HEALTH AND SPORT COMMITTEE

Wednesday 6 May 2009

Session 3

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HEALTH AND SPORT COMMITTEE
14th Meeting 2009, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
*Rhoda Grant (Highlands and Islands) (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:

Margo Fyfe (Scottish Government Primary and Community Care Directorate)
Geoff Huggins (Scottish Government Primary and Community Care Directorate)
Adam Ingram (Minister for Children and Early Years)
Boyd McAdam (Scottish Government Children, Young People and Social Care Directorate)
Shona Robison (Minister for Public Health and Sport)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

Seán Wixted

LOCATION

Committee Room 4

Scottish Parliament

Health and Sport Committee

Wednesday 6 May 2009

[THE CONVENER *opened the meeting at 10:00*]

Interests

The Convener (Christine Grahame): I welcome everyone to the 14th meeting in 2009 of the Health and Sport Committee. I remind members, witnesses and the public to switch off their mobile phones and other electronic equipment. No apologies have been received.

Item 1 is a declaration of interests by Rhoda Grant MSP.

Rhoda Grant (Highlands and Islands) (Lab): I do not have relevant interests to declare, but I am a member of Unison, which also represents health service workers, so it might be worth putting that on the record.

The Convener: Thank you. On behalf of the committee, I take this opportunity to thank Jackie Baillie MSP for her services as a member of the committee. She was excellent, which is not to say that Rhoda Grant is not excellent, too.

Child and Adolescent Mental Health Services Inquiry

10:01

The Convener: Item 2 is our inquiry into child and adolescent mental health services. We will take evidence from Shona Robison MSP, the Minister for Public Health and Sport; Adam Ingram MSP, the Minister for Children and Early Years; and from the Scottish Government, Geoff Huggins, who is deputy director of the mental health division; Boyd McAdam, who is head of branch in getting it right for every child; and Margo Fyfe, who is a nurse adviser in child and adolescent mental health services.

We will hear introductory remarks from both ministers, starting with the Minister for Public Health and Sport.

The Minister for Public Health and Sport (Shona Robison): Thank you for the opportunity to come to committee today to talk about this important subject. Our belief is that investing in a child's earliest years pays dividends in that child's physical and mental health later on in life. That is why we developed the early years framework, which is founded on the knowledge that the first few years of life have a huge influence on the future welfare of a child.

Building parenting capacity is a key theme of the early years framework. To achieve better outcomes for our children, we need flexible, accessible and responsive services that are predicated on the needs of the child and his or her family. The early years framework builds on our existing commitment in getting it right for every child. Our aim is to ensure that parents have the skills to help their children, but there are some parents whose behaviour prevents that from happening. I am thinking specifically of children whose parents misuse substances. Such children are also entitled to the best possible start in life, which is why we are working with partner agencies to implement the approach outlined in the national drug strategy, "The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem". The approach will improve the identification and assessment of vulnerable children and strengthen the services that are available to support them.

The Scottish Government's curriculum for excellence will provide a framework for young people to gain the knowledge and skills for work and life, and healthy and active lifestyles. Furthermore, the new policy and action plan for mental health improvement, "Towards a Mentally Flourishing Scotland", to be published tomorrow, includes several commitments to mentally healthy infants, children and young people.

The new commitment to the mental health improvement of children and young people builds on the important work outlined in "The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care". Full delivery of the framework by 2015 will ensure that there is throughout Scotland equity of access to services that are designed to meet the prevention, care, transition and recovery needs of children and young people. We know that much more is to be done, but we are making progress and are engaged in a range of work—of which, I hope, I have given members a flavour—including training and workforce planning, reducing inappropriate hospital admissions, early interventions, supported transitions, improved primary care, and better planning and delivery of specialist care in in-patient services.

Our priority attention to child and adolescent mental health services is reflected in our work with NHS boards in setting a target to deliver faster access to CAMHS. To support that, we are focusing our attention on workforce, services, data collection, quality of care, referral protocols and information systems.

All of that has highlighted a need for further expansion of the workforce capacity, and we must address the long-standing underfunding of CAMHS in Scotland. We have begun to do that through the £2 million of new money that we have offered to NHS boards, starting from this year, to accelerate the development of specialist CAMHS. That money will continue over the next two years of the current spending review period.

