school stage? Do health visitors see children for a check-up at any stage between the ages of 15 months and five years? You say that whoever identifies an issue tends to have ownership of it while the patient is on the waiting list, until someone sees them.

Linda Morrison: No—we do not want a person to be referred only for them to fall into a black hole.

Mary Scanlon: I would like to stick to nursery. How is a child's developmental problem identified up to the age of five years—up to school age?

Linda Morrison: Our integrated assessment framework is based around community school networks, and multi-agency groups work together around those networks. If an issue is identified in nursery, the nursery staff will first consider whether they can deal with it themselves. If they cannot deal with it, a group of people working together can call a meeting of the—

Mary Scanlon: I am sorry, but I do not think that we are speaking about quite the same question. It is not a case of whether or not a nursery can deal with the situation. I want to know whether staff are sufficiently trained. Does someone see children between one and five years, and are they able to pick up issues that might potentially be harmful mental health issues later in life? I am not just talking about schools; I am also referring to private or charity sector nurseries—the whole range.

Linda Morrison: I cannot answer that for the health service, but I know that, if it is identified early that a child might need on-going health visiting support—

Mary Scanlon: What mechanism is there to identify issues early? That is my final question.

Linda Morrison: It would be around maternity staff health visiting at an early age, and whatever in the community that is there for individual children—

The Convener: I am going to move on and let other members in. We can return to those issues.

Dr Simpson: The committee has identified the issue of early intervention. We know about the problems of CAMHS and understaffing. CAMHS are tier 3 services. We are predominantly interested in, and have been discussing, the question of early identification. We know from the evidence and from framework reports that, for example, the witnessing of violence, having parents with drug and alcohol problems, or having "harsh and unsympathetic parenting", as the Royal College of Psychiatrists mentioned, are all factors that may or may not result in a problem in a child. Sometimes they will not, because of the child's in-built resilience, but not all children have that.

Mary Scanlon's question, which I am also asking, was this: what mechanisms exist among all the various services, including health, social work, education, nursery education and child minding? How are we picking up at an early stage those children with potential problems, who are at risk, so that they can be given—I presume—additional support and help? Is there a mechanism in place for ensuring that that is happening? I am particularly interested in North Lanarkshire, which is a pilot area for getting it right for every child. If it is not going to work there, it is not going to work anywhere.

One issue that was put out for consultation was whether we should back GIRFEC with legislation. That has been rejected for now, but the object was to ensure that the information to which I referred is shared compulsorily and statutorily between agencies so that early identification takes place. I want to know whether that is taking place without our having to resort to legislation.

Martin Egan (North Lanarkshire Council): A considerable amount of work is taking place in North Lanarkshire on developing as a learning partner, and considerably more work is still to take place. Systems are in place in each of the agencies in relation to the first point of contact with young children, considering wellbeing indicators, picking up concerns arising from them and considering whether the agency can address those sufficiently and deal with the deficits or whether a multi-agency response is required. We do not yet have in place fully developed interagency screening and resource teams in each of the localities—those are in development. Systems are in place in agencies to consider how they can support the child and effectively address problems, and how to refer or involve other agencies when necessary. Work is taking place to make that process more seamless through multi-agency screening and resourcing at an early stage.

Dr Simpson: Do any of the other witnesses want to comment? If not, I have a supplementary question.

The Convener: You asked a specific question about North Lanarkshire.

Dr Simpson: North Lanarkshire should be ahead of the rest, because it is a learning partner. However, the other witnesses might want to comment.

When I was the Deputy Minister for Justice, we promoted "Getting our Priorities Right—Good Practice Guidance for working with Children and Families affected by Substance Misuse", which related mainly to drugs. That was six years ago. The guidance said that the children in families in which there are drug or alcohol problems should be identified, have their needs assessed and be provided with support. We are six years on, but even the GIRFEC pilot project in North Lanarkshire is still talking about "developing". That is distressing and disturbing, so I seek reassurance. Let us take the specific example of families with drug and alcohol problems, at least 50 or 60 per cent of whom are identified because they are in contact with a general practitioner or a drug or alcohol service. Is information on children passed to social work and education services and is the impact of the family problems on the children assessed?

Anne Ritchie: Yes, that information is passed on. To reassure you about "Getting our Priorities Right", West Dunbartonshire has recently reviewed the protocol and procedures in relation to that. I chaired the meeting and found a considerable difference from when we started down the road. There has been a creditable improvement in understanding in adult services that provide support to families in which there are addiction problems. Previously, the main focus of those services was not on the needs of the child, but people now clearly understand that it is their responsibility to consider those needs. All our single shared assessments contain information on whether a child is involved. We have moved a long way from the point at which that was not even asked about, which is the point at which—I suspect—Richard Simpson was involved. Considerable strides have been made.

I hope that I can also give reassurance on the wider issue of the time that Richard Simpson perceives that it is taking for GIRFEC to be developed. The GIRFEC programme is just the latest version. I link it back to "For Scotland's children—Better integrated children's services" in 2001, which first identified the tiered approach and the need for universal services to get children the help that they need through excellent mainstream services wherever possible. People throughout Scotland signed up to and understood that.

When we talk about developing GIRFEC, we are actually talking about developing the more specialised systems for doing GIRFEC in the form that we would now expect. We are building on the tiered and staged approach that we have been using. We identify children at a younger age and we get them the help that they need, as close as possible to where they are, through health visitors, schools and nurseries. If the children need more targeted support, we help those universal services to provide that targeted support, if they can. Only at the end of a long process of more and more targeted and specialised support do you arrive at a point at which some young people need a more specialised service because they cannot survive without it. I want to be reassuring about that, because we have improved markedly over the time that committee members are talking about.

Linda Morrison: I, too, would like to offer reassurance. We have rolled out "Getting our Priorities Right" with a lot of joint training among people who work in adult services and people who work with children and families. All our adult services that come into contact with people who may be misusing drugs always ask whether they have children. They continue to ask the question, because when we are talking about chaotic families—[*Interruption.*]

Martin Egan: I am sorry—I thought that I had switched my phone off.

Linda Morrison: Children sometimes move from one family to another—[*Interruption.*]

The Convener: I sometimes put them in sand buckets.

Dr Simpson: Not the children, though.

Martin Egan: I am sorry, convener.

The Convener: Do not worry, Mr Egan. I have been guilty myself.

Linda Morrison: The adult services continue to ask the question. We have done a lot of joint training, and that has increased the understanding of people in services for adults and for children and families. The system works well. We receive referrals, and then there is an assessment report of the services needed. There is always feedback to the adult services, as well.

Dr Simpson: Linda Morrison mentioned children's nurses for looked-after children. Is such provision universal? Of the 11,000 looked-after children—or 14,000, as the figure is now—the percentage that ends up in the children's hearings system or in prisons for young offenders will be greater than that among the general population. It will already have been demonstrated that looked-after children do not have the resilience in the family, and can be a problem individually. Are there specialist services in place at all tiers?

Anne Ritchie: I cannot comment on universality, but in West Dunbartonshire we are fortunate in having a successful support programme for looked-after and accommodated children. The programme is called young people in mind, and it is linked to the child and adolescent mental health services based in Dumbarton. The capacity of the service has recently increased; we had been trying to recruit a psychologist for a considerable time. We have had the service for a lot longer than it has been at the level it is now. The increase in capacity has made a marked difference. Not everything can be solved by an increase in resources—we would all acknowledge that—but some things can certainly be helped, especially when the level of support that we can offer reaches a critical mass.

Young people in mind works with few individual young people directly; instead, it supports foster carers and residential workers, to give them confidence and a clear steer. It also works with teachers, so everybody is working to the same set of principles in helping young people. The programme is working very well. I was talking to colleagues earlier, and we would all agree that the service is very important.

Martin Egan: A similar service exists in North Lanarkshire in CAMHS and in the accommodated young people's service. Capacity has been an issue. When the service started, it was only for children in residential units, with the focus on training and supporting staff. There is a very effective and highly regarded training programme for our residential staff. We are trying to broaden that service so that we can offer it to children and young people in foster care.

I would like to go back to a previous point about development work in North Lanarkshire. I want to make it clear that we have some quite robust systems in place; it is a process of continuous review and development. It is not the case that no systems are in place or that we have not addressed the need to develop services that have been required for a long time.

10:30

Linda Morrison: In Aberdeenshire, we had a specialist CAMHS post to provide advice to residential workers and foster carers. Unfortunately, that post was withdrawn because of staffing problems in the NHS, but as part of its commitment to our corporate parenting policy, NHS Grampian has promised that it will reinstate it. NHS Grampian has given quite a strong commitment to corporate parenting. For example, it has guaranteed that every child in care, whether at home or in residential accommodation, will have access to an NHS doctor and it has made a commitment to offering some consultation to people who work with children with the most complex needs.

