HEALTH AND SPORT COMMITTEE

Wednesday 29 April 2009

Session 3

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HEALTH AND SPORT COMMITTEE

13th 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:

Pauline Bell (Partners in Advocacy)
Roger Catchpole (YoungMinds)
Ilena Day (Depression Alliance Scotland)
Brian Donnelly (Young Scotland in Mind)
Amber Higgins (Penumbra)
Kenny MacIvor (Highland Users Group)
Graham Morgan (Highland Users Group)
Linda Paterson (Choose Life—Aberdeenshire)
Carolyn Roberts (SAMH)
Cliff Watt (Choose Life—Aberdeen City)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

Seán Wixted

LOCATION

Committee Room 1

Scottish Parliament

Health and Sport Committee

Wednesday 29 April 2009

[THE CONVENER *opened the meeting at 10:02*]

Decision on Taking Business in Private

The Convener (Christine Grahame): Good morning. I welcome everyone to this the 13th meeting this year of the Health and Sport Committee. I remind committee members, witnesses and members of the public to switch off their mobile phones and other electronic equipment. No apologies have been received.

Agenda item 1 is a decision on whether to take item 4 in private. Item 4 is consideration of issues that have arisen from evidence in our inquiry into child and adolescent mental health services. Do members agree to take item 4 in private?

Members *indicated agreement*.

Subordinate Legislation

National Health Service (Travelling Expenses and Remission of Charges) (Scotland) Amendment Regulations 2009 (SSI 2009/124)

10:03

The Convener: Agenda item 2 is consideration of a Scottish statutory instrument that is subject to negative procedure. The purpose of the regulations is to ensure that parity of treatment is maintained for people who claim help with health costs under the terms of the national health service's low income scheme, and to increase the income level cut-off for passporting to help with health costs.

No comments have been received from members and no motions to annul the regulations have been lodged. The Subordinate Legislation Committee, which considered the regulations at its meeting on 22 April, did not raise any issues that it wished to draw to our attention. Are we agreed that we do not wish to make any recommendations on the regulations?

Members *indicated agreement*.

Child and Adolescent Mental Health Services Inquiry

10:04

The Convener: Agenda item 3 is another evidence session in our inquiry into child and adolescent mental health services. I welcome our witnesses: Cliff Watt, who is co-ordinator and locality manager for choose life in Aberdeen; Linda Paterson, who is co-ordinator for choose life in Aberdeenshire; Graham Morgan, who is advocacy project manager of the Highland users group; and Kenny MacIvor—is it pronounced "MacKeever" or "MacIvor"?

Kenny MacIvor (Highland Users Group): It is pronounced "MacKeever".

The Convener: I win, because that is what I said beforehand. Kenny MacIvor is a member of the Highland users group.

I thank the witnesses for their written submissions, which were very useful. We will move straight to questions from committee members. I call Mary Scanlon to be followed by Richard Lochhead.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I would accept many comparisons, although perhaps not that one.

The Convener: Oh, dearie me. I am sorry. That was a bit cruel for Richard Simpson at this time in the morning. I will need to slow down, as I am ahead of myself. I call Mary to be followed by Richard. I have lost the will now. They are very wicked to me, but there we go.

Mary Scanlon (Highlands and Islands) (Con): Thank you very much for the excellent written submissions that we have received.

I want to start with three topics, the first of which has been raised by the Scottish Association for Mental Health in Aberdeen. I appreciate that none of you is representing SAMH, but I would still find your views helpful. SAMH says that there needs to be a named person for each school, and so on, for mental health and that that policy is written into legislation but with no resources attached to it. Are you familiar with what, according to statute, should be done for children in schools? I was a member of the then Health and Community Care Committee when the Mental Health (Care and Treatment) (Scotland) Act 2003 was passed, but I cannot remember.

The Convener: Please just self-nominate to answer.

Graham Morgan (Highland Users Group): I believe that the primary mental health workers who are in a network across the Highland NHS Board area are attached to, and named for, each school. They have specific duties within the schools, although I am not sure that that fits very well with their ability to do all their other work. I think that that work is done on top of the work that they already do with young people. They provide preventive and educational advice to the schools, as well as providing a link to the schools, but that is merged with the wide job that they already do.

Mary Scanlon: I can find out elsewhere, but I wonder whether any of you is familiar with what should be in place in each school according to the Mental Health (Care and Treatment) (Scotland) Act 2003.

Linda Paterson (Choose Life—Aberdeenshire): I understand that, according to commitment 7 in "Delivering for Mental Health", there should have been a named mental health link person for each school by the end of 2008. However, that is not the case in Aberdeenshire. That was the target, but no resources were attached to that commitment.

Mary Scanlon: That is something that we can look into.

My next two questions are about exclusions. We often talk about school discipline and school exclusions. In the many committee papers that we received for today's meeting, we are told that many children are excluded from school because they have attention deficit hyperactivity disorder, Asperger's syndrome or other problems and are not getting support. Graham Morgan's written submission covers that, too. There is an assumption that such children will be excluded, because they exhibit bad behaviour, but exclusion exacerbates their condition.

The other issue is waiting times—

The Convener: We will deal first with exclusions.

Mary Scanlon: If children are excluded they might have to wait for six to 18 months. I wonder whether we could roll the two issues together.

The Convener: We will deal with exclusions, then move on to waiting times. It will help with the drafting of our report if we separate the issues.

Does anyone want to comment on exclusions? This is a bit like "University Challenge"—you are allowed to confer. It is a team question.

Graham Morgan: Exclusion is not always down to behaviour. Pupils are inadvertently excluded because they are ill and cannot attend school. They may miss out on a lot of their education as a result of that.

Do you want to say anything on that, Kenny?

Kenny MacIvor: No—that subject is best left to the team.

The Convener: Does anyone want to talk about waiting times for just being seen, let alone treated?

Linda Paterson: Can I say something about exclusion?

The Convener: Yes—I am sorry.

Linda Paterson: There are a high number of exclusions. I agree that a lot of the behavioural difficulties that children exhibit are the result of underlying conditions for which they are not getting help. People do not look behind the behaviour to see what is causing it; instead, the children are just excluded from school. During the time for which they are excluded, nothing will necessarily be done to make it easier for them to return to school, and they might—

The Convener: Are you referring to exclusions from primary and secondary schools?

Linda Paterson: Yes—I refer to exclusions across the board. In secondary school, the children will be asked to sign a contract of behaviour when they return to school after their exclusion. However, if they are not behaving because they have a condition, it makes no sense to get them to sign up to something that they cannot possibly stick to. That is just setting them up to fail again.

Waiting times are a big issue: the standard waiting time for young people in our area who have mental health issues is eight months, but it is longer—about 16 months—for young people who have autism spectrum disorder, who are discriminated against in that way, as well.

Mary Scanlon: This helps us to understand exclusions, which are not always due to bad behaviour and discipline problems—there are often underlying problems.

The Convener: Does anyone else want to comment on waiting times?

Mary Scanlon: My final point concerns page 39 of the submission from Graham Morgan of the Highland users group. It details a person's experiences in New Craigs psychiatric hospital, and I would like some clarification on that. It is about a young person who

"was treated a bit like a baby",

although they were well looked after. The young person goes on to say:

> "A problem was that there were a lot of drugs around. I was offered drugs and also people tried to take advantage of my youthful innocence."

Are we talking about legal or illegal drugs?

Kenny MacIvor: The person you are talking about is me.

Mary Scanlon: I am sorry.

Kenny MacIvor: It is fine. A number of things like that happened when I was in New Craigs. There were illegal drugs like cannabis, and people were smoking valium in the smoking rooms. I was offered sex and drugs. There was religious extremism in there too. It was a concoction of various negative things.

Mary Scanlon: You were offered all that as a residential patient in New Craigs?

Kenny MacIvor: Yes—I was 16 or 17 at the time.

Mary Scanlon: Were illegal drugs widely available?

Kenny MacIvor: Yes. The patients all smoked cannabis—well, not all of them, but a lot of them did. At one point the hospital had to have the police in because there was dealing going on.

Mary Scanlon: Was alcohol available?

Kenny MacIvor: Yes.

Mary Scanlon: Was it widely available within the hospital?

Kenny MacIvor: It was not widely available, but it was available from certain people. I was on a detox ward, and people were smuggling in certain things to try to help them with what they were going through.