In addition, I am pleased to be able to tell you that we have identified further investment of £1 million in 2009-10, rising to £3.5 million in 2011-12, to support an increase in the specialist CAMHS workforce. That means that, over the three-year period 2009-12, we will spend an additional £12.5 million on CAMHS. I hope that the committee will welcome that. That money will be targeted on increasing the number of clinical and masters-grade psychologists working in specialist CAMHS, and it will support both additional training places and additional posts to ensure that the investment in training is translated into increased capacity.

With the existing growth in the system, we estimate that the investment should increase that component of the workforce by 80 by the end of 2012. Continued growth at a similar level to 2015-16 would increase the workforce by 170 to 180 posts. I hope that you agree that that will represent a significant improvement on the current position. Of course, those staff will be able to offer direct services and will support teachers and social workers in their work. In parallel, we expect to see a growth in the number of psychiatrists, and we are working with NHS boards on their plans for specialist CAMHS nurses and allied health professionals. Current planning suggests that we should have an additional 35 psychiatrists in post by 2015-16.

Our view is that the new investment—the £2 million that has already been announced, the investment that is being made by NHS boards and the additional amount that I have just announced—will help us to increase CAMHS capacity significantly. I reiterate my commitment and the commitment of the Government to the improvement of the mental health and wellbeing of children and young people. We are all clear about the challenges that we face. I look forward to receiving your questions.

The Convener: Thank you very much. Adam—do you want to add anything?

The Minister for Children and Early Years (Adam Ingram): Yes, thank you, convener. In the concordat, we have agreed with partners some high ambitions for children and young people and the Scotland in which they live.

We are clear on a number of things. We must intervene as early as appropriate where that will make a positive difference, and we must do so in as integrated a way as is necessary. We must prioritise the early years to make as much difference as possible early in people's lives. That time in our lives sets the pattern for a large part of our future.

We must also support capacity building within the child's family unit as far as possible. The early years framework provides the structure within which services can address the key issues in children's early years, and the getting it right for every child programme is the mechanism by which that can be achieved.

I spent yesterday in Inverness, hearing about progress in the GIRFEC pathfinder project there. There were very encouraging signs of how all services are refocusing their activity, sharing information early and taking action to address the needs of children, especially in their early years. There is still some way to go, but where the GIRFEC approach is being implemented, the workforce is coming together as a team and ensuring that concerns are responded to when they arise. Services are becoming targeted on identified need. It was put to me that GIRFEC is changing crisis intervention into early intervention.

From my policy perspective, we must do all that we can to improve outcomes for children. That means drawing on practitioners' skills and the contacts that a range of practitioners have with children at various stages in their lives, and ensuring that signs that a child may not be developing as might be expected are identified,

shared appropriately, and acted on. We have to see provision of CAMHS in that context.

It is just as important that we build the capacity of parents to help and support their child. The determining factors in securing good mental health and wellbeing are complex, but a major one is a good start in life, even before we are born. Good antenatal care is vital. Alongside that, we want children to have a strong and sensitive relationship with their main carers, which is why I am focusing on developing parenting capacity pre-birth and post-birth as one of the key factors in the early stages of implementing the early years framework. We want to enable parents to have the skills that they need to help their children. I have seen examples of that happening throughout Scotland as community planning partners begin to take forward the early years framework agenda.

The family nurse partnership project, which is being piloted in NHS Lothian, has had proven benefits in the United States for the most vulnerable families. I look forward to its being tested here in Scotland.

We want wherever possible to take a dual approach to prevent problems happening in the first place and, where problems have already manifested themselves, to provide appropriate, proportionate and timely support. That points to a need to strengthen universal services and to ensure that those who deliver such services are appropriately trained and supported, in turn. Workforce development is therefore a key theme of the framework.

All the evidence points to play being central to children's mental and physical health, so the early years framework makes clear the Scottish Government's commitment to developing play opportunities for children.

I want the early years framework to make a real difference in the lives of our youngest children regardless of need; to focus on wellbeing and well-becoming; to involve families and carers, and to give every child the best start in life. That is why my ministerial colleagues and I are making the importance of the framework clear to all community planning partners.