The Convener: What is corporate parenting?

Linda Morrison: Ah, corporate parenting is—

The Convener: It involves the local authority taking responsibility for parenting. Is that right?

Linda Morrison: No—not the local authority.

The Convener: Oh—I am sorry. I was misinformed by Richard Simpson.

Linda Morrison: It goes wider than the local authority—it involves the members of community planning partnerships. In Aberdeenshire, we have had commitments from the local authority, from health and from the police. It is about making life much better for children and young people while we are looking after them and when they leave care.

The Convener: Thank you. I thought that I had omitted to do that at some point in my parenting career.

Helen Eadie (Dunfermline East) (Lab): Good morning, everyone. I have been reading the *Official Reports* of the meetings that we had before the recess. A big issue that emerged was that it was the view of the group that produced the Scottish needs assessment programme report that we do not need new strategies and new frameworks; we need more implementation. That provoked some discussion about training.

When the SNAP report landed on your desks, how did you cascade it to your staff? What monitoring and evaluation have you done to ensure that the good strategies and frameworks that the SNAP report provided have been implemented? We were concerned that the SNAP report might have landed on people's shelves without being read.

Mary Scanlon: A report does not land on a shelf; it gets put on a shelf.

Helen Eadie: Yes. We are worried that the report might have been put on a shelf without being read.

The Convener: What were you doing with it, Helen? Were you dropping it on shelves?

Helen Eadie: I was landing it on shelves.

The Convener: You were landing it on shelves, like an aeroplane.

Ian McKee (Lothians) (SNP): That is better than being on the shelf.

Anne Ritchie: My copy of the report is not on a shelf.

The Convener: Ah!

Helen Eadie: You have come prepared.

How was the report cascaded, how was it implemented and how are you monitoring that process to ensure that it is happening?

Anne Ritchie: We built the SNAP report into our integrated children's services planning. Any new document—for example, the new guidance on corporate parenting—would go the same route. It would be brought into integrated children's services planning. All our partners are signed up to working together collaboratively to implement all those strands of work to improve services for children and young people. That is where the report went.

Within our system, there is a sub-group of the integrated children's services planning process, which is a working group on children who are affected by issues of mental ill health and emotional wellbeing. That group covers early intervention, building resilience and emotional wellbeing issues for our whole population right through to children who suffer from a diagnosable mental illness. That is where the report went.

Within that framework, health needed to do a lot of things. The higher level measures—the tier 3 measures—are very much in the sphere of health, but the people in health report back to the rest of us on what they are doing. Early intervention services have been developed that would have an impact on that issue. For example, we have a service called SNIPS: the special needs in pregnancy service—

Ian McKee: SNIPS? That sounds a bit late, really.

Anne Ritchie: The service has a dedicated group of staff who identify issues at the antenatal stage of pregnancies, where we are looking at—

The Convener: Do not rise to any of those sotto voce comments.

Anne Ritchie: Sorry—it is one of those unfortunate acronyms.

The Convener: Yes, we know. We will leave that where it has landed on Helen Eadie's shelf, and proceed, as you are making a serious point.

Anne Ritchie: I will try to carry on.

We identify babies early—before they are born—as having particular issues, perhaps because the mother has a mental health problem or, quite often, an addiction issue. We identify vulnerable children in that way, and the work of SNIPS feeds into the working group. All the work and the nurturing that is done with children in our schools, even at an individual level—

Helen Eadie: I am sorry to interrupt; I am sure that the professionalism comes through in all those actions, but I am looking for past reports that we as a committee could examine, which have clear action points and timelines that show the plans, outcomes, assessments and evaluations. Would we be able to see those historical documents?

Anne Ritchie: To see a process? Yes, there would be a process.

Helen Eadie: In relation to the SNAP report specifically?

Anne Ritchie: You would find that among all the other business, rather than finding a document that said, "Implementation of SNAP report", because a lot of the issues in the report tie in to other strategies, as you have identified. A lot of things in the report were not particularly new ideas.

Helen Eadie: I was really thinking about the fact that a Government produces a framework and a strategy—how are those implemented through a training process? Training is always an issue for local authorities, and a soft target for budget cuts.

How do you ensure that everyone is clear about the message—"This is what we have to do, folks, and how we are going to do it"—and how do you measure that in terms of outputs, evaluation and assessment? Can you clearly point to that within your local authority? If I were the leader of your local authority, would you be able to demonstrate to me how that had been done?

Anne Ritchie: Yes. I would be confident that you could be shown where that is happening, but not necessarily in a separate document that says, "SNAP implementation". If we did that, we would need an implementation plan for corporate parenting, getting it right for every child and getting our priorities right; we would end up with a sheaf of plans.

We have tried to integrate: that is our overriding instruction. We have to integrate new guidance, instructions and frameworks into the existing process as they come in. That means that sometimes we would need to unravel a specific issue, but I am confident that we could do that.

The Convener: Thank you—that is a very clear explanation.

Helen Eadie: Can I ask one more question?

The Convener: We will not pursue an audit of SNAP on its own.

Helen Eadie: My question is on a separate matter.

The Convener: Not that I could stop you, Helen.

Helen Eadie: It is on another issue that has emerged previously and again today. How big a problem is the shortage of psychiatrists throughout all the local authorities? For example, Aberdeenshire Council states in its submission:

> "According to social workers, there was previously an adolescent psychiatrist involved in routine discussions on the North Aberdeenshire Assessment Team however there has been no representative since the post-holder retired. There were also two psychiatrists who previously travelled to the area to see their clients in local facilities" —

and it goes on. It is all about the shortage of trained psychiatrists. How big a problem is that throughout Scotland?

Linda Morrison: There is certainly a problem in Aberdeenshire. I believe that no one has been able to be recruited to the consultant psychiatrist post. Certainly in Aberdeenshire, CAMHS staffing is at a different level from what it was previously, as we now have more primary mental health workers and fewer clinical psychiatrists. Colleagues in NHS Grampian have had problems with recruitment.

The Convener: Does Mr Egan or Ms Ritchie wish to comment on that?

Martin Egan: My understanding is that NHS Lanarkshire has been able to fill the posts, although there have been some delays. However, the size of the establishment is a significant concern. The workforce recommendation is that a teaching unit should have around 20 members of CAMHS staff for 100,000 children. In NHS Lanarkshire, our current establishment is 4.5 members of staff.

The Convener: I take it that Ms Ritchie does not wish to comment. She need not do so.

Michael Matheson (Falkirk West) (SNP): From the discussion so far, I am still having some difficulty in understanding how children with potential mental health problems are identified. I can understand that, when a family is in contact with services for an alcohol or drugs problem, that potentially allows us to get a foot in the door to identify such children. How do we measure our effectiveness at identifying children in those types of living environments, who are potentially at greatest risk? However, what I am really struggling to understand is how we identify those children who might be developing mental health problems but who are not in contact with statutory services such as children and families social workers, their GP, a health visitor or whatever else.

The Convener: That was two questions. First, how do we measure the success of those interventions in which it is perhaps easier to identify the children because the fact that the family is already in contact with social services—whether for a drug or alcohol problem, or because of a parent's mental illness—means that the children are already in the system? Secondly—

Michael Matheson: I am not asking how effectively services are provided to children who have been identified. I am asking how effective services are, when dealing with those who have drug and alcohol misuse problems, at taking forward issues that might present with any children.

The Convener: The other question was about how those who are not already in the system are identified. Is that right, Michael?

Michael Matheson: No. My other question was not about those who are not already in the system; it was about those who are not in contact with statutory services, whether those services are health or social work.

The Convener: Thank you for correcting me.

Martin Egan: Let me respond to that. Studies identify that approximately 10 per cent of children might experience a mental health difficulty at some point. The majority of those will not be involved in social work services and are likely to be in contact only with primary mental health services. Therefore, we are talking about the mental health of children and young people in the wider sense of wellbeing rather than of diagnosable mental illness. Universal services such as education—which nearly all children access—have processes in place to identify children who are experiencing some level of difficulty, which might not be labelled as a mental health difficulty but as an identified concern about the child's wellbeing. Initially, support services within the universal service might then help those children with identified difficulties. For example, nurture time and circle time are among the strategies that education services put in place. From those, any more significant difficulties that arise—those for which the universal service feels that it is unable to meet the child's needs—can be referred for additional support from social work and from more specialist health support.

Anne Ritchie: Schools are key. We talk about children not being in contact with statutory services, but most children are in school most of the time. If they are not, that itself is a trigger for concern that would be followed up.

A lot of effort has gone into assisting schools to recognise the difficulties that young people have and to offer guidance. That goes all the way through from very small children who show signs of distress to the kind of issues that arise more in secondary schools, such as self-harming. We recently issued guidance for staff on helping young people who are self-harming. Such issues are routine in the identifications through health services when children are tiny and through school later on.