Cliff Watt (Choose Life—Aberdeen City): The problem is not limited to the Highlands. We hear the same stories from service users about mental health units throughout the country. Aberdeen has a similar problem with patients having access to drugs and being offered illicit substances while they are on the ward. That can be extremely difficult for patients, because many of them already have substance misuse problems and are trying to remain free of them. One would expect that hospital would be the safest place for them, but that is not the case.

Mary Scanlon: Is it possible that being taken into adult wards is, for some young people, an introduction to illegal substances?

Kenny MacIvor: Yes—without a doubt. There is definitely temptation and there is pressure to fit in and conform as a way of being accepted in that environment.

The Convener: I will let other members come in, as they may wish to pick up on that.

Richard Simpson is next—I am terrified to speak to him since I got his name wrong.

Dr Simpson: I cannot quite believe that.

When I started reading the submissions, I thought the first paper was by Carl Jung, because his name was in bold type.

The Convener: That made us all read it.

Ian McKee (Lothians) (SNP): You were at school with him, weren't you?

Dr Simpson: That is very cruel.

As Mary Scanlon said, the submissions were useful. I thank the witnesses for them.

The committee is engaged in an iterative process, in that we are taking evidence and beginning gently to formulate views, after which we get more evidence, and our views change slightly.

I am particularly interested to hear about self-harm. The recent paper from Professor Rory O'Connor of the University of Stirling began by stating that suicide rates are twice as high in Scotland as they are in England, and went on to say that 14 per cent of the respondents in his study had self-harmed. They were adolescents: mostly 15 and 16-year-olds. The paper went on to say that as many again—another 14 per cent—had had thoughts of self-harm. Professor O'Connor estimates that about one in five girls self-harms, which is a very frightening statistic.

I want to ask the witnesses from choose life—and those from HUG, with regard to access—whether we are handling the issue appropriately, and whether we are picking up on problems early. What stage should we be picking it up at, and how should we change things so that we can deal with the problem?

10:15

I want to put on the record that, according to Professor O'Connor's paper, the background issues are sexual abuse, sexual orientation problems, bullying, lack of self-esteem, poverty and deprivation, parents' mental health problems and drug and alcohol misuse. In other words, they are the usual risk factors. Can you comment on the current situation and suggest recommendations that the committee could make to improve it?

The Convener: Just for clarification, is your question about how we can identify these matters?

Dr Simpson: Yes. At what stage should we begin to pick up on the problems? I also want to know what is and what should be happening.

Cliff Watt: It will be helpful to clarify the definition of self-harm. Self-harm is often linked with suicide. However, someone who is regularly self-harming might have no thoughts of suicide, and someone who attempts suicide might not previously have harmed himself or herself. We also need to re-evaluate the age at which children start to be at risk, because I think that it is lot lower than we would normally expect it to be. In its recent "Casenotes" report, ChildLine said that, last year, it received four calls from children under five years old whose main reason for calling was suicide. That shows that we are simply not aware of how early we need to intervene.

At the moment, the resources for children and young people who are self-harming are quite limited. There is certainly a lot of peer-guided support available, which means that children look to their classmates to find out what they should do about the problem.

When the issue arises, it can be difficult to access appropriate services initially. After all, most services require referral from general practitioners, who—I am sad to say—do not consider the condition to be particularly serious or to warrant specialist intervention. Any support that is provided tends to come from the voluntary sector, to be underresourced and to touch only the tip of the iceberg of the number of people who could benefit from seeing someone. In Aberdeen, for example, there is a small number of project workers who deal specifically with young people who self-harm, and their case loads are quite extensive. Although the opportunity for self-referral exists, the majority of referrals still come from what we term statutory services, such as primary care, education and so on.

Graham Morgan: One of the key issues is awareness. For example, we produced with Eden Court theatre a play called "Stigma", which we took around all the Highland schools for four years, reaching about 6,000 young people. By making self-harm and suicide a key theme of the play, we were trying to make young people aware of the need to get help, of positive coping strategies to deal with the problem and of what they could do to support their peers. I believe that, in the last round of performances, 50 young people sought help from the primary health workers who were working with us. I certainly think that it was a good way of raising awareness.

In an attempt to help teachers and ground staff at schools come to an understanding of how to deal with young people in such situations and how and where to make referrals, we have also worked with NHS Highland's department of child and adolescent psychiatry to raise awareness of what it is like to self-harm, why people like us do such things and what does or does not help. With that kind of approach, which raises young people's awareness of how to get help and teachers' awareness of what they can do to help and who they can pass people on to, we might begin to deal with the problem.

The Convener: When you said that you took the play to all schools, did you mean primary and secondary schools?

Graham Morgan: We took it to all secondary schools.

Dr Simpson: I have not seen the play, but is the reason for that based on evidence that you have received and your awareness of the situation?

Graham Morgan: The average age for self-harm is 13 or 14: our last play was aimed at that age group. There are risks with taking a very powerful performance into schools, so we would be cautious about going to a younger age group.

The Convener: I suspect that that is because of mimicking and primary children experimenting.

Linda Paterson: I agree with Graham Morgan. Raising awareness is our key issue. Choose life in Aberdeenshire is trying to roll out awareness training to all front-line workers because there is a real lack of understanding about self-harm and why people do it. People are inclined to panic, or to avoid or dismiss something if they do not understand what it is about. It is crucial that people on the front line get trained and are aware. In many cases, they can support the young person without that person having to use further mental health services.

The Convener: What is parents' awareness of self-harming? Do they take it seriously, or see it?

Linda Paterson: I think that their understanding is like that of teachers and front-line staff: there is a real lack of it. They are very concerned, but they do not have a clue what to do about it, so raising parents' awareness is also crucial.

Cliff Watt: I would like to make a personal comment on that. Parents' awareness of issues around self-harming is changing—we now have a generation of parents who knew about it in school from friends or, perhaps, experienced it themselves. Awareness is increasing, but it is just awareness of the issue of self-harm rather than awareness of how to support a child who might be at risk from self-harm. The question is how to increase that awareness.

A major factor and blockage to getting schools, teachers and other people involved in helping strategies is a fear of making it worse. Educating primary and secondary teachers is of paramount importance so that they are comfortable talking about the subject and they know what to do about it. We all know that if we talk about it, then we massively increase the safety of those who might be at risk.

Linda Paterson: I agree with Cliff Watt. I also want to raise the issue of GPs, who are often the first port of call if a parent is worried that a child is self-harming. There is among GPs a huge lack of knowledge and understanding about self-harm, particularly. Sometimes their attitude is that the behaviour is attention-seeking and time-wasting, which can alienate the young person further. That is a huge issue. Trying to engage GPs in suicide intervention training and so on is, to put it mildly, a massive challenge.

Dr Richard Simpson: The answers have been extremely helpful. It seems that we have a disjunction between health and education services. From what I hear, we need to bulk up awareness in teachers and have more school nurses who are then available as a first port of call and as the referring agent.

Let us face it: only 30 or 35 per cent of any GP's post-graduate training is in psychiatry as a whole, far less self-harm. My knowledge of adolescent psychiatry and self-harm among children is not fantastic. I was able to do some work in it, but I was by no means an expert and I was a psychiatrist, for heaven's sake.

I am hearing very strongly that we need to find another way of getting in—through awareness and counselling—and that we then need a level 2 type service that is not the tier 3 CAMHS services, I presume, but a service that offers counselling from people who have particular and expert training in self-harm. Is that right?

The Convener: Linda Paterson and Cliff Watt are nodding.

Cliff Watt: I think so. The earlier awareness can be raised and the sooner children and young people who might be at risk from self-harm feel confident about being able to talk about their feelings and why they feel like that, the less need we will have for such intensive intervention. We can do a lot of preventive work that would give children and young people the resources that they need to be able personally to become resilient to emotional distress and to deal with it in a way that does not involve hurting themselves. If we build up that capacity within young people, we dramatically reduce the need for later intense therapeutic work.

Dr Simpson: You mean improved emotional literacy.

Cliff Watt: Very much so.

Dr Simpson: Perhaps we also need counselling teams in which the primary and secondary feeders work together with a counselling team so that they pick it up at those levels. Is that the sort of thing we need? All the witnesses are nodding.

The Convener: We move on to Ian McKee. At least I got your name right.

Ian McKee: Indeed—that is very nice. Well done.

The Convener: There will be no supplementary question.

Ian McKee: I would like to ask two questions.