Helen Eadie (Dunfermline East) (Lab): I welcome the announcement of the additional resources that will go into the workforce. I am sure that the long standing issue with the workforce has been fed back to the ministers by their officials. We were all concerned when we heard that in one instance there were only 4.5 members of staff per 100,000 population dealing with CAMHS. The issue was raised when Ian McKee and I went to visit the CAMHS team in Lochgilphead.

One of the issues that struck me when we took evidence from the Scottish needs assessment programme core working group—this issue was raised by all the witnesses—is that although there are strategies, there seems to be a lack of clarity throughout authority areas about implementing the report that was produced by the previous Government and ensuring that it translates into reality. There is certainly good practice out there and there is no lack of knowledge.

The view was expressed that we do not have to look abroad for inspiration, because we have good professionals in this country. However, there seemed to be an issue around training. It is not just about setting targets; there has to be a target date for meeting the targets, if you know what I mean. Does that feature in your thinking? What will be your target dates for meeting the targets? How will you ensure that the training is cascaded in a way that reflects the various reports and the strategies that the Government wants to see in place?

10:15

Shona Robison: A lot of the strategies that I have outlined are interlinked but, for me, the key one is "The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care", which was published in 2005 and is to be implemented fully by 2015. When I looked at the milestones for implementing that framework, I found that we are actually doing pretty well. We have implemented the key recommendations that one would have expected to have been implemented by now; for example, the aim of having a mental health link worker in every school was, I think, achieved in 2008 and we have also implemented a range of other key elements, including the training of staff who work in schools or who come into contact with children and young people. It was always expected that the framework would not be fully implemented until 2015, so there is still work to be done. However, nothing in the question suggested that we are off target in any of this activity, and the new investment in CAMHS will make it all the more certain that full implementation will be achieved by 2015.

I hope that that reassures Helen Eadie. If it helps, I can certainly provide the committee with a list of all the milestones that have been met.

The Convener: That would be very helpful.

Mary Scanlon (Highlands and Islands) (Con): I, too, welcome the additional resources for CAMHS, particularly the additions to the workforce, which will be crucial.

Having been convener of the cross-party group on mental health for eight years, Adam Ingram has extensive experience of this issue. I noted that, when he talked about his visit to Inverness, he mentioned the need to turn crisis intervention into

early intervention. That is the key. If intervention does not happen early enough in a particular case, it will simply turn into something more complex five or 10 years down the road, and will require additional CAMHS resources and staff. As a result, I would like to think that staff would work smarter by identifying problems earlier.

However, the committee has found that early identification is not happening throughout Scotland. People have to wait for problems to be identified, they have to wait for an assessment, they have to wait for a report and then they have to wait for a service. When my 15-month-old granddaughter had her measles, mumps and rubella jab, for example, the health visitor said to her, "I'll see you again when you're five". In certain parts of Scotland—Inverness, in particular—there are no services for children between 15 months and five years, unless, of course, the parents call for help. I suggest that the parents who most need the help are less likely to make the call.

I therefore wonder whether you can tie your response on early intervention to changes to health visitor services in Scotland. As I say, there is nothing in Inverness for children in the three and three quarter years between 15 months and five, although I appreciate that that is not the case in the rest of Scotland.

Adam Ingram: Mary Scanlon is right to highlight the need for early identification of problems and early and effective intervention. Certain simple interventions can be made very early on via the universal services before a situation develops and requires a range of specialist services to be called in. Identification of needs as early as possible is a much more effective approach and has far lower human and resource costs.

That is the aim of the getting it right for every child approach. We are trying to change the culture, systems and practices in the service environment so that we can ensure that, when a child comes to the notice of one professional and a need becomes established, all the other services group round, discuss the case and put together a plan to meet the child's needs.

Health visitors are clearly important front-line practitioners in that process, as are midwives: a vulnerable family and what needs to be done about it can often be flagged up during a pregnancy. In terms of the "Health for All Children 4" guidelines, there has been some inflexibility, shall we say, in some of the health board areas. Shona Robison might want to talk about that a wee bit more, but I believe that that has been recognised, and that responses have to be much more flexible so that a child is not just seen for the last time at the age of six to eight weeks. My understanding is that a new care pathway for vulnerable children is being developed that will go from pregnancy through to two years of age and beyond. A new competency framework is also being developed. I hope that those developments will address the particular issues that Mary Scanlon highlighted about health visitors. Shona Robison might want to add something.