10:45

Michael Matheson: How good are teachers at identifying children who are in distress? I am conscious that, with the exception of the very early stage soon after birth, health service involvement with children tails off significantly. There is then a gap from about 15 months through to what is roughly primary 1 when children are five. How are we meant to pick up on children in that age group who might be starting to present with mental health problems? Some of those children might be in pre-school education, but not necessarily that which is provided by a local authority. Are private sector nurseries as well equipped to access such services for the kids whom they look after?

Anne Ritchie: All the pre-school facilities that are not run by local authorities are still subject to care commission inspection. In my authority area, those inspection reports come to committee. Most of the reports show facilities of a high standard that are interested in the care needs and wellbeing of the children in their care.

There is no doubt that there has been considerable debate around Hall 4 and the targeting of health visiting services. From a social work point of view, the relative neutrality of a health visitor calling was certainly seen as a benefit. People are not too alarmed if the health visitor comes, but they might have a different reaction to social work.

Children in the higher risk groups—you identified some of them, such as parents having a mental health problem or addiction issues, or domestic abuse in the household—would be picked up and raised from the core health visiting service into an additional or intensive service. A number of support mechanisms exist for vulnerable young families. We have one in West Dunbartonshire whereby we identify families who are struggling and try to give them extra support.

If you are asking me whether any child slips through, the safeguard for the little ones involves identifying the higher risk groups and ensuring that they are part of the health visiting workload; after that, there is the early years provision at school.

Michael Matheson: I was not questioning the standard of care that is provided in private nursing establishments; I am just conscious that local authority nursery provision sometimes takes place in a school environment where there might be more ready access to teachers and school nurses, with whom nursery providers can explore the issues.

I am still left with the view that unless the child has a parent who is in contact with a statutory service for their issues, it is likely that there is no service out there that will pick up on any problems among children in the 15 months to five age group. Is that a fair comment?

Martin Egan: That is quite possible unless there is some presenting issue in the family.

Jackie Baillie (Dumbarton) (Lab): I will go to the other end of the age spectrum: the transition from CAMHS to adult mental health services. All the witnesses, without exception, have raised significant problems with that. I invite them not only to identify the problem, which they have already done, but to tell us what they believe the solution would be. We will start with Anne Ritchie. [*Laughter.*]

The Convener: We can start with someone else for a change. It is a major issue and has been raised in other submissions from psychiatrists and so on.

Linda Morrison: I will certainly come in on the challenge, but I am not sure that I have the solution. In Aberdeenshire Council, we find that, if a CAMHS patient has a recognised mental illness, their transition into adult services is easy and smooth. However, meeting the needs of those who have difficulties but perhaps not recognised mental illnesses is a continuing challenge, and I am not sure that any of us has the services in place for them. As part of our consideration of how to do better for young care leavers in particular, we need to discuss that transition much more and get better at it. It involves our social work adult mental health services as well as the clinical services. That transition can be difficult for 17 to 25-year-olds.

Martin Egan: In North Lanarkshire Council, we suggest considering services for adolescents and young adults. The onset of significant mental illness often occurs in adolescence and early adulthood, so we would support the establishment of services that were arranged around that age group, bridged the gap—as opposed to separating children and adolescent services from adult services—and provided a specific response to adolescents and young adults as a positive way forward.

Anne Ritchie: Martin Egan is right about that. To echo the point that Linda Morrison made, if there is a diagnosis, we do not experience any great problem in West Dunbartonshire Council. Our CAMHS are stretched, but they do good transitions and will hand on clearly to adult services if there is a clear illness. The problem arises if there has not been a diagnosis. Sometimes, there is a mismatch between the need for a diagnosis and a service that tries not to label. Moreover, particularly with early onset, it might not be entirely clear what is wrong. The transition is definitely more difficult when it is not clear what is wrong or if there is no actual illness but considerable disruptive behaviour, a conduct disorder or clear signs of marked emotional distress.

The Convener: I think that the submission from the Royal College of Psychiatrists referred to the transition to specific mental health services.

Jackie Baillie: The idea of a service for adolescents and young adults is interesting and I am curious to know whether it would require a bundle of new resources or would mean restructuring the current services. It is easy to say, but what does it mean? What should be in our report?

Anne Ritchie: The starting point would be to ask whether there are enough CAMHS anyway. There is clear evidence that they are stretched so, however we organise the services, they will be stretched.

Jackie Baillie: So the issue is not tier 1 or tier 2 staff, but tier 3 entirely.

Martin Egan: For the transition stage, tier 3 is the area where the significant difficulties lie.

Jackie Baillie: The submission from West Dunbartonshire Council mentions a fast-track access system into specialist CAMHS. I was not aware of that. Is it available only in NHS Greater Glasgow and Clyde? Is it wider? How does it work?

Anne Ritchie: I think that it was asking for such a system.

Jackie Baillie: Ah. It says that such systems

> "are in operations in some areas of service in Scotland".

So it is wishful thinking; I am clear about that. How would such a system operate if it were to exist? Who would you fast track?

Linda Morrison: I would like to see something that fast tracks looked-after children, who are some of the most vulnerable children with whom we work.

Martin Egan: In North Lanarkshire, we have some capacity in relation to looked-after children and looked-after accommodated children. Social work can make direct referrals. We get support from CAMHS staff in relation to training and consultation. Within their limited capacity, CAMHS in North Lanarkshire are doing a significant amount of valuable work, but capacity remains a big issue.

Ian McKee: Like my colleague Mary Scanlon, I was slightly concerned by the evidence from Aberdeenshire Council. It read more like a complaint from an individual about people not understanding them, lack of communication and poor division of responsibilities. I note that the submission does not have Linda Morrison's name at the bottom of it. The submission says at the beginning that it was written in a fair degree of hurry and that not everyone could be consulted, but it quotes extensively front-line workers and so on. Does the submission still represent your considered opinion or, three months on, would you make modifications to it?

Linda Morrison: I come from social work. The report shows clearly the perception of social work staff in Aberdeenshire. I know that colleagues in the NHS are outlining to the health board the deficiencies in CAMHS in Grampian and telling it what is needed to provide a different and better service. The people in management in NHS Grampian to whom we speak recognise the difficulties, and there is a willingness to address them.

Ian McKee: You state in your submission:

> "where health professionals are unable to make a clear diagnosis of mental illness a service is unlikely to be offered."

That goes back to Anne Ritchie's earlier evidence. I can see how that is a problem in one sense, but it made me wonder whether people are being referred down the line slightly too quickly, or inappropriately.

Later in your submission, you state that you accept that mental health and wellbeing is "everyone's business". However, you go on to say:

> "A recent survey … indicated that some people … regard mental health as an issue for health professionals."

You might already have an overburdened CAMH service and, in addition, inappropriate referrals are made because people further up the chain feel that something is not their business but CAMHS' business. We are dealing with not just severe mental ill health but mental health and wellbeing problems. A variety of people—general practitioners, health visitors and teachers—can all add something, but there seems to be an impression that the aim is to get everyone down the line to CAMHS as quickly as possible and that, as far as social work is concerned, that is the problem solved. I am sure that that is an unfair perception. Would any of you like to address that point?

Linda Morrison: I do not think that that is the case. My colleagues have been saying that they have had CAMHS support for consultation and advice to carers and residential staff. We have agreed with NHS Grampian that that is really important in giving people confidence to do the work. Sometimes when that is missing, there is an element of people thinking that they are out of their depth and wondering whether they should refer a case on. However, I do not think that there is a big issue with inappropriate referrals.

11:00

Ian McKee: I have a question along the same lines for all three witnesses. I do not think that community health partnerships have been mentioned at all, although they are meant to be a way of integrating social work and health services at the basic level. I appreciate that community health partnerships perhaps have little influence on how child and adolescent mental health services are run, but they certainly have a lot of influence on what happens before the level of specialist advice is reached. You have complained a lot about a lack of communication, but social work departments should probably take some ownership of that problem and do something about it. Surely one way of doing something about it is involving the community health partnership and all the workers at that level in the problems and getting rid of some of the problems that your staff have found as a result of not receiving adequate guidance.

Linda Morrison: Our submission describes how we find the situation, but it does not explain that we are in constant discussions. We have a framework for the development of children's services and a strategic group that considers mental health and wellbeing, which involves health, social work, education and other agencies. Therefore, there are on-going discussions, and we are considering what needs to be in place. Our submission outlines the situation rather than what we are trying to do about it.

Ian McKee: It outlines a situation of total confusion; there is a feeling of being rudderless. Is that not a matter of great concern?

Linda Morrison: I do not think that Aberdeenshire Council is in great confusion and rudderless; rather, we have some issues. There are severe resource issues relating to CAMHS, but we are doing very well in identifying early on children who may have emotional issues. We have a difficulty in accessing enough specialist CAMHS for those with the most complex needs—we are both aware of that—but we are trying to do the best that we can together with our scarce resources.