First, I turn my attention to potential obstacles to getting help. As you say in your evidence—and as is common sense—school is an important place for picking up whether self-harm is taking place, and whether behaviour among children that could lead to self-harm exists. In previous evidence, a headmaster said that his definition of "in loco parentis" meant that he had to tell parents everything that happened in school that could be of concern to them. He was speaking in the context of underage sex, but I would have thought that if you discovered in school that a child was, in your estimation, in serious danger of killing themselves, that could come under the same category.

However, we know from experience that many of children's feelings of suicide and self-harm stem from the home. Sexual abuse, bullying and all sorts of things may be going on at home. If the child is aware that teachers have a duty to inform parents about problems at school, might that put the child off seeking help in the first place?

Cliff Watt: Absolutely. I would suggest that that is one of children's main fears, and that it prevents them from talking about their concerns about what is happening. I feel strongly that any school that establishes that a child might be at risk of self-harm should consider that as a potential child-protection issue and should first establish whether involving the parents at that early stage could, in fact, compound the problem.

The legislation is clear about that—schools must ensure that the child remains protected. Until such time as it has been established why the self-harm is occurring or has the potential to occur, we have to be careful about who we involve in that discussion. The first stage would be to establish whether the child is thinking about, or is, self-harming. We must then try to find out the reasons for that. As Ian McKee said, one of the main reasons why children think about suicide and self-harm is family relationship difficulties, which could be associated with abuse. We need to protect the child from the causes of their feelings, which could be purely symptomatic of their experience at home.

The Convener: I want to challenge you on that. Abuse would be a clear case for child protection. However, what if you have really good parents whose child is self-harming—for example, because of bullying—but does not want to tell their parents, just because that is the way that that child is?

Cliff Watt: First, it is important to establish whether there is a risk factor in the home environment. Once it has been established that there is not—that the home environment is supportive and that the parents are good parents—it is absolutely essential that the parents become involved. However, that can be done in a way that the child understands and that supports the child to tell mum and dad what is happening. The child's fear of the potential consequences of that discussion can be removed.

The parents must also be supported in that discussion because it can be quite traumatic to hear that one's son or daughter might be at risk of self-harm. Support is needed such that the child and parents can get the best out of that understanding, and so that the parents realise that knowing about the problem is the first step to helping to prevent it.

Ian McKee: Everyone would agree with that, but we heard evidence from a teacher who is involved in counselling. At the beginning of term, she warns the children that there are some issues that, if they are brought to her attention, she will have to disclose to the parents. It is a subtle point to get across: if a pupil is having sex with her boyfriend, she should not go to the teacher; but if she is thinking of committing suicide, she should go to the teacher. It might be required to take a matter to the parents, but the parents might be in the background of the situation. Do you agree that we are giving out a mixed message?

10:30

Cliff Watt: It is undoubtedly a complex issue, and each case needs to be considered individually. As you said, it is incredibly difficult to support a school full of pupils to understand that teachers cannot keep all things secret and yet they can promise discretion. That is a really difficult message and, as you said, it is a subtle point to get across. How best to do that? I guess that it comes down to each school knowing its pupils and what the best approach is.

Graham Morgan: I do not have a solution, but the key element is that the young people trust the people they go to. This is not to say that schools overreact, but I agree that, because of their worries and anxieties about what are such serious subjects, schools sometimes do not act in a way that helps the children concerned, who therefore might lose trust, feel alienated and feel that they cannot contact the school for help. That definitely causes problems.

On other occasions, schools are superb in providing help, but the idea that there is a need to protect everyone means that people—even if they do not overreact—can sometimes get things wrong in how they build up a relationship with a child who is revealing something very private in an intimate setting and who might be worried that the information might go further afield.

Ian McKee: Teachers will also be protecting themselves—if something goes wrong, they are in the firing line.

Graham Morgan: Yes.

Ian McKee: I was in general practice before I became a member of the Scottish Parliament. We did some work in my practice to compare a fairly deprived area with an area that was not so deprived. There was a much higher incidence of self-harm and all sorts of other problems in the deprived area. Do you know of any services that are targeted to areas where the risk is greater, or are they all global services that people can choose? Is there any advantage in aiming resources at certain geographical areas?

Cliff Watt: As far as suicide is concerned, we do a lot of work to identify what we could call locations for concern and to ascertain whether preventive measures can be put in place in particular areas. A lot of work goes into identifying higher-risk groups, and I imagine that similar work is done with self-harm in order to focus limited resources on where they might most be needed. It is a balancing act: although there might be areas of deprivation where instances of self-harm are higher, they are not the only places where it occurs. It is naturally a matter of trying to be all things to all people and of providing easy access to services for everyone—particularly for those who are most at risk.

Helen Eadie (Dunfermline East) (Lab): One issue that has arisen in previous evidence-taking sessions, in the documents that you have kindly provided for us today and in the briefing from the Scottish Parliament information centre, is that of training, particularly for front-line staff. Do you feel that enough resources have gone into training? Are there any cutbacks in training budgets? What impact are they having on mental health services? What more could be done to help make those services a priority among different agencies in both the voluntary and statutory sectors?

Cliff Watt: Training is obviously fundamental. When we have tried to provide suicide intervention skills training using the health improvement, efficiency, access and treatment targets—HEAT targets—for 50 per cent of front-line NHS staff, we have found a blockage: it is an issue not necessarily of getting funding for training but of being able to release the staff to go on the training.

A secondary blockage to that suicide intervention skills training has been a reluctance among front-line staff who are identified as requiring the training to acknowledge that they need to do it. Some people think, "I've been doing this job for years, so I don't really need to know this stuff." We argue that it is always good for people to update their information and share a commonality of language. I imagine that the same will be true for specific training on self-harm.

There are several issues, as well as those to do with resources. Ploughing money into training might not be the only answer; we might also need to acknowledge the incredible time demands that are placed on the people whom we want to train and that they have other training priorities. We need to find a way in which to increase their capacity to be released to do training.

Helen Eadie: I want to explore that issue a little further. I suppose that, if somebody is to be released for training, money has to be available to pay for another person to carry out their duties. The written submission from SAMH in Aberdeen gives an example from Aberdeenshire, where only one general practitioner has attended suicide prevention first-aid training. The submission states:

> "As GPs are often the first port of call for desperate people, this is a worrying statistic, and one which I believe is reflected across the country as a whole."

That is concerning.

Linda Paterson: We realise that capacity is an issue. The course that that refers to was a two-day ASIST course—applied suicide intervention skills training. We realise that GPs are busy people, and we do not expect them all to give up two days to go on a course, but we are keen to discuss how to address those capacity issues. Other approaches are possible—for example, using shorter courses or protected learning time—but there has to be a will and people have to be keen to do the training. As Cliff Watt said, we come across quite a lot of professionals who have the attitude that they do not need to be trained in something or who are not interested. It is hard to engage with people to ensure that they want to do the training. If there was a will, we could work out a practical way for the training to be done.

Helen Eadie: If I could ask—

The Convener: I think that Mr Morgan wanted to comment.

Graham Morgan: I can wait.

Helen Eadie: My other question is about services in the voluntary sector versus statutory services. The choose life submission states that we should give much more recognition to and place more value on the voluntary sector. It argues that integration and planning should embrace voluntary sector services as well as statutory ones. Will you expand on that?

Cliff Watt: We have long had a problem—not just on health issues but in general—with an unspoken boundary between the voluntary sector and statutory services. The voluntary sector and large sections of the statutory services are working hard to overcome that, but, particularly in relation to health, we often come across a perception that the voluntary sector is not qualified to train people in the statutory services or the NHS on any aspect of what they do. That initial resistance to what we have to offer can form a boundary. We need an opportunity to consider the value that both sectors can bring to the common problem and to acknowledge that neither sector can do the job on its own. We need to work together to provide the best that we possibly can for the people who are most at risk in our communities.

Graham Morgan: I will return to Helen Eadie's previous question. In our group in HUG, which is composed of people with a mental illness, a recent evaluation confirmed again that the key people whom we need to train and raise awareness among are young people and those who work with them. That confirms what has been said.

There are many forms of training, but we provide user-led mental health awareness training. On occasion, nothing can replace the direct testimony of people who have been through the problem themselves speaking directly to teachers or young people about what the experience is like, what has helped or not helped and how they managed. We are fortunate because HUG is funded to do that, but we could certainly do more and better training if we had more funding. I am keen to see the development of user-led awareness training on the issue of self-harm and other issues for young people and teachers in schools. Such delivery is scarce, and it would be useful to develop it.