Shona Robison: The principle of Hall 4 is right in that we have a universal service with contact, and then we narrow our focus and give additional attention to those children who need it most. The question is whether six to eight weeks is a bit too early to identify those needs, which is why the working group has been looking at whether there needs to be more flexibility around that.

When Hall 4 was originally put together, the assumption was that immunisation, for example, would mainly involve health visitors. Of course, practice has determined that it is almost exclusively practice nurses who do that, so the opportunities for contact with health visitors might not be as they were originally envisaged. That is why the working group has considered some of the concerns that have been raised by health visitors about having to allocate on the health plan indicator at six to eight weeks the interventions that are required for the child. Health visitors want more flexibility and a period of support and assessment in which they can revisit and see the child again. That has been recognised, and the working group is considering that. I hope that we will soon be able to have some revision to allow more flexibility.

Mary Scanlon: I have one supplementary question for Adam Ingram. I have been asking this question all along and trying to understand. Are staff in the nursery sector trained to pick up potential developmental, speech, communication and mental health issues? Over and over again, we have heard that that is not that case. Is that part of your plan? You talked about a child seeing a health professional. I have given you an example of a child who I hope does not need to see one. However, in Inverness, children under five do not see a health professional to address the issues that I have mentioned for three and three quarter years.

Adam Ingram: I reassure you that the current big drive is to upskill the early years workforce. I am impressed by the workforce's enthusiasm to register with the Scottish Social Services Council, which puts people under the obligation to extend their qualifications and take extra training. There is a great demand for that from the workforce itself.

I make visits all round Scotland to a lot of early years centres, family centres, nursery schools and the like. Significant workforce development is going on. I offer an example: a couple of weeks ago I visited Angus where former nursery nurses are now put through additional training to become

outreach workers with families. So the teacher might pick up on something in the pre-school setting and pass it on to the early years worker who arranges to go out and see the child in the family environment. Alternatively, a parent could come in and say to the nursery teacher, "Wee Johnny doesn't seem to be developing skills in this direction", or whatever. That contact is made, people go out into the family home and we kick off the whole process of identifying a need. We then pull in all the other professionals as required. That is the kind of system that is being developed.

Shona Robison: I add that one of the six priorities laid out in the plan "Towards a Mentally Flourishing Scotland", which we will launch tomorrow, is mentally healthy infants, children and young people. There will be a lot in there about how we better support those who are working in early years provision—pre-school—as regards their training and support needs. People will be able to see the action plan, but I would be happy to encapsulate some of the detail in a letter to the committee, if that would be helpful.

Rhoda Grant: It appears that GIRFEC crosses social services and education, but it does not involve the justice system. It is important that young people get protection when they are victims of crime otherwise it can lead to mental health issues. The crime itself can cause mental health issues, but if the justice system does not act appropriately with young people, it can make the situation worse. Has consideration been given to rolling out GIRFEC to the justice system?

Adam Ingram: Yes, indeed. Getting it right for every child should encompass all services with which children and young people come into contact. I was speaking to children's panel members in Inverness yesterday and the day before. One complaint that children's panel members tend to make is that they might not get reports in time and therefore cannot make the disposals for young people that they would like to make. Alternatively, when they do so, they feel that their decisions are not acted on.

I hope that the getting it right for every child approach, which brings together professionals around and about an identified need, creates a single shared assessment, promulgates a record that can be shared between all the various professionals and contributes to a single plan for that child to which all can relate, will address the kinds of issues about which you are particularly concerned.

Rhoda Grant: My concern is about the adult justice system rather than the children's panel, which does a lot of good work. I was talking about a child who is a victim of crime and who appears as a witness in the adult system, for whom there appears not to be the same protection and care. Given that being a victim of crime can lead to mental health issues, it is important that children get such support.