Ian McKee: Do the other witnesses want to say something about the use of community health partnerships?

The Convener: They have not indicated that they wish to comment. I was about to say that if they wish to—

Ian McKee: I wish them to comment.

The Convener: You may wish them to do so, but you cannot force them to. The witnesses should indicate if they wish to comment; otherwise, I will make a presumption and move on to the next question. We are making Mr Egan blush.

Martin Egan: A lot of local work is being done in primary health care, and several quite innovative projects are being implemented. North Lanarkshire has been a pilot area for an infant mental health project, for example, which we are looking to roll out.

The work that we are talking about is taking place in the same context as all the other areas of work under the GIRFEC agenda to build capacity in each of the agencies; meet need at the point of need; support staff with training, advice and skills to do that; and then involve other agencies where it has been assessed that that is required. We have robust systems in place to do that.

It is not my perception that there is a significant number of inappropriate referrals to CAMHS. In NHS Lanarkshire, two thirds of the referrals to CAMHS are from GPs. We are not talking about inappropriate fast-track referrals from social or education workers who do not try to address issues within their agencies before seeking additional and more specialist support where that is assessed as being required.

Anne Ritchie: I am sorry if I have not made clear the role of community health partnerships. That is simply because I take community health partnerships for granted as natural partners, just as I take it for granted that my education colleagues are natural partners. Everything that I have mentioned to do with special needs in pregnancy, getting our priorities right and the young families support service is approached using a multi-agency arrangement in partnership with them.

The Convener: Thank you. We shall now move on.

Ross Finnie (West of Scotland) (LD): As the witnesses will have gathered, finding out how we identify and respond to the need for early intervention is a main element of the committee's work. I want to pick up on another aspect of that, which is your ability to deal with the stigma that society continues to attach to anyone who is identified as having a mental health problem. Most of you identify that issue in your written evidence. Miss Ritchie placed great emphasis on the importance of the early years and school. However, if a problem were to be drawn to the attention of parents, a number of them would immediately enter into denial. You, as professionals, and we, as the committee, would wish to move to early intervention. Could all of you concentrate for a moment on the difficulties and conflict in such a move? What can we do about the continued societal stigma that is, unfortunately, attached to mental health problems? Will you expand on what is in your evidence? How, in promoting early intervention, can we overcome the difficulties and indeed the parental denial associated with mental health?

Linda Morrison: We have reclassified our child and adolescent mental health strategy group—which is a multi-agency group—as dealing with mental health and wellbeing. Every one of us has a level of mental health and wellbeing. We want to get away from an illness model. The more we talk about promoting resilience and wellbeing, the more we are able to get over that stigma.

We also considered the transition between primary and secondary school, which we are aware is a time when young people often have a lot of emotional distress. We used some of our choose life funding to do a research intervention project. As part of that, staff considered which children they thought were vulnerable, and then did so again after they had had some training. Often, it was not the children who were loud or acting up who were considered vulnerable, but the quiet ones.

We followed that group of children all the way through school. The Robert Gordon University did a research project on the group, and told us what kind of help it thought the group needed when things were difficult and, interestingly, who the children looked to for help. That changed as they went through school. They relied on parents and teachers in the earlier years, and more on their peers later. One of the things that came out of that was a peer mentoring scheme, which we have been able to roll out to other academies. We were using money that was for the prevention of suicide to look at children at a vulnerable and emotional stage. It is about concentrating on resilience and wellbeing.

Ross Finnie: I understand that. Nevertheless, it does not completely overcome the difficulty that even if teachers and headteachers in the early years are aware of the need to identify mental health problems, those same teachers will seek to access the very psychological services that you identify as being a little short in supply. There is also the issue of stigma. How do you overcome that?

Linda Morrison: The more we can skill people in the universal services to do what they are able to do, the less pressure we put on the more specialised services. We find that in social work as well, with our integrated assessment framework. People in universal services have felt more skilled to deal with the issues. However, I am not sure that I have the answer on how to overcome the societal stigma.

Martin Egan: One of the issues is access to services. Developments in North Lanarkshire in that regard include a school counselling service, which children and young people can access in a normal school environment. It is perceived as an accessible support service that is part of that environment. Those who use the service do not perceive themselves as being referred. In fact, there is a self-referral process in secondary schools. The process allows children and young people and families to seek the services that they need without being required to attend a clinic. We identified in our written evidence that clinic-based models of intervention are extremely difficult to access, especially for some of our most difficult families. Other means of providing services in normal venues in the community are likely to be more effective.

Anne Ritchie: The stigma about mental ill health goes across all age ranges. Public information campaigns such as see me, I'm a person, not a label help. They start to shift public perception. However, we are unlikely to get better at destigmatising mental health services for young people until we manage to do it for all of us. That is the issue on the big scale.

On the small scale, it is inevitable that a scarce resource at tier 3 level is unlikely to be local or to be delivered somewhere familiar, which makes the situation harder. However, we can see why that happens, because the resource must be used in the most efficient way, if not the most effective.

I agree that much of the support—for example, peer support in relation to bullying, and other kinds of early intervention—should be put into schools because young people find it more acceptable to access it there. However, the issue of stigma certainly still applies at a higher level.

The Convener: Mary Scanlon will ask the definitive brief question.

Mary Scanlon: In response to a question from Michael Matheson, Anne Ritchie mentioned the care commission. Could the panel members confirm to us whether the care commission can pick up mental health and other development issues in pre-school children in private, voluntary or council nursery schools? Could they kindly send us some care commission reports that confirm that it has picked up that issue and that it regularly monitors it?

The Convener: I think that I am correct in saying that the reports can be found on the care commission's website—they are public documents. Rather than ask the witnesses to deliver that information, the Scottish Parliament information centre or the committee clerks can provide it.

Anne Ritchie: It might be helpful if I clarify why I said what I did. I partly misunderstood what Mr Matheson was asking. The issue was whether private nurseries have a different ability to pick up on signs of distress from young children. I misunderstood Mr Matheson's point, so I apologise for that. The point that I was trying to make was that there is insufficient difference between the scrutiny of private nurseries and that of our own nurseries, and that the warmth, caring and nurturing that are offered to young children are certainly part of what is looked at.

The Convener: I am going to stop there because we have overrun quite a bit and we have a huge panel of witnesses coming before us next. I thank you all for your evidence. I suspend the meeting for a short break of five minutes maximum.

11:14

Meeting suspended.

11:23

On resuming—

The Convener: I am conscious of the time—we are 25 minutes behind my schedule. I welcome for a round-table discussion our second group of witnesses, who represent a variety of service professions in psychiatry and counselling services.

To those who have not participated in a round-table discussion before, I say that we are more interested in interaction between the professionals than in interaction between committee members and professionals. If you wish to comment on what a colleague or another professional says, just indicate that to me and I will call you. Committee members will speak only occasionally to obtain clarification. We are more interested in the discussion among the experts, on whom we are eavesdropping, as it were.

I ask you all to introduce yourselves briefly, starting from my left—your right.

Professor James Law (Royal College of Speech and Language Therapists): I am a professor of speech and language therapy, or language and communication science, at Queen Margaret University. I represent the Royal College of Speech and Language Therapists. Is that all the information that you want?

The Convener: That is fine. We have read all your submissions, which were extremely useful.

Dr Chris Wiles (British Psychological Society): I am a clinical psychologist and the head of service at the multidisciplinary CAMHS team in Elgin. I represent the British Psychological Society's faculty for children and young people, which comprises clinical psychologists throughout Scotland.

Martin Gemmell (British Psychological Society): I am the chair of the British Psychological Society's Scottish division of educational psychology. I am an educational psychologist in the city of Edinburgh, and I work with children, young people and their families in their schools, their communities and—sometimes—their homes. My contact with CAMHS in the national health service relates to attention deficit hyperactivity disorder, on which a project is running, and autism spectrum disorder. Those are my two big subjects.

Elizabeth MacDonald (College of Occupational Therapists): I am the Scotland policy officer for the College of Occupational Therapists. Before taking that position, I spent 13 years as an occupational therapist in a community paediatric occupational therapy service in a child development centre.

Gwyneth Bruce (College of Occupational Therapists): I am a head occupational therapist. I work in a multidisciplinary CAMHS service and manage a team of 10 occupational therapists.

Brian Lister (Scottish Children's Reporter Administration): I am a reporter manager with the Scottish Children's Reporter Administration. I was a member of the SNAP reference group and I have had a long interest in mental health services. With my colleagues, I am responsible for the SCRA in nine local authority areas, but I can speak on the SCRA's behalf.

Fiona Bonnar (Royal College of Nursing): I have been in nursing for 24 years and I am an accredited clinical leader in CAMHS with the Royal College of Nursing.