The Convener: Mr MacIvor, do you want to comment on what would be useful?

Kenny MacIvor: Yes. I have given talks in schools across the Highlands for the past two years. The amazing thing is that none of the young people has an idea of what mental illness is about. They just have preconceptions or stereotypes, so it is important to bash through that and destigmatise the issue.

We had no education on mental health when I was at school, so I literally did not know what was going on when I became depressed and psychotic. I just thought that I was basically going mad. Some form of prior education on mental illness would have been helpful not only for me but for my sisters and my family. It is therefore very important to go into schools and to talk about mental health and mental illness in a positive but informed manner.

The Convener: Do you ever find out what the follow-on is from that? Is there a reaction whereby young people come out of the closet, as it were, and talk about their problem, as happened when the "Stigma" play was shown? After you go into schools, do you find that young people feel more relaxed about saying stuff?

Graham Morgan: From memory, the most recent evaluation of responses to our play, which was done shortly after it was performed, showed that 97 per cent of the young people who saw the play said that they would be more tolerant and understanding of people with a mental illness as a result of the play. However, we have not done an evaluation of the long-term effects of seeing the play.

Helen Eadie: I have one more question. When a child attempts suicide and is admitted for care, that is obviously an issue for the wider family. We have had evidence that no support or training is given to the family in such circumstances to help them understand how to deal with the issue. In your experience, is that a problem? Does that chime with you in any way?

Cliff Watt: Very much so. That is an issue not just for the serious situation of a suicide attempt but for dealing with mental health problems in general. Families do not get useful information and are not supported to understand what strategies they can put in place to support a younger family member who might be experiencing mental health problems. I have heard from many people who have struggled with the situation of a family member being at risk of suicide or having attempted suicide that the hospital and GP did not offer any help on what to do and how to have a supportive conversation about what most terrifies them. Moreover, there is often little support for the person who has attempted suicide to enable them to access help quickly if they need it.

There is evidence of good practice in hospital-based interventions in which staff are incredibly supportive, but generally the picture is less optimistic. Patients and their families can often feel vulnerable after the patient has spent time in hospital following a suicide attempt, and we know that such patients are at high risk from suicide in the period after discharge. There is therefore concern that there is not enough support after the initial intervention.

Linda Paterson: I agree with what Cliff Watt has just said. When I am out and about in the community to deliver training in suicide intervention, I hear anecdotal evidence about people who have tried to access support but have not even been able to get information about their child who has attempted suicide. That is an issue, although I think that the situation is patchy: like Cliff Watt, I am sure that there is support sometimes but not all the time.

10:45

On the previous question about the voluntary and statutory sectors working together more closely and about promoting emotional awareness in schools, the Samaritans developed an excellent pack for schools on developing emotional awareness and learning. It contained a double DVD and was sent to every secondary school in the country. From what I have heard, use of that pack has been patchy. It can be used in personal and social education lessons and by guidance teachers. The feedback from those who have used it is excellent, but many schools probably do not even know that it exists and it probably sits on a shelf gathering dust. There is a lot of good material, but, as I said, use is patchy and happens only in certain places rather than across the board.

Kenny MacIvor: I became psychotic when I was 15, and I attempted suicide many times. Because there is not a dedicated in-patient unit for adolescents in the Highlands, I was just left to go through it. I made various attempts at suicide, and my family just had to do their best 24 hours a day to prevent me from falling over the edge. It was terrible because I had a 10-year-old sister and an older sister who were still going to school and there was no support for us. When getting over a suicide attempt, I saw a psychiatrist once or twice, but ultimately it was a case of being left to deal with it and move on. It took a long time to get over it.

The Convener: What about the GP?

Kenny MacIvor: Because he saw mine as a specialist case, he just left it to the local community psychiatrist.

Graham Morgan: Although it is important that any professional support is given to a family, often that is an add-on to the professional's job. In Highland, we have a dedicated carers support worker from the National Schizophrenia Fellowship. One worker to cover the entirety of the Highlands seems ludicrous because families are hugely affected. It would be good to see such workers in greater numbers in Highland as well as throughout Scotland.

The Convener: Yes, that is in your submission.

Mary Scanlon: The NSF worker in Ullapool, who covered a huge area, has been made redundant, leaving that area with no cover.

I am trying to understand from the submissions the place of autism in mental health, but I am not sure that I am clear about it. My question is about training. One of the submissions says that someone would not get a mental health service if they had Asperger's. I understand that people with autism are at risk of developing mental illness, but are they excluded from services or do they follow a different path?

Linda Paterson: I was given that information, too. Although it is not the case across the board, it is well recognised that people on the autism spectrum are more likely to suffer from mental health problems as a result of their difficulties. In my area, the waiting list for such people to receive help is far longer than the normal one, which is already long.

Mary Scanlon: So it takes longer than six, eight or 18 months to get help for a child with autism.

Linda Paterson: The latest figures that I heard for Grampian showed that the waiting time was eight months for young folk who are not on the spectrum and 16 months for young people who are. Resources are a huge issue.

Mary Scanlon: Without training, how do people pick up that a child has autism or a mental health issue? It must be difficult for a non-clinical person such as a teacher or nursery teacher. That is what I am trying to understand.

Linda Paterson: It comes from awareness and training. The reason why so many cases do not get picked up is that there is a lack of information and knowledge among front-line staff about the issues and what to look for.

The Convener: I have a specific question about waiting. It comes from the evidence of Brian Lister of the Scottish Children's Reporter Administration when he referred to children in need who were up before the children's panel:

> "I checked the most recent case that I could access, and it will take around five months … to get a report."—[*Official Report*, *Health and Sport Committee*, 22 April 2009; c 1821.]

So it takes five months to get a report to the panel, and that is before it even does anything. Is that right? I presume that you have contact and involvement with children's panels. It seems an extreme situation when a child has got as far as the children's panel.

Cliff Watt: Neither Linda Paterson nor I have contact with children's panels; I do not know whether our colleagues do. The stories that we hear from child protection trainers and social workers suggest that it takes an extraordinary length of time to go through that process and, in the meantime, everyone is left wondering about what will happen and what to do.

The Convener: And a child could be at risk in that family during that time.

Cliff Watt: Yes.

The Convener: That is not a happy thought.

Linda Paterson: The other thing that can take a hugely long time is an assessment that someone is on the autism spectrum or has any kind of learning disability. In some cases, it can take years before we get an assessment of the underlying problems behind behaviour that is being exhibited.

The Convener: So your figure of months relates to the treatment that is received following the assessment. Can you give us an assessment timescale?

Linda Paterson: I cannot give you that, I am afraid. I think that it varies across the country, but I know that some people have been waiting for years for an assessment. Some people get an assessment quite quickly, however: I think that it depends on the severity of the symptoms that the child exhibits.

Graham Morgan: I would like to respond to Mary Scanlon's question. My wife works in a learning support unit with people with autism. She says that many of the young people there also have mental health problems but that it is nearly impossible to put them in contact with mental health services.

Another issue is that, when young people who have Asperger's and develop mental health problems come into contact with mental health facilities, the facilities sometimes do not know enough about Asperger's and autism to respond appropriately to those young people.

The Convener: I thank our witnesses for their attendance. Your evidence was helpful, and your written submissions were thorough. I think that we will follow up on assessment waiting times, as that is an important issue.

We will have a short suspension.

10:52

Meeting suspended.

11:00

On resuming—

The Convener: The committee is reconvened. We will now have a round-table discussion with our second group of witnesses, who represent a variety of voluntary and non-governmental organisations in Scotland that are involved in supporting children and young people in the field of mental health services. In a round-table discussion there is more interaction from the witnesses; committee members make occasional interventions. Witnesses therefore get a bigger bite of the cherry than do committee members. I have really said that for the benefit of committee members.

I ask the witnesses to introduce themselves.

Roger Catchpole (YoungMinds): Good morning. I am the principal consultant at YoungMinds.

Brian Donnelly (Young Scotland in Mind): I am the director of respectme, which is Scotland's anti-bullying service. I am representing young Scotland in mind.

Carolyn Roberts (Scottish Association for Mental Health): I am from SAMH, which is a mental health service provider that works to influence mental health policy.

Amber Higgins (Penumbra): I am the project manager at Penumbra's Fife youth project. We work with young people aged 12 to 21 in the community and support mental health and wellbeing.

Pauline Bell (Partners in Advocacy): I am from Partners in Advocacy, which supports children and young people between the ages of 0 and 22, many of whom access mental health services.