Adam Ingram: The police, who are central to all this, would probably be the first professionals in line to identify a particular problem with a victim. That would be the trigger to involve the getting it right for every child approach. Whoever the problem is flagged up to, the kind of response that I am talking about should be mobilised. It might not be the police who are involved; it might be a victim support organisation or a teacher. The important thing is that the need is identified and that the services are mobilised around that.

10:30

Rhoda Grant: I want to ask about using e-health services in rural areas to provide assistance to young people. I know that e-health services are used quite successfully in adult mental health services. What thought has been given to the use of e-health for young people's services, given the access problems that are caused by the geography of rural areas?

Shona Robison: I understand that a number of e-health packages that are aimed specifically at young people are under development. I ask Geoff Huggins to say a bit more about that.

Geoff Huggins (Scottish Government Primary and Community Care Directorate): We have been trying to use the same approach for young people that we have used for adults by creating resources that can be used by parents, teachers or children themselves, such as the handsonScotland toolkit, which I will ask Margo Fyfe to say a bit more about, and the living life to the full resource, which can be used by younger people with low mood. In addition, the choose life resources can be accessed by many people in rural and island communities; there are other self-help approaches, too. It is a developing area. We are looking to do more and to increase capability.

Margo Fyfe (Scottish Government Primary and Community Care Directorate): The handsonScotland toolkit is really aimed at anybody who comes into contact with children; it is not necessarily just aimed at professionals. It uses straightforward language—there is no jargon in it—so parents and young people can tap into it. It is not just about the severe end of not being well; it is about wellness and helping people to get over feeling a bit down or a bit anxious. It outlines the different techniques that are around. The website is well used, including internationally, and well promoted.

Michael Matheson (Falkirk West) (SNP): I want to raise two issues—one for each of the ministers. I will start with my question for Shona

Robison, which is on the framework for children's and young people's mental health, to which she referred earlier. Although it appears that some of the early milestones in the framework are being reached on time, I suspect that, as we move towards 2015, some of the more detailed and complex aspects of the framework will start to come into play, which might face greater obstacles to implementation. What is happening at a central point in Government to ensure that health boards and local authorities throughout Scotland are reaching the milestones? There might be common ground among health boards and local authorities—for example, particular problems in reaching the milestones might be identified. What is being done to monitor that? Are you considering whether more direction and guidance could be issued centrally to assist local authorities and health boards in meeting the targets?

Shona Robison: The short answer is that, through the performance management systems that we have in the directorates, Geoff Huggins's team will engage with each health board to check that they are making progress against the framework and milestones. That is done twice a year. A more public opportunity arises during the annual review process. Either last year or the year before we focused specifically on mental health and the boards' plans—we do not do that in every annual review. The twice-yearly check as part of the performance management framework is pretty robust. Boards will be left in no doubt that, if they are not on track, they will have to get back on track in order to meet the targets.

The attention that we have been giving to CAMHS—with the £2 million that I referred to earlier and the expectation that boards will give a financial contribution from their resources, plus the additional money—has given boards more of a sense of priority and of what is required. That is likely to ensure that they focus on delivering the framework, as well as the other elements that they have to deliver—not everything is in the framework, although a lot of it is. I am confident that I would find out if a board was having issues and did not have that sense of priority.

Michael Matheson: That is reassuring. From some of the evidence that we have received, I have been left with the impression that there is a danger of a piecemeal approach and that health boards might move at different speeds on the issue. We need to ensure a consistent approach, so that we do not have a situation in which one board achieves targets fairly well and provides effective services while a neighbouring board struggles to meet some of the basic targets.

Shona Robison: It is fair to say that some boards are further along the road towards implementing the framework by 2015 than others are. Of course, those issues will be picked up by the performance management systems. The investment in CAMHS varies between boards, as happens with other services. Boards have done things differently and at different speeds, but the bottom line is that, by 2015, they must all implement the framework. As I said, our focus on CAMHS sends out a clear signal to boards on the priority that those services must be given. I must say that the situation is not helped by underfunding over several years. Boards have not necessarily had sufficient resources from Government previously and a sense of priority was perhaps not given. That is changing, which will help to drive forward work on implementation of the framework by 2015. I give Michael Matheson an assurance that I will keep a close eye on all boards to ensure that they make the necessary progress.

Michael Matheson: That sense of priority is welcome.