Karen Cromarty (British Association for Counselling and Psychotherapy): I work for the British Association for Counselling and Psychotherapy throughout the four nations of the United Kingdom with opinion formers, strategists, policy makers and statutory and voluntary services to ensure as best we can that we have the highest ethical standards and practice in counselling for children and young people, based on the best current research.

Professor Mick Cooper (British Association for Counselling and Psychotherapy): I am a professor of counselling at the University of Strathclyde and I specialise in research on counselling in schools.

Dr Kathy Leighton (Royal College of Psychiatrists): I am a consultant in child and adolescent psychiatry. My clinical base is in Greenock and I am one of the clinical leads for NHS Greater Glasgow and Clyde. I am the specialty adviser on child and adolescent mental health for the Scottish Government.

The Convener: You will have heard the evidence that we took earlier this morning. We will start by throwing in a question, as time is short. Jackie Baillie will ask a question, so that everybody can start to discuss matters.

Jackie Baillie: I will ask a question that I have previously asked about adolescent mental health services. The submissions seem to show some unanimity that a bespoke service is needed. How would that be shaped and structured? Does agreement about such a service, which I sensed from reading the submissions, exist?

Fiona Bonnar: I am delighted that that question has been asked. Without a doubt, we are in a great position to break down barriers in the transition phase between adolescent care and adult care. We should not forget that the teams in community nursing look for transparency on processes, to ensure that care pathways are identified with which we can move forward in unison to support young people in partnership.

Dr Leighton: I am interested in the use of the term "adolescent". Many services, agencies and people have different views about what adolescence is and about the boundaries around it. In society, young people are staying dependent for longer. Adolescence is a more modern concept. The health service and all services need to embrace that. Our college would certainly welcome work on developing the concept of services to target older adolescents and younger adults.

Research has shown that that group is particularly vulnerable to more severe disorders. Adversity or problems that have been identified early in life may become cumulative around the crucial transition from adolescence to adulthood, or people may reap the benefits of good early intervention.

11:30

Gwyneth Bruce: I welcome the opportunity for much closer working between adolescent and adult mental health services. As an occupational therapist, my focus is on developing a work identity and life skills. Many of the life issues that arise do not disappear when people turn 18—they go on for much longer than that. It would make much more practical sense for us to have the opportunity to address those issues up to people's early or mid-20s.

Dr Wiles: I welcome the concept of bespoke services. We need to capture the fact that experience of transition varies between individual young people. There is a significant shift in services for the transitioning age group. The developing children's services are much more integrative, whereas mental health services for adults tend to be much more linear and based on a medical model. Much good work disappears because there is no encompassing structure, so a bespoke or specific focus is important. It is not just about NHS services. There are clear gaps in other areas, especially for groups such as looked-after children. The disappearance of other services is a huge gap.

Brian Lister: I, too, will use the word "bespoke", because it sums up nicely the benefits of such an approach for the children's reporters' client group, who panel members see on a daily basis. Members have read the SCRA's written submission. All four of the pieces of research to which we refer identified mental illness in a goodly proportion of the unfortunate, sometimes very damaged, children who are referred to the SCRA.

As Dr Wiles indicated, the transition to adulthood of 16, 17 or 18-year-old children, who are still within the remit of the children's hearings system, is critical. Although the Children (Scotland) Act 1995 places a duty on local authorities to continue to work with children and adolescents of that age—even beyond the children's hearings system—I do not think that quality work of that sort is being done. If reporters, whose task is to divert children and young people away from compulsion, and panel members—who, when assessing children's cases, must decide whether children should be made subject to supervision requirements—had ready access to the facilities and expertise of a service that tapped into their needs and requirements, I guarantee that the outcomes for children and families would be much better. The evidence suggests that they would.

The Convener: It is excellent that you are prepared to guarantee that.

Brian Lister: I am. Such a service would be timely and appropriate.

The Convener: You have provided us with evidence on the percentage of young people—especially those with more criminal or disturbed behaviour—who have mental health problems

Brian Lister: Exactly.

Martin Gemmell: In educational psychology, we have developed post-school psychological services, with funding from the Scottish Government. Others may wish to look at that model. Such services are not focused on specific children—they are open to anyone who wishes to be involved. All of the 32 psychological services in Scotland now have post-school services that are looking at the transition from school to college and the adult world.

Dr Leighton: We are jumping around in the discussion, but I want to return to the specialist end of transitions. It is important to highlight the fact that the criteria for accessing CAMHS are significantly different from those for accessing adult mental health services. An earlier witness spoke about the difficulties that young people with diffuse and non-labelled disorders have in accessing appropriate services once they have passed the cut-off boundary for CAMHS locally. That leaves the young person very vulnerable.

There are models for transition services that embrace 16 to 25-year-olds; indeed, in our submission, we mention a Royal College of Psychiatrists paper on that very issue. That is not to say that good work is not being carried out at individual or case-based level; I simply do not think that any identified child would be allowed to fall through a gap. However, we certainly support opening up services and making them more accessible to that particular group. I know that the RCP's mental health division has carried out work on integrated care pathways for particular disorders in adults, and we in the child and adolescent psychiatry faculty of the RCP would be very keen for that work not only to embrace the child and adolescent age range but to encompass specific work on pathways around transition.

Karen Cromarty: I want to interpret the question in terms of universal CAHMS rather than specialist CAHMS and link it to the issue of stigma, which was raised in the previous evidence session. Our evaluations of school counselling services show that if young people access non-stigmatising counselling services at school they are quite happy to access adult services when they move into adulthood. If we ensure that, as adolescents, they become desensitised to any stigma in that respect, we might begin to have an adult population that is not so concerned about the issue.

Fiona Bonnar: What I find exciting about being part of this discussion is the belief that we should never get too far from what our young people have asked us to be mindful of in the early years framework and new mental health legislation, which is the need to create a service that best meets their needs in the here and now. However, my nursing colleagues want to be able to access more joint training opportunities. In the choose life forum, for example, we learned skills together and promoted the wellbeing of our young people.

Martin Gemmell: Particularly with CAHMS—and particularly in Edinburgh—we have to deliver a service that is suitable for the client instead of saying to people, "You can't have this service because you're psychotic," or, "You can't have this service because you have anxiety or conduct disorders that we can't do anything about. See you later." At the moment, people are sort of funnelled into the system.

I do not know what the situation is like in other parts of Scotland but, in Edinburgh, CAMHS are perceived to be middle-class services. The system there also illustrates the dangers of a fast-track system; people in Edinburgh are sent a letter saying, "You've got an appointment at CAMHS. Please phone and book an appointment within the next two weeks or we'll assume that you don't want the service." Such a development is ludicrous.

The Convener: I could see you rising to that comment, Ms Bruce.

Gwyneth Bruce: I understand people's anxieties in that respect. However, we do not have the kind of cut-off that Mr Gemmell has described; there are a number of checks and balances in place. For example, when people do not respond to an opt-in letter, we check the notes and follow up those whom we think have fallen through the net.

The Convener: Is that what happens in Edinburgh?

Gwyneth Bruce: Yes.

Professor Cooper: Our research has found that young people often just want to talk and get things off their chest. Some young people out there—you might call them troubled young people—feel that they cannot talk to their parents or teachers about certain issues. Instead of being treated, they should be given the chance to talk to someone.

Dr Wiles: We need to be mindful of the need to integrate multi-agency practice across universal services and also with specialist services. I have a great fear that we will get into a debate about where to invest or where to structure development. Much very good work went into the framework, "The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care". The big message that we want to get across today is that implementing the framework will meet many of the concerns that have been expressed during the inquiry.

Dr Simpson: The recent paper in *The British Journal of Psychiatry* from the University of Stirling on levels of self-harm was quite scary. It suggested that 13.8 per cent of teenagers self-harm, and double that number—another 14 per cent—had thought about self-harming. I reinforce Professor Cooper's point that we need a universal, readily accessed and destigmatised counselling service in the early stages to prevent worse problems from developing at a later stage. That paper was a real eye-opener because I did not think the levels were that high.

The Convener: After hearing from Brian Lister, Dr Leighton and Ian McKee, we will discuss early intervention—unless there is something else to be said on transition.

Brian Lister: My point is directly related to early intervention. Previous speakers have correctly commented on readily accessible services for children and young people. Among the biggest problems, as far as we are concerned, are the huge waiting lists and the unacceptable timeframe, although panel members and reporters have to accept those because of inadequate resources. I am not being critical of colleagues; we are all working in partnership. However, on Monday, I checked the most recent case that I could access, and it will take around five months, from 26 May to the end of August, to get a report. In the life of a young person of 14 years of age, that timeframe is unacceptable.

A good comment was made earlier by one of the committee's members: it is all very well to talk of structures but where is the delivery and what is the outcome? Five months can make all the difference in the life of a young person between their thinking about doing something and actually doing it.