Ilena Day (Depression Alliance Scotland): I am the chief executive of Depression Alliance Scotland, which is a Scottish mental health charity that works specifically for people in Scotland who are affected by depression.

The Convener: Thank you very much.

I think that the witnesses heard quite a bit of the evidence that was given in the previous session. I have a general question to start the discussion. Do you have anything to say about anything that you heard in that evidence and which you particularly want to get off your chest right now, or about anything that you have not heard that the committee ought to know?

Brian Donnelly: I would like to say something about the role that reporters can play in the children's hearings system. I have quite extensive knowledge of that through working with looked-after and accommodated children for 16 years. Reporters can and do sometimes play a significant role in seeing through very challenging and risky behaviour and helping to direct services towards an appropriate assessment; they do not focus only on dealing with criminal or risky behaviour. However, the system is under considerable pressure and stress, and the process takes a long time. Reporters can make recommendations that help with the care that people receive, but it is down to local authorities to act on those recommendations.

Carolyn Roberts: I want to follow up a point that was made about the importance of training. Since the introduction of the curriculum for excellence, particularly the health and wellbeing outcomes, we are being asked to go into schools more to talk about mental health and emotional wellbeing, which is excellent, and the children and young people to whom we speak respond really well. However, the teachers say that they have not received any training on those issues, although they want to support children and young people. As far as we have been able to find out, teacher training does not seem to involve such training, and neither is a consistent or comprehensive approach to training taken for existing teachers.

Roger Catchpole: I support that point, but add that the issue is not just about raising the awareness of teachers and other professionals who work with children and young people through training, although that is significant. In the work that we have done with teachers, there has often been a sense of their wanting training so that they can help children. Teachers need to have greater awareness of their own emotional wellbeing so that they model good mental health for children as much as put things into the curriculum. It is about how the whole school functions, which is a huge training and leadership issue for schools and other organisations.

Ilena Day: I would very much welcome training around good mental health. I came in at the tail-end of the previous evidence session, but there seemed to be a focus on when children and young people have problems at the moderate-to-severe end of the mental health spectrum. That is quite right, but in tackling obesity the starting point is to increase awareness of good physical health, diet and lifestyle choices, and exercise. We would like the same principle to apply to mental health. We should be thinking about what it means for young people to have good mental health and what good mental health is. From that starting point, we should empower young people to recognise when problems are starting to arise and to develop skills for life and resilience. A lot of the work that Depression Alliance Scotland does with over-18s is around problem solving, increasing confidence and developing people's ability to manage the difficulties that we can all experience from time to time.

The Convener: I see lots of heads nodding in agreement.

Amber Higgins: There is a focus on knowledge and experience, but training on personal relationships should run in tandem with that. We have all experienced working with young people who were involved in CAMHS or other services when there was no doubt that the training and experience were available but the support failed because of the personal relationship. Training for staff is not just about knowledge and experience of mental health issues; there has to be training on interpersonal skills and the way in which workers relate to young people to ensure that they feel that they are respected and listened to.

Dr Simpson: Who is responsible for training youth workers and other front-line staff? I know that choose life has worked on that. In the drugs field, we introduced the Scottish training on drugs and alcohol organisation specifically to train staff at all levels and to develop and provide courses. Does a similar organisation provide front-line mental health workers with such support and training, and, if not, should we have one?

Roger Catchpole: There is a general absence of that kind of strategic approach to training in this area. It all comes down to how individual local authorities, health boards and other organisations prioritise training, given the competing pressures that they face.

We have recently finished a piece of work for NHS Education for Scotland to scope workforce development needs. Even within the specialist services, there is still a need for a more co-ordinated approach. That is even more the case with universal services for children and young people. Individual local decisions determine priorities.

Mary Scanlon: I understand why Tam Baillie from Barnardo's is not here with the other witnesses. The Barnardo's submission is very good. It raises the point that children who misuse drugs or alcohol are, in effect, barred from mental health services. We see that in adults. Does anyone have experience of that?

Brian Donnelly: That can be the case because agencies are set up to deal with presenting behaviour. Sometimes, significant issues about safety and the impact on others are presented. For a young person, the person who sees them first is important. If a doctor picks up the behaviour and is concerned, the young person might be referred to mental health services, but if the police or the school pick it up, they might regard the behaviour as criminal or challenging and might not go down the route of trying to access mental health services. Instead, they might take a punitive approach to trying to change the behaviour.

Roger Catchpole: A conceptual problem arises with how we think about children. Services are often set up to deal with problems, and might be focused on drugs, alcohol or learning disabilities, as was discussed earlier. Children who misuse substances or who have a learning disability have a much higher risk of developing mental health problems. Those children have to be able to access mental health services, but we tend to put them into pigeonholes as substance misusers or as children with learning disabilities, so that they become someone else's problem, not ours. We have to become much more child centred. It is a big challenge, but we have to think about children's needs rather than the problems that we or other people deal with.

Carolyn Roberts: I support the points that both of the previous speakers have made. The service that you receive depends very much on who first picks up your problems or issues, and you are likely to be referred down the route with which that person is most familiar. That can have a big impact on how your issues are dealt with. In adult services too, we tend to put people in boxes and label them, and then tell them what their problem is and how we can deal with it. However, as we know, people just do not work like that.

In our submission, we say that children who grow up in poverty or who are affected by inequalities are more likely to experience mental health problems. To put a label on a child and say, "You have a problem with substance misuse," or, "You have a drink problem," or, "You have a mental health problem," is neither helpful nor productive.

Amber Higgins: I agree that what happens can very much depend on who refers the child. If there has been drug or alcohol misuse, the children's panel or the probation services will most likely be involved. The child will most likely be referred to a drug and alcohol agency, and the outcome will most likely be a reduction in the child's use of drugs or alcohol. I am not saying that that is not an appropriate referral route, but the question that tends to be asked is, "How do we reduce this young person's drug and alcohol use?" If criminal behaviour goes along with the misuse, the question might be, "How do we reduce the criminal behaviour?" That is all valid work, but it does not tend to consider why the young person misused or overused drugs or alcohol in the first place. If there were a more holistic approach, in which drug and alcohol use were seen as coping strategies or types of self-harm, the support might be different and longer lasting.

The Convener: Do children's panels not offer a good model? All the events in the child's life are taken into account—whether they present offending behaviour, whether they are at risk or whether there is a mix of the two.

Amber Higgins: It is a good model, and children's panels do their best, but they do not have a lot of time to spend with young people. I have trained members of a children's panel in Fife, and they were very interested in the support that Penumbra offered and in children's mental health issues. I congratulate those people on their aims for what they want to do for young people. However, when I did the training, I was told that panel members were often able to spend only 45 minutes with the young person, and that they could not always spend that time with the young person on their own.

Children's panels consider reports from social work departments and other agencies, but those reports are not always written in conjunction with the young person, so the young person might not agree with or even be aware of what is in them. Children's panel members do their best, but it would be better if they spent more time with young people.

Brian Donnelly: The vast majority of people who come before a children's panel for care and protection—and the numbers are on the increase—are not seen in the system again. It is when children keep coming back, because they lack protective factors in their lives, that offering support becomes more and more complicated.

11:15

Michael Matheson (Falkirk West) (SNP): I might be wrong, but I am forming the impression that some of you are concerned about the overspecialisation of some services for children. The comment was made that a child might be funnelled into drug or alcohol services when their behaviour might be symptomatic of a more deep-rooted issue, for which other support should be provided. In recent years, services—including children's services—have moved ever more towards specialisation. I am interested in how you think that services for children and adolescents should be remodelled. How would that sit in the existing framework of voluntary and statutory service providers?

Pauline Bell: That touches on the earlier point that statutory and voluntary services should work much more closely together. Many voluntary organisations work with and see young people daily. They spend much time with young people and are aware of their family circumstances and the whole picture of their situation. Better communication between statutory and voluntary services would go a long way towards allowing us to offer more flexible services to meet individuals' needs.

Roger Catchpole: A change is taking place—there is evidence of more integration of services throughout Scotland. That is happening slowly and has a long way to go, but it has been detectable in the past few years.

We argue in our submission for a model of progressive universalism. We want staff in universal services to be able to identify issues early and to intervene early, when appropriate, and we want children to move through the system in relation to their needs. It is clear that specialisation has a role, but the difficulty is that children are put on a specialist path too early, and once they are on that path it is difficult to leave. If a child is defined as having a particular problem, they are likely to follow that trajectory. Children need to enter specialist services when their needs justify it, but that implies a huge job in training people in universal services to intervene and be more effective earlier.

Amber Higgins: We need to focus on early intervention. Too often, statutory services work at the other end of support—they have to work with crises—and cannot put resources into early intervention work as much as they would like to. That is where the voluntary sector can come in.

Services for young people need to be available where they are and need to be community based. We need to get away from medicalising services in young people's eyes, because that stigmatises them, which means that they do not access the services. Where we are, how we provide our services, and the language and images that we use need to suit young people.

Too often, services are medicalised and young people are anxious about accessing them. Services need to be easily accessed by young people, so that we do not rely on GPs or social workers picking up mental health needs and making referrals. Young people should be able to refer themselves to services if they think that that is appropriate.

Brian Donnelly: At the heart of the issue are prevention and promotion—that point comes through loudly in all the submissions. Prevention and promotion need to be emphasised. The feedback from members of young Scotland in mind is that the prevention agenda has somehow been lost. I noticed that the summary of evidence for the inquiry states that there is no evidence that mental health problems can be prevented. In a way, that skews the issue. It is not a question of whether we can prevent mental health problems—such problems will arise—but through prevention and early intervention work we can build up resilience and address some of the risk factors that have been highlighted. That is where prevention and promotion come in.

We know that inequalities exist and that people in certain bands are more likely to develop problems. The spending on prevention work is minute in comparison with the spending on care and treatment. It is not a case of one or the other—that is not the argument that is being made—but many people in the voluntary sector feel that it probably is a choice between prevention and care and treatment, and that the money is being spent on care and treatment.

The current financial situation in Scotland, the United Kingdom and the world is having an impact. Many of our members are telling us that their relationship with the statutory sector has changed: they now receive one-year funding rather than three-year funding; staff are being put on temporary contracts for a year at a time; there has been no 2.5 per cent uplift; and placements are being pulled. That puts further pressure on the system, which has a significant impact on vulnerable young people, whom the risk factors could help us to identify. For me, the heart of the matter is that our members feel that we have lost the prevention agenda.

Carolyn Roberts: I agree completely. Ilena Day made a good point about prevention and promotion when she gave the example of obesity. The answer seems to be to focus on the promotion of healthy eating.

I want to pick up on accessibility. SAMH runs an information service. We take phone calls from members of the public who are looking for mental health information. The most common questions that we are asked—this applies to adult services as well as services for children and young people—are about the services that are available, how they can be accessed and where information on them can be found. People do not know what is available. CAMHS are not well known about and, in general, are not accessible. In our experience, parents find it hard to find and get their child into the right service.

Is there too much specialisation? We need greater accessibility as well as better communication between services. That is partly about promotion and prevention work and making people aware not only of how to build resilience and try to prevent mental health problems, where possible, but of what specialist support services are available to those who need them, how they can be accessed and how they work. We need to break down some of the mystery that surrounds such services so that they are more accessible.

Ilena Day: I would like to pick up on a number of topics. There is an opportunity for services to get smart by putting the right young people into the system. One objective could be to keep as many young people out of the system as we can. Over the past two years, Depression Alliance Scotland has adopted a heavily community-based approach in its look ok … feel crap? campaign, which has involved us working with organisations—

The Convener: Could you repeat the name of that programme? I saw the official reporters frown.

Ilena Day: It is called look ok … feel crap? It is a campaign specifically for young adults who are experiencing depression. It has received widespread coverage at a political level in Scotland.

The Convener: We might get a note from you afterwards.

Dr Simpson: It is mentioned in the evidence.

The Convener: That is fine. I am sorry to have interrupted you.

Ilena Day: The campaign was designed for young adults with the involvement of young adults. Our target was to address the problem of suicide among 18 to 35-year-olds in Scotland, but during the past 18 months we have found that the campaign is connecting with younger people who are reaching out for help and support for the first time. I support what SAMH said about basic messages. Many of those young people have no awareness of what is happening to them or of the options for help and support that are available. When the committee considers the problems of young people who are in the system, I urge it to think about the difficulties that they encountered in getting into the system and the amount of suffering that they endured before they got to that point.

The Convener: I think that Mr MacIvor also made some key points about that in his evidence.

I will take a comment from Ms Bell before we move on to the next question, which will be from Mary Scanlon.

Pauline Bell: There have been some examples of good practice, such as the edspace website that was set up by Health in Mind. The website aims to provide a single resource from which people can access information about the various services that are available for people in Edinburgh. Not enough people know about the website, but it is a good attempt to solve the problem that, while workers might be aware of the services that are available, 16-year-olds and parents might not be aware of where to get information on those resources.

The Convener: The website will help schoolteachers, too.

Pauline Bell: Absolutely.

Mary Scanlon: I want to ask about communication between the statutory and voluntary sectors. The submission from, I think, the SAMH service in Aberdeenshire states:

> "From my experience I would say that many personnel in the NHS have not fully grasped the concept of partnership working and information sharing in the best interests of the patient, instead often using policies such as confidentiality and data protection as an obstructive barrier to hide behind."

Is it the experience of others that the NHS uses confidentiality and data protection as a barrier to working together in the best interests of the patient?

Carolyn Roberts: The submission was from Linda Paterson, who was part of the previous witness panel. That point certainly reflects some of the local experience, but it is only fair to say that we have also had positive experiences of working and sharing information with the NHS. The situation really depends on the relationships, as was pointed out earlier. Where there are good relationships between the NHS and the voluntary sector, things work well. Issues arise when such relationships do not exist, because the barriers between the different sectors can mean that people do not work in the interests of the most important person, who is obviously the child. There are areas of good practice that we can learn from, but there are undoubtedly areas where there are problems and where information sharing does not happen.

Roger Catchpole: I agree. It takes a long time to develop mature partnerships. I can certainly think of examples of NHS organisations putting up barriers to working together but, equally, local authorities and other organisations—all of us—do that. Time needs to be taken to build relationships and partnerships at local level and to find ways to overcome barriers. Many barriers are not artificial but arise from issues that professionals face.

The Convener: Can you describe those barriers?

Roger Catchpole: Confidentiality is an obvious example. Different organisations also have different priorities, planning timescales and budgetary constraints. We could list all sorts of issues like those. Over a long period of time, we have all been guilty of just saying, "We need services to work together better." That is true, but services need some help to learn how to do that. Working together cannot easily be taught; it is best learned from the experience of trying to work together and from reflecting on that experience. It is a step-by-step issue. In some ways—

Mary Scanlon: For clarity, can I give an example? If the NHS referred someone to Penumbra or to another organisation, would some information be held back? Would only limited information be shared? What should happen? Does the NHS basically say, "Here is a person. Find out for yourselves about their problem"? How much information is given?

Roger Catchpole: The situation is different in different cases. The young person might not want a lot of information to be shared. Professionals might have come by information that it is legally or ethically difficult for them to share. However, such barriers can generally be overcome. The key—

Mary Scanlon: Would the organisation have to contact the NHS—

The Convener: Just a minute, Mary. I want to let Mr Catchpole finish. Ms Higgins wants to comment on barriers as well. Can you just finish what you were saying, Mr Catchpole?

Roger Catchpole: I was just going to say that, in general, such barriers can be overcome. Key to that is the consent of the young person and good relationships between the professionals involved.

11:30

The Convener: Did you want to comment, Ms Higgins?

Amber Higgins: I simply want to feed back on barriers, confidentiality and the information that someone referred to Penumbra would share with me. The issue is very much about how well someone knows the service that they are making a referral to and the professional relationships that are in place.

I would hope that any referral to Penumbra would be carried out in close contact with the young person. We make it clear that referrals to Penumbra must be made voluntarily, which means, for example, that someone cannot be referred to us as part of their probation order. The young person must want to work with Penumbra and give their consent. Indeed, I would hope that the person making the referral and the young person would work together to ensure that we had as much information as possible to help us to provide support. That does happen. For example, Penumbra has good relationships with the main agencies in Fife—the schools, colleges, social work department and the national health service—that make referrals to us. However, information is not always shared, and we need to encourage organisations to do so. That said, it is difficult to strike the right balance between sharing information that you think might be relevant to another organisation and maintaining your relationship with the young person. The young person has the right to say, "I don't want you to share information about me without my permission." In such cases, information can be shared only if their safety is at risk.