The Convener: You said it would take five months for a report.

Brian Lister: Yes.

The Convener: What type of report?

Brian Lister: A psychological assessment report by CAMHS.

The Convener: So it is not even for intervention purposes. What happens before that report is received?

Brian Lister: I do not know.

The Convener: Perhaps somebody else can tell us.

Dr Leighton: I will pick up on the point made by Mr Lister and Mr Gemmell about access to specialist CAMHS, which I think has been raised by a number of people. I am pleased that the difficulty is acknowledged. Specialist CAMHS are most definitely underresourced—that issue has been considered in a number of policy papers, through SNAP, the framework and the workforce document.

We are dedicated to providing a high-quality service. Access is a real issue, and the waiting list is a travesty. Now that we have the framework and the recognition that mental health is everyone's business, we hope that developments at the more generic, universal level will provide more ready and less stigmatised access for young people who have difficulties such as the wish to self-harm.

There is a good research base that shows that universal services in our schools—school nurses, school counsellors and so on—which are walk-in, drop-in services, are well used, particularly by adolescents. They can start to break down the stigma, provide some early intervention and do hands-on work that might prevent the young people from deteriorating to the point at which they have to be referred on to specialist services.

11:45

There is a role for specialist CAMHS in providing outreach training to services. That spreads the butter even more thinly in terms of CAMHS staff, as CAMHS are involved in increased activity to support the development of universal services. We are stretched at both ends.

There is variation across the country, as some services are better resourced than others. That needs to be examined.

Ian McKee: I am reassured by some of what Dr Leighton said—not the bit about the lack of resources but the bit about the mechanisms.

When I was in practice in Edinburgh three years ago, it was impossible to get NHS counselling for adult patients without referring them to a community mental health team, which meant that we were automatically labelling people as having mental health problems even if they only required counselling. Are there any areas in Scotland in which children have to be labelled as having a mental health problem before they are given access to counselling?

Karen Cromarty: The provision of counselling for young people in Scotland is patchy. There has been huge growth in some authorities, with some even putting counsellors in every school. However, young people in other areas of Scotland do not have that level of access.

When counselling exists in the school, the medical type of intervention that you describe does not take place. The service is designed to be easy to access. Teaching staff are excellent at knowing the young people they deal with. They know when young people are troubled and can see when they start to behave unusually. Referral in schools is extremely easy and does not have a stigma attached to it.

The framework was mentioned earlier. Confidential, accessible and non-stigmatising counselling is mentioned in the framework as an aspirational target for 2015. However, we are worried about the fact that implementation is patchy. Northern Ireland and Wales have implementation strategies for counselling in all their schools. Scotland has that target, but implementation is not happening. On a positive note, England is far behind Scotland.

The Convener: That was tactful.

Dr Wiles: On the issue of timeframes, which links to the issue of the type of service, I point out that specialist CAMHS are multi disciplinary rather than being simply medical. As the evidence grows about what works best for children, young people and their families, the targets also grow wider and wider.

The quality of those services is hugely variable across the country, but the common factor is the degree to which the quality is slightly less than poor—I think that that is the best way to describe it. Related to that point is the fact that the good work that has been done on workforce development has not been followed up. The development of the new MSc in applied psychology, which targets early intervention specifically and supports many of the framework outcomes, has been supported by NHS Education for Scotland, but there has been little support by way of jobs for the staff who have that qualification. That is an example of the thinking being good but the use of the results of that thinking being extremely patchy, at best.

Fiona Bonnar: One of the important aspects of this debate is the need to ensure that we have cross-education, pre-imposed registration in many parts of our profession so that we are able quickly to identify the young people who have severe-end mental ill health and can gather knowledge about mental health issues.

Turning around a young person who has a suicidal intent is one of the most satisfying jobs that it is possible to have. I could not be any more excited about it. We need to get that message across so that we can attract skilled staff into those positions, and we need to ensure that they are supported adequately, so that they can do their jobs positively.

The Convener: We will move to the other end of the spectrum at this point. Mary Scanlon has a question about early years.

Mary Scanlon: I was concerned to read in the submission from the British Psychological Society that

> "Children and young people with mental health problems are often identified in primary healthcare settings where the concern is largely presented by their parents."

I was also concerned to read another passage, which said:

> "There is considerable confusion at times about how to respond to self harm, aggressive or acting-out behaviours. It is also evident that young people who are withdrawn, depressed or struggling socially can often be missed."

Another concerning passage stated:

> "Often primary care health and education staff can be unclear and disconnected from the integrated children's services processes".

In the submission from the Scottish division of the Royal College of Psychiatrists, I was concerned to read that

> "a number of professionals still deny the existence of disabling mental health disorders in children, or maintain that mental health disorders are somehow the result of 'labelling' of children by psychiatrists".

On the nosological classification of attention deficit hyperactivity disorder, it is concerning for me, as a politician without any health background, to read that there are still arguments in the profession about whether ADHD exists. Never mind the services or the intervention, all of that is still going on in the background, which is confusing in itself.

I am just trying to find a clear pathway by which someone—whether in nursery, primary or secondary school—can pick up on the fact that a child has a mental health or developmental issue and ensure that they are helped at the earliest opportunity, but what I am seeing in these submissions is total confusion.

The Convener: There was a lot in your question, Mary, so I suggest that we put the issue of ADHD to one side for the moment and concentrate first on the issue that, largely, it is parents who come forward to say that their child has mental health problems and that it is parents who are resistant to the idea that that might be the case, as no one wants either to think that their child is imperfect or to stigmatise them.

To start with, then, how can problems with very young children be picked up on?

Professor Law: I am interested in the universal aspect of the situation, not in the highly specialised end of the market. Identification, especially in the very early years, has a lot to do with the type of professionals whom the parents come into contact with. For example, health visitors are a critical part of the process. We know that children with attachment disorders or difficulties with attachment—it is probably not necessary to explain what that is exactly—can be identified by about 10 months to a year. The question of how many of those children are likely to go on to have serious mental health problems is a bit of a moot point.

My interest is in communication skills, and it seems to be true that, if children with attachment problems develop communication difficulties later on, they are likely either to have externalising behaviour problems or to be more reserved in their schooling. Of course, at this stage, they are not psychiatric cases, and we are talking about people in schools offering them support in the early years of their lives. The majority of the children about whom we are talking can be identified in the first five years of life.

We have done work recently to follow up children with language and communication difficulties from school entry at five up to their mid-30s, by which time we can detect any mental health problems in those people. Once we have taken into account the control for social class and the social disadvantage issues, we can still detect a relationship between problems with early communication skills and what people are like as adults. The key message is that many of the risk-type cases can be identified long before the problems manifest and a person needs to go to CAMHS. The key is to skill up people on the ground to deal with that.

We have heard reference to Hall 4, or the fourth edition of "Health for all Children". One real problem is that health visitors, who used to be the key people in identifying such children, are now not doing much in the way of core services; instead, they focus on additional services and the children who have complex and intense needs right from the start. The universal service that has been provided is beginning to slip away.

As an illustration, I can tell the committee that traditionally about half—40 or 50 per cent—of referrals to speech therapists in the pre-school period used to come from health visitors. The Royal College of Speech and Language Therapists carried out a review at the end of last year about how much had changed post "Health for all Children 4", and it found that the figure is now about 15 per cent. Health visitors are not identifying children with needs and referring them to the same extent, unless they have very risky families or identifiable issues in the first few months of life. If they are not in that category, the chances of their being picked up without their parents coming forward are non-existent.

We know that there are social class gradients with all the speech and language issues. If there are more cases in the lower socioeconomic status groups, loads more of them will be missed unless health visitors or nursery nurses pick them up. That is a really important issue. There is a massive role for support staff.

The Convener: Richard Simpson wants to pick up on that, but some of our witnesses have been very patient, so I will let them speak first, if it is on that topic.

Elizabeth MacDonald: It is on that topic: I have a comment about the early identification of children, although not as early as has been talked about but in nursery.

My experience is that nursery staff are extremely capable of raising awareness of children in their nurseries who have developmental difficulties of any sort. The staff often know the parents and the backgrounds, and they should be used to identify children at that stage. Occupational therapists go to nurseries a lot, and nursery staff often highlight children who are not on our books or who are not known to the child development centre but whom the staff are worried about because of a behavioural or other problem. Children with a developmental co-ordination disorder or ADHD can be identified very early. We need early intervention so that children do not end up with mental health issues and issues such as school exclusions, behavioural problems and underachievement.

I want to reassure members that, in my experience, nursery staff are capable of raising awareness of children who have issues, but they need support from services. I know that they get a lot of support from child health services and that there is a good team, but I am not so sure about CAMHS. Again, that is a resource issue rather than anything else.