The Convener: So you can overcome the hurdle of data protection if there is an immediate risk to the young person or if the young person gives consent.

Amber Higgins: Yes, but the point is that we need to encourage young people to consent to sharing information.

Ian McKee: I am interested in this idea of working together. Before I became an MSP, I was in general practice and was therefore in the NHS's front line. During my time as a GP, I could have referred people to certain organisations that were perceived to be—or which turned out to be—unsuitable. A flurry of organisations can very often be set up to help people, and in the past they have been very variable in quality. If you have the responsibility of being someone's medical adviser and keeping their confidentiality, you have to be careful about the people with whom you share information or you might choose an entirely inappropriate organisation.

Of course, there will never be an easy way of sorting out this issue, but one approach might involve physically working together a little more. In that respect, I wonder what you think of the development of healthy living centres, in which voluntary and professional workers work alongside one another, get to know one another's strengths and limitations and can establish a more trusting relationship in which confidentiality can be shared.

Roger Catchpole: Not so long ago, I heard of a case in which workers in educational and clinical psychology teams simply did not talk to one another. When a new team leader was appointed, they decided that the two teams should have lunch together once a month. As a result, the workers began to know one another as human beings, to form relationships and to develop all kinds of good professional practice. As others have made clear, the relationship between professionals is key in this area.

Amber Higgins: Fife has a child and adolescent mental health and wellbeing strategy group, which is made up of representatives from various agencies in the area. As the voluntary sector rep on the group, I think that it is a good example of partnership working. For example, we have put together a document called "Investing In Our Mental Wealth", which contains 10 priority commitments and a number of aspirations that have been informed by the framework for promotion, prevention and care. Work on priority 1, which is to

> "Design, develop and implement a range of integrated promotion, prevention, care and treatment pathways between agencies"

has been led by the CAMHS service, while I lead on priority 5, which is to

> "Create inter-agency secondment opportunities in order to foster better understanding and develop joint working."

Initially, we are looking to have work shadowing. We hope that that will make a difference to people's understanding and appreciation of the type of work that the different agencies in Fife do.

Ilena Day: Depression Alliance Scotland is a member of a number of key steering groups. We often hear the sentiments that Ian McKee has expressed about the quality of the services in the voluntary sector to which referrals are made. There are a number of issues. Most voluntary organisations have a complex funding make-up. They receive some money from the Scottish Government, some trust funding and some health and local authority funding. From my experience of bigger funding work in health boards, I know that the work of the voluntary sector is scrutinised and evaluated rigorously; if objectives and outcomes are not met, funding is held back. Over the past three or four years, the voluntary sector has had to work hard to ensure that targets are met. In the work that we have been doing with young adults, we have had to demonstrate improvements in both clinical and subjective outcomes and in the quality of life of that group.

Questions in different sectors about the quality of the services to which people are being referred cannot continue to be a barrier, as otherwise such reservations will become a self-fulfilling prophecy. There needs to be real, not tokenistic, recognition of the value of the voluntary sector, in which there are wonderful examples of work that has been done with young kids at a local level. One such example is the Place2Be, which worked in 11 primary schools in Edinburgh. The organisation took an holistic approach and worked with children who were experiencing emotional health problems, with teachers and with families. What has happened to that initiative? Homage is always paid to the idea of working more closely with the voluntary sector, but there is huge scope for the sector to deliver in problem areas. It needs to be commissioned to do so, which is always a challenge.

Pauline Bell: Again, the issue is related to funding. I often hear from statutory sector staff a reluctance to refer to voluntary sector agencies because funding is for such a short period and organisations are constantly changing. New organisations are created, but they lose their funding after two years. There is often reluctance to refer a young person to an agency when there is no guarantee that that agency will still exist in six months' or a year's time.

The Convener: The committee is well informed about the precarious and short-term funding of the voluntary sector and how strangely the system works. Organisations must reinvent themselves to get funding, even when they have been successful. All members have seen that over the years.

Dr Simpson: I have two quick comments and a question. First, we need to distinguish between project funding and funding for continuing work. One of the big difficulties in the voluntary sector is that there is often funding for a project, but that is not followed up by mainstreaming. Once an organisation has been mainstreamed or has continued for some time, it should be placed on the same funding basis as local authorities and health boards, which receive three-year rolling funding. They do not get funding for more than three years, but they have a pretty clear idea that their core funding will continue. You said that there have been moves from three-year to one-year funding; it would be helpful if you could provide us with specific examples of that, because it is extremely destructive of the relationships that have been built up over the past 10 years or so.

The second issue is co-location. When I worked in the drug field in West Lothian, we relocated the health service to the social work open-plan office. We worked closely with West Lothian Drug and Alcohol Service, which is a voluntary organisation. Each locality team had somebody from the local authority social work team, somebody from WLDAS and somebody from the health service, and that ensured that there was team working. I agree entirely with Mr Catchpole—it took me almost two years to build that up and to get people comfortable about sharing information at the right level. We need training in that regard, and we need to help people develop their leadership roles.

Who monitors all that? We keep hearing that provision is patchy, albeit there is good practice. There are two aspects to the question. First, how in goodness' name do we ensure that good practice is maintained and spread? Secondly, who monitors the local authorities and health boards in the community health and care partnerships or community planning partnerships to make absolutely sure that best practice is spread, that training is provided, and that all the other things that we all want are in place? Who does the monitoring? Who should do the monitoring?

The Convener: How do you share best practice and ensure that we get rid of patchiness? Who is guarding the guards, or whatever the expression is?

Roger Catchpole: I will respond on the sharing good practice element of the question. Over a couple of years, YoungMinds ran what we called a collaborative network, which brought together people who were involved in implementing the framework for children and young people's mental health in an action learning capacity. That provided an opportunity for people who were actively trying to bring about change to share their experiences with others who were doing that in different areas. The work of that network showed that it is not necessarily possible to transplant good practice from one area to another, because it does not necessarily fit. However, it is possible to translate good practice and people can still learn from what has proved effective in one area—perhaps they can adapt or tweak it to replicate it in their own area. That can be done, and collaborative learning across health boards and local authority areas is one vehicle for doing it.

Brian Donnelly: One factor that goes to the heart of the inquiry's purpose—this backs up what Ilena Day was saying—is the not inconsiderable role that the voluntary sector plays in prevention in all the areas that we have talked about. The inquiry into CAMHS has been about recognition of the role of the voluntary sector, and about prevention and promotion.

Carolyn Roberts mentioned the curriculum for excellence. Having health and wellbeing as a curriculum area presents huge capacity issues. For example, the role and responsibilities of teachers who have spent their whole working life delivering the chemistry curriculum now include recognising and responding to what might previously have been considered to be pastoral issues. We have a huge joint responsibility to facilitate capacity building. In addressing the risk factors that we discussed earlier, we must engage with children and young people at an early stage, rather than simply devise services for them or just respond to problems. We need to get in there early and consider what is working and what is needed.

I have gone on for ages—I am sorry about your point, Dr Simpson. I was trying to bottle that succinctly.

Helen Eadie: Could you expand on your point about promotion and prevention activities? Your paper discusses

"developing a proper integrated infrastructure".

I would like to know a bit more about what you have in mind. I accept what you say about great emphasis being placed on action only once the illness has been identified. What more can be done? Perhaps your colleagues could expand on the integrated infrastructure that you have mentioned.

Brian Donnelly: Is that in the young Scotland in mind submission?

Helen Eadie: Yes.

Brian Donnelly: To be perfectly honest, I am not sure what is meant by that.

Helen Eadie: You speak about

"developing a proper integrated infrastructure of support for children and families."

That is in the context of promotion and prevention.

The Convener: What page is that on?

Helen Eadie: It is in the second last paragraph on page 2 of the young Scotland in mind submission. It discusses

"The traditional models of child and adolescent services".

The Convener: Yes—there we are.

Helen Eadie: Can you expand on how you envisage that happening? Perhaps some of your colleagues round the table might also see how that could be done.

11:45

Brian Donnelly: It is more about the lack of working with families from a preventive point of view to identify mental health factors in the behaviour of the mother, the father or whoever is in the family. People are deciding to have specialists work with the mum on her addiction or her mental health problems but not with the children, although we know that that is one of the biggest significant indicators of their developing further problems. Alternatively, people just deal with the child's presenting behaviour, which can be anything from criminal behaviour and risk behaviour to self-harm or attempted suicide, and they do not do anything with the family. It is about taking a more holistic view, as colleagues mentioned, and working with children and adolescents and then adults. There is a need to work with families in communities.