Dr Wiles: I have two points about early intervention. First, we have talked a lot about stigma. In some of the processes around understanding children's needs, particularly at the early intervention or early identification stage, much more use could be made of existing structures, such as the GIRFEC programme and the additional support for learning agenda. We should be talking in an integrated way about young people's needs. A specific mental health or developmental need can be encompassed within that, which therefore reduces the stigma. We should also identify within those processes the interpersonal difficulties in families and communities that cause mental health difficulties for children and young people in their development. Much more could be made of that early intervention in the wider reality.

My second point is about universal understanding and development of the intelligent networks that the framework talks about. The idea is that all those who work with children and young people should understand mental health and wellbeing sufficiently to identify, track and understand what they can contribute. Those intelligent networks are grossly underdeveloped in Scotland. There is a need for access to specialist support to develop the networks—it is not just a universal development; specialist support needs to be given to develop them.

12:00

Martin Gemmell: I will try to answer a few of the questions. On early identification, as educational psychologists we are fortunate that the nursery or school staff will identify children and young people with whom we need to work. We work with those children in the school context or sometimes at home with their families in the community.

We weigh up whether we are able to do the work or whether referral to a CAMH service is worth investigating because we are aware of extensive waiting lists. One proposal that would help CAMHS is that they follow our lead, come out of the hospitals and forge much closer links with schools. There does not seem to be a particular need to be based in a hospital when delivering a mental health service.

Many referrals come through parents. You have to put in quite a lot of work with young people if, for example, you are setting up a service in a school whereby young people help other young people. For the clients to appear and be helped by the young people, you have to advertise the service and really push it. If you are looking for young people to self-refer, you have to—[*Interruption.*] Perhaps I have picked you up wrongly—did you mean that it is the parents who are pushing for the referral and not getting picked up?

Mary Scanlon: I would not expect a three-year-old to self-refer.

Martin Gemmell: Clearly not; parents make referrals too.

Fiona Bonnar: Colleagues in community nursing have a valuable role to play in contributing to early identification. They provide a suitable interface that embeds service provision locally and ensures that local families get the support networks to which they are entitled.

Dr Simpson: Professor Law mentioned in his report the changes in Hall 4 to the role and targeting of health visitors that are leading to delays of two or more years in referral to speech and language services. Surely the situation has changed radically in the past seven or eight years in that we now have nursery education for all three and four-year-olds, which we did not have 10 years ago. Therefore, the opportunity for picking up on problems must come through nursery nurses—and not through health visitors to nearly the same extent as before.

The figures on the massive drop in referrals by health visitors that Professor Law quoted are exactly what I would expect, provided that referral numbers were increasing overall and coming from nursery nurses. The pilot that we were running to offer nursery school education to two-year-olds in special needs groups and families at risk has been abandoned. My question to all the witnesses is: who is training the child minders and nursery nurses who look after the younger age group in which children develop communication skills, and are they being trained adequately? It is in that group that we need to pick up on problems.

The Convener: Before the witnesses answer that question, I invite Professor Law to comment on the figures that might have been skewed.

Professor Law: I understand exactly what Dr Simpson is saying. This is not to do with CAMHS but speech and language services. The reports, such as they are, tell us that children with such difficulties are coming through later. There is a delay: they would have been picked up at two and a half; now, they are picked up at four. That is an issue.

Dr Simpson: Is it a training issue?

Professor Law: A lot of training goes on, but there is no consistent training on speech and language as far as nursery staff are concerned. There are local initiatives, but I would suggest that the arrangements are a bit ad hoc.

Dr Simpson: That is very helpful evidence.

The Convener: You say that the report that is coming to us is—I hesitate to use the word “anecdotal”—not a formal report.

Professor Law: It is not a formal report; it is a consultation that the Royal College of Speech and Language Therapists completed last year. It is available, although it is not publicly available as yet.

The Convener: It would be useful to have that.

Professor Law: If you like, we can send it to you.

The Convener: If it refers to the fall-off in referrals, it will be useful. I just wanted to catch up on that point.

Dr Leighton: I, too, wish to pick up on the point about the changes that Hall 4 has brought about and the move towards targeted health visitor services and early screening. Some good work has been done to target more vulnerable groups, and that is supported by research. Those groups include children who are identified during pregnancy and socially disadvantaged, looked-after and accommodated children. Children in those groups are very vulnerable. There is a potential for some children to slip through the net, and that should be highlighted.

Although nursery provision is available for all children, not all children will access it, particularly those in some of the most vulnerable families, such as families in which there are mental health problems or drug addiction problems that have not fully been identified. Young people in those circumstances might be in itinerant families who move from area to area—that is a gap group.

Work is being carried out across agencies in all areas. There is a role for all workers who provide services for children and young people to get together, at some level, in screening groups. Some of the evidence from local authorities has referred to those groups, and good work is going on at that level to identify the gaps. We continue to meet and discuss such matters through children's service planning.

Martin Gemmell: We educational psychologists are heavily involved in training nursery nurses and nursery teachers and helping them to work with children whose behaviours present as problematic. That does not necessarily mean that they have an issue that will develop into a mental health problem—it may or may not. We cannot say, when children are three, that one will have a mental health problem and another one will not; we merely deal with problematic behaviours. Therefore, we have to have a universal service rather than a specialist one. Many children will present with behaviours, but they will not all develop mental health problems.

Helen Eadie: I am not sure whether it is possible to change tack slightly.

The Convener: Does anybody else wish to comment on early-years identification? If not, we can move on.

Helen Eadie: My point is about the role of universities and research. I get the sense from many of the contributions that we have heard, both today and previously, that people are always trying to suck it and see—finding out what works and what does not work. The question arises, who actually does the research? What problems do they face? One of our papers from SPICe suggests that there is

> "concern at the decline in funding of and staffing of academic services relating to children's mental health in universities in Scotland."

What are the issues? A lot of good work is being done in the field, but how do we assimilate it all and ensure that best practice is spread via the universities?

Dr Wiles: In the universities and specialist CAMHS there are highly skilled, highly trained professionals who should be able to be involved in research. However, because of difficulties in resourcing specialist CAMHS, clinical psychologists often forgo research to keep services alive, to keep response times minimal and to meet the multiple demands on CAMHS. Clinical psychologists' research skills are undervalued in CAMHS because of the pressure on services.

Professor Cooper: The University of Strathclyde is involved in research on counselling in schools, but the main problem is funding—finding the money to research what is effective and to what extent, and to identify the young people for whom it is most effective.

Professor Law: I have a general point about research in relation to children. It sounds like I am flogging my job, but we must be aware of the fact that remarkably little research is taking place. I am interested in the relationship between communication skills and mental health problems, which was identified academically in the late 1980s and early 1990s. I can safely say that 3.8 speech therapists are working in CAMHS teams in Scotland. As far as I know, children's language and communication skills are not formally assessed by any CAMHS teams. My message is that not much research is taking place, and the research that is taking place tends to be international, rather than Scottish, and does not feed into practice. I do not deny that clinical researchers are doing much good work on the ground, but academic work does not filter down well and a lot of what we know is not translated into practice.

The Convener: What will allow research to filter down?

Professor Law: The key terms nowadays are knowledge transfer and knowledge management. Knowledge transfer could easily be implemented around CAMHS activity. The gap that exists in that area is important. Practitioners do what they were taught in college but do not keep up with all of the literature. That happens all over the place, although I accept that psychologists might be better in that regard than some other practitioners. [*Laughter.*] Perhaps they are not.

The Convener: You have certainly not pleased everyone.

Professor Law: I suggest that we know more than we are putting into practice.

The Convener: I must let the Royal College of Psychiatrists rebut that suggestion.

Dr Leighton: I must respond to that. A range of professionals in CAMHS have research skills. Dr Wiles made the point that resourcing underlies our ability to free up time for research. All psychiatrists complete research as part of their core training. Clinical psychologists and many multidisciplinary colleagues, including nurses and all therapists, do the same. Research is a core part of training, but when we hit the ground in clinical services our job planning means that research time is marginalised.

Another issue is the funding of academic posts. In the modernising medical careers programme, there is less emphasis on supporting academic doctors and psychiatrists, so it is more difficult for academic child and adolescent psychiatrists to access training. The only professor's post in Scotland has not been filled for a number of years. Resourcing of academic departments for child and adolescent psychiatry across the country is low and is being cut: the senior lecturer post in Edinburgh has gone, with the retiral of the incumbent. A whole can of worms is associated with keeping research alive.

Professor Law: I have a quick retort.

The Convener: Not if you dig a hole for yourself, Professor Law.

Professor Law: My point is not about psychiatry: it is about general practice and universal services. How many general practitioners in Scotland are active and publishing researchers on child development? The answer is one, in Glasgow. Just think about that.

Dr Leighton: That is another resourcing issue.

The Convener: Please speak through the chair. I am sure that you will have a lot to say to each other afterwards.

Professor Law: I do not want to comment further. Clearly, there are lots of gaps.

The Convener: Mr Gemmell, you did quite well to keep out of that.

12:15

Martin Gemmell: I accept that resources are problematic and that everybody is stretched everywhere, but certainly in my work, in the children and families department of the local authority, if you are willing to try to make something happen you can do so without it having a huge cost implication, although you will have to make sacrifices in other areas. It depends on what your priorities are and where you feel there are service gaps. If research is useful in that direction, there might be more of it. However, you cannot sit about waiting to be awarded money. You just have to get stuck in and do it yourself.

The Convener: I feel that the "to research or not to research—that is the question" debate could go on for a long time. Are you going to deal with research, Ms Bonnar?

Fiona Bonnar: Perhaps I can give an alternative to equal status. We should never forget the importance of leadership within CAMHS environments and beyond, such as in our community resources. We should also acknowledge that leadership must involve keeping up with the latest research and what is available to us, and providing clinical supervision on a regular basis—or, if not providing it, ensuring that others have access to it.

Dr Wiles: I support that view. However, there is also the issue of the pressure on specialist CAMHS—and the huge leadership task within that—to support not just the development of services but the development within universal services of better and faster provision in a multi-agency context. That is a huge task for a resource that is widely understood to be hugely underresourced. There are significant fatigue and morale issues among CAMHS leaders. I do not want to sound like a whinger, but we are trying to get more and more from something that, in reality, is not getting any bigger.

The Convener: I feel that we are losing momentum. I am sure that the committee will stop me if this is not what it wants, but would it be useful to go round the table and get each witness to tell us something that it is crucial is in our report? We can then decide whether the points are useful. We have aired all the issues. The obstacles have come up in general comments on other areas. Would that approach be useful?

Witnesses *indicated agreement*.

The Convener: Professor Law, tell us one thing that you think we must put in our report.

Professor Law: It is critical that children's communication skills are included, not only because examining them helps us to identify which children need help in the first place, but because what we do with children—often it is talking therapies—reflects their ability to communicate in the first place. Communication is my bid.

Dr Wiles: Implementing the framework for promotion, prevention and care will take us where we need to go. In order for that to happen, we must increase health boards' and local authorities' accountability for implementation in an integrated way.

Martin Gemmell: Professionals give up models that suit them—that they like delivering—and develop models that suit their clients better. To do that, NHS staff should come out of their hospitals and work more in communities and in schools and nurseries, to help children and young people with mental health issues.

Elizabeth MacDonald: Occupational therapists supply occupation or activity-based therapeutic interventions to the range of therapies that the CAMHS teams supply for children. However, not all teams have occupational therapists. Occupational therapy is based on looking at what the child finds important within their environment, at the child's own pace, and the child's activity goals. The fact that occupational therapists are not in all CAMHS teams is concerning. I hope that they will at least be in CAMHS teams' plans, perhaps when they get more resources.

Gwyneth Bruce: I reinforce that. We are a small profession within CAMHS. My team, which has 10 occupational therapists, is unique in Scotland and shows that if someone can demonstrate the usefulness of occupational therapists in CAMHS teams, posts will be created. However, that is not the case throughout Scotland, and that needs to be addressed.

Brian Lister: Also on the theme of prevention, Adam Ingram has set up a working group to review national child protection guidance, which nobody has mentioned yet. The committee will be aware of that group, but I am not sure that everybody around the table is aware of it. There are also two sub-groups, the first of which will focus on the sharing of information and the assessment of risk and need. Anne Ritchie is chairing that group, which is helpful, because she will champion some of the things that she has mentioned today. The other group, which is also directly relevant to a lot of what has been discussed, will focus on child protection definitions, procedures and processes.

One of the main focuses in this morning's discussion has been prevention. Volunteers were sought for those sub-groups, and I do not know whether anybody around the table has put their name forward. Nevertheless, it is critical that the committee's report—which will be fundamental to some aspects of the review of national child protection guidance, which intends to proof child protection for the next 20 to 25 years, according to the minister—is linked to that work. I make that plea to the committee.

Fiona Bonnar: Mindful of the fact that I am a CAMHS clinician who is anxious about the transition from adolescent care to adult care, my message is that we should be encouraged to break down the barriers and ensure that the needs of young people and their families are foremost in our mind as we move forward and develop pathways.

Karen Cromarty: I would like the committee to consider a recommendation that a strategy for school-based counselling be introduced in Scotland, such as has been introduced in Northern Ireland and Wales. Such counselling is a cost-effective, non-stigmatising early intervention. Research shows not only that children, young people and their families would like such a strategy, but that it works.

Professor Cooper: I reiterate what Karen Cromarty said. Counselling in schools is rated as highly effective by young people, and pastoral care staff respond positively to it. I also support the implementation of the framework guidance for a service across all secondary schools that provides an easily accessible, non-stigmatising form of early intervention.

Dr Leighton: I echo all of what has been said and I remind the committee of the framework and the getting the right workforce documents, which have already come out. It is important to address the balance of universal and targeted services and to work together in a multi-agency way with the child at the centre. Resourcing is a real issue in specialist CAMHS across the board, but particularly around transitions. I could go on.

The Convener: No, you cannot. I thank you all very much. That was very helpful and will assist with drafting our report. The senior clerks will be delighted to have had some structure delivered to them. I also thank everyone for their attendance.

12:23

Meeting suspended.

12:25

On resuming—

Guidance on NHS Boards Accepting Donations (Correspondence)

The Convener: Item 2 is on proposed guidance to NHS boards on accepting donations from external parties. I direct members to paper HS/S3/09/12/15, which contains a copy of a letter from the Cabinet Secretary for Health and Wellbeing, who seeks our views on whether the proposed guidance is appropriate for dealing with the issue and whether Parliament should debate the subject. Can I have members' comments, please, on the guidance and whether a debate in Parliament is required?

Mary Scanlon: At first glance, the guidance seems all right, and I do not particularly want to have a parliamentary debate on it. However, I would like the opportunity to run the guidance past a couple of my colleagues. Would it be possible to submit any comments by the end of the day?

The Convener: There is no particular timescale. If you give me guidance today, we can draft a reply to the minister on behalf of the committee and send it to members to ask whether they are content with it or want to make amendments. If there is disquiet and members want to discuss the issue further, that will be fine. Does anybody else want to comment?

Mary Scanlon: I am content with that approach.

The Convener: The guidance seems common sense and provides a lot of sensible discretion. I do not think that we require a debate on the matter in Parliament. Does the committee agree with the proposal?

Members *indicated agreement*.

The Convener: Item 3 is consideration of our draft report on the pathways into sport inquiry. As agreed at the meeting of 14 January, we will take this item in private. I ask members of the public to leave.

12:27

Meeting continued in private until 12:54.

Members who would like a printed copy of the *Official Report* to be forwarded to them should give notice at the Document Supply Centre.

No proofs of the *Official Report* can be supplied. Members who want to suggest corrections for the archive edition should mark them clearly in the daily edition, and send it to the Official Report, Scottish Parliament, Edinburgh EH99 1SP. Suggested corrections in any other form cannot be accepted.

The deadline for corrections to this edition is:

Monday 4 May 2009

PRICES AND SUBSCRIPTION RATES

OFFICIAL REPORT daily editions

Single copies: £5.00
Meetings of the Parliament annual subscriptions: £350.00

The archive edition of the *Official Report* of meetings of the Parliament, written answers and public meetings of committees will be published on CD-ROM.

WRITTEN ANSWERS TO PARLIAMENTARY QUESTIONS weekly compilation

Single copies: £3.75

Annual subscriptions: £150.00

Standing orders will be accepted at Document Supply.

Published in Edinburgh by RR Donnelley and available from:

Blackwell's Bookshop

53 South Bridge
Edinburgh EH1 1YS
0131 622 8222

Blackwell's Bookshops:
243-244 High Holborn
London WC 1 7DZ
Tel 020 7831 9501

All trade orders for Scottish Parliament documents should be placed through Blackwell's Edinburgh.

Blackwell's Scottish Parliament Documentation Helpline may be able to assist with additional information on publications of or about the Scottish Parliament, their availability and cost:

Telephone orders and inquiries
0131 622 8283 or
0131 622 8258

Fax orders
0131 557 8149

E-mail orders
business.edinburgh@blackwell.co.uk

Subscriptions & Standing Orders
business.edinburgh@blackwell.co.uk

Scottish Parliament

RNID Typetalk calls welcome on
18001 0131 348 5000
Textphone 0845 270 0152

sp.info@scottish.parliament.uk

All documents are available on the Scottish Parliament website at:

www.scottish.parliament.uk

Accredited Agents
(see Yellow Pages)

and through good booksellers

Printed in Scotland by RR Donnelley