The Convener: That is also applicable to the evidence that we heard about communication skills in young children at nursery, where family involvement is required. That can lead to a lack of mental wellbeing.

Brian Donnelly: Absolutely. Those are the people who can make the most difference. That is where children take their cues from and get their support from. Children who are looked after away from home feel the loss when they are taken away from those people. It is they who are being dealt with, not the family.

The Convener: Are you saying that it is a bad idea to take children away to be looked after?

Brian Donnelly: No. I am saying that there are times when the loss and trauma that a child can experience through being taken away from their family are not given any credence or paid attention to. No matter how dangerous, difficult or risky a situation can be, most children would rather stay at home. Some can accept the reasons why they cannot live at home, but they miss their families. For years, we have not spoken about that as a traumatic event, about the impact that it can have and the loss that the children feel or about the difficulty in making significant attachments that it can lead to. Those things can be repaired, but there are times when we need to give more serious consideration to the damage that we could do by just saying, "That's not safe. You're coming out of there." That is a really traumatic event for children and young people.

Roger Catchpole: I will give an example of what I think of as the infrastructure support. We had a project in Falkirk that centred on building resilience in children and families in a school cluster. It focused particularly on the primary 7 to secondary 1 transition, when children are more vulnerable. The project worked with staff so that they could do some work with children, through the curriculum, to develop their emotional literacy—their resilience skills. It also worked with parents and other agencies that worked with that cluster in the school.

The work with parents was fascinating. When we gave them some basic information about brain development in children, the parents asked us why nobody tells people about that when they are having children. They are told about physical care, but nobody tells them what is good for the emotional wellbeing of their child. Parents elsewhere have said that to us when we have done that kind of work with them. We know that that information is hugely empowering. We know what is normal when children are going through the transition from primary school to secondary school or developing as adolescents, and we can support them much better.

That kind of holistic approach is needed.

Carolyn Roberts: I want to follow up a couple of those points. First, as Brian Donnelly said, it is important to work with families. It comes back to the point about not putting people in boxes and saying, "You're the child, you're the adult and we'll work with you separately." The respect me service provides a good model of working with everyone who is involved with a child. Brian Donnelly will correct me if I am wrong, but I believe that it works with anyone who has a role in a child's life in the context of anti-bullying work. There is a strength in not focusing entirely on local authorities, health boards or whoever, but working with anyone who has a role.

Secondly, it is true that parents ask why no one talks to them about their children's emotional wellbeing. We had a very recent experience of that: SAMH was at the baby show in Glasgow over the weekend and spoke to approximately 1,000 parents of young children and expectant parents, none of whom had been given much information about their own or their child's mental health. It struck me how much of a gap there appears to be.

The Convener: What kind of information were you giving them?

Carolyn Roberts: We were asking them for information on what gaps they saw, because we want to expand our work. We want to know what the gaps are and how can we help. We asked people what they knew about parenthood and mental health and what would they like to know. Generally, there was a sense that there was very little focus on mental health. There is a great focus on the physical changes involved, but no one had mentioned to them the impact on their own mental and emotional health of that transition into parenthood.

Amber Higgins: A good example of what can happen when integrated work is effective is the case conference. A case conference can be called by workers who are involved in supporting a child. All agencies involved in support of that child will meet, and it is hoped the child and carers will attend, to talk about what they provide as a service, what they can provide specifically for that child and what they can provide as a group. Penumbra youth workers are involved in such work regularly. We attend one or two case conferences—or that style of support—every month, at which we discuss our input in the context of what services other people are providing at the same time. That is a good example of where integrated work is effective. The best examples are where the child and the parent also attend and they are able to input, although often they do not and it is just a group of professionals.

Roger Catchpole: Much of the work that is done with parents is on quite basic things that very often parents do naturally anyway in bringing up children. They need someone to give them confidence that those things are important and to understand why they are so important. Those are things such as the way they respond to their child and issues around attachment, which most parents do but they do not think that they are building an attachment relationship with their child—they are just interacting with it.

The difficulty is that parents are often suspicious of professionals because the stereotype is that professionals criticise people for being bad parents. Effective services are those that go to parents and tell them that what they are doing is fantastic and to do more of it because it is important for their child's emotional wellbeing.

The Convener: We went down that track with health visitors and how they are more acceptable at the door.

Helen Eadie: On the one hand are the care and treatment costs that Amber Higgins discussed and on the other hand are promotion and prevention. The paper that was submitted by Brian Donnelly discusses the need for balance in all that. I get the impression that there is not enough balance and that more emphasis is being put on treatment and care. That is what strikes me about what we have heard this morning.

Brian Donnelly: If I wanted to leave you with one thought, that would be it.

The Convener: I am coming to your one thought at the end—you will get your chance then. After we have heard from Ilena Day, I will ask members of the panel, as I did with the previous panels, if they had one recommendation—I cannot guarantee that we will include it—for the committee's report, bearing in mind that our remit is how children and adolescents who are potentially at risk of developing mental health problems are identified and how those problems should be prevented; what the obstacles are in identifying children and adolescents with mental health problems and how they might be overcome; what action is being taken to facilitate early intervention and what else can be done; how access to services and on-going support can be improved and what problems there are around transition from CAMHS to adult mental health services. I am telling you that now so that you have time to think about it.

Ilena Day: I would like to refocus and put young people at the heart of the topic and where possible have older young people involved in the different types and tiers of support that have been spoken about today. The findings of our work are that it is possible to be really innovative in the ways in which we offer people information and support. There is huge potential for web-based resources to widen the net for younger people. We know that that is a very acceptable way for people to get initial support.

The Convener: That sounds like a good recommendation—can we take that as your recommendation?

Ilena Day: You can. I wanted to highlight another couple of things, too. The mental health first aid programme has been widely embraced in Scotland. I am aware of the development of a youth programme in Canada, and perhaps the committee would consider the potential for something similar to be done here.

The Convener: Your recommendation would be to use the kind of techniques that young people would use—the internet and so on—and, judging by your submission, youth-based approaches.

Ilena Day: Yes.

The Convener: I am taking that as your recommendation.

Ilena Day: Okay—

The Convener: That is it, though. You do not get any more recommendations.

Ilena Day: I am sure that the committee is aware of some good work by the Scottish recovery network. What has worked well in supporting people at the more severe and enduring end of the spectrum has been the concept of peer support. I see great scope for a role for young people who have been through mental health problems and have come out the other end, and who have positive stories to tell about their journey. That model works well—we have used it for older young adults.

The Convener: Your recommendation would be that support should come more from the grass roots—from the youth—than from those further up, and that modern techniques should be used.

We come to Ms Bell. If you could write a recommendation for our report, what would it be?

Pauline Bell: I am sorry; I thought that you were going round the table the other way and that I had ages.

The Convener: Okay. Are you all right, Mr Catchpole or shall I ask someone else?

Roger Catchpole: My recommendation would be that all professionals working with children and young people should have training in mental health and psychological development.

The Convener: Mr Donnelly? You are the man who likes to put things in a bottle. Is it a little bottle or a big bottle?

Brian Donnelly: We need to address the risk factors that we know contribute significantly to inequality and mental health problems, through prevention and promotion.

The Convener: The underlying causes.

Brian Donnelly: Yes.

Carolyn Roberts: Everyone who comes into contact with children and young people, but particularly teachers, should be given information and training on mental health, in whatever format is most appropriate, whether it is actual training, web-based or DVD.

Amber Higgins: We should recognise that young people are the experts in their mental health and wellbeing, not us. That should be the starting point. We need to develop services that suit young people rather than services that suit ourselves.

The Convener: Are you ready now, Ms Bell?

Pauline Bell: I am still trying to decide which issue I think is most important—they are all important. What still comes up often in advocacy is the stigma and fear associated with mental health, which prevent young people from wanting to access services. I second the idea of the peer support model. We often hear about the fears of 18 or 19-year-olds who, when they are first admitted to hospital, think, "Oh my God, this is my life. I'm going to be using services for the rest of my days." We need people—whether it is celebrities or just ordinary, everyday people—to stand up and say, "I went through this period in my life but I've come out the other side. There is hope. There is recovery." The Scottish recovery network has done a lot of work in that area. The image of mental health services is still very negative.

The Convener: You are talking about removing the stigma.

That concludes an interesting evidence session. I thank all the witnesses for attending.

11:59

Meeting continued in private until 12:50.

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