My second issue, which Adam Ingram has already raised, is the importance of workforce development if we are to identify children's needs at an early stage and ensure that the right services are provided. This is somewhat anecdotal, but friends of mine who work in the sector present a rather unhealthy picture of their ability to access the specialist training that they would like to access to help them develop their practice and clinical skills. Although they can undertake continuous professional development for registration purposes, they often find it difficult to access more specialised forms of training that do not fall into that category. They can find a lack of support from senior managers for spending time on such training.

Workforce development is to be given priority, but how will that message be got across in practical terms at local authority and health board levels? We need to ensure that middle managers, who often make the call on whether staff can go on training programmes, are aware that they should support their staff in doing training, particularly specialist courses, which can be valuable to those who work with children who have complex needs.

Adam Ingram: I understand exactly where you are coming from.

I recently visited the Jordanhill campus, where a cohort of students are taking the new childhood practice degree. Many of the people on the course were supported by their local authority—they were already in management positions, and we have laid down a timetable for managers to have that qualification. However, among those students were people who were doing the course off their own bat without any local authority support. I came back with the view that we should encourage

people to upskill and to seek their own career development path independently. That resulted in a discussion in the Government about how we can better support people who are doing that. Often, those people will be young women who have considerable other responsibilities to fulfil. We therefore considered the ILA 500 eligibility criteria and relaxed them to allow people in that situation to take the qualification at a pace that suits them, with appropriate support.

We are aware of such issues and try to be flexible in responding to them. I am certainly keen to support the workforce in its desire to upskill and increase its qualifications because, as I said at the outset, developing workforce capacity is essential to enable the introduction of the early identification and intervention approach that we want to take.

Michael Matheson: That is helpful.

My other concern is that workers in services such as CAMHS, social work and education have very heavy workloads. There are often lengthy waiting times for the assessments that they conduct, and there is pressure on middle managers to ensure that they keep pushing assessments to completion, which limits the opportunities for staff to take time out and engage in the professional development that they would like to engage in outside their personal time. Given the nature of the workforce, that presents further difficulties. More must still be done to ensure that those who work for health boards and local authorities recognise that staff must be given time to do courses, as opposed to their having to do courses in their own time. They should get time out of their work time to allow them to do courses. From my experience, many staff have been told that that is not a priority at the moment, given the waiting lists.

Adam Ingram: I agree that it is vital that local authorities and others ensure that staff have continuous professional development opportunities. Perhaps Shona Robison would like to pick up on that matter.

Shona Robison: NES is developing a workforce development plan, which it will have completed by the end of the calendar year.

The Convener: I am sorry, but did you say NES?

Shona Robison: Yes—NES stands for NHS Education for Scotland, which is responsible for ensuring that there is workforce planning in the NHS, and that the required skills and education needs of cohorts of staff are considered. It is working on a workforce development plan for CAMHS, which will not just include the new posts that will be funded, but cover the skills and education needs of the existing workforce and how those needs will be met. Obviously, that plan can be shared with the committee once it has been developed.

We press each health board quite hard on the knowledge and skills framework in the annual reviews. Boards for remote and rural areas in particular must consider how they can release staff for training and CPD if they have a very small staff cohort in the specialism. That is a challenge, and is why we need to use e-learning and teleconferencing, for example, to make available to staff in smaller boards all the training opportunities that staff in larger boards can access. We need to be a bit smarter about how we facilitate that. It is still a challenge, but boards are certainly giving the matter more attention—for example, they are considering organising back-filling on a managed basis so that the service is maintained while they release staff members who require to be released. It is a balancing act and a challenge for boards, but they are getting better at it.

10:45

The Convener: I think that Adam Ingram mentioned a childhood practice degree.

Adam Ingram: Yes.

The Convener: I have never heard of that before—I do not know whether other members have—so perhaps you can tell us what it is, when it started and how many people are doing it.

Adam Ingram: It is a new degree course that focuses on child development in the early years and is particularly for the likes of managers of family centres. As I said, we want to upskill the early years workforce. I can send the committee more detail on that.

The Convener: That would be useful, because I had never heard of it before.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I apologise for being slightly late this morning.

I welcome the extra money specifically for CAMHS over the next few years. The increase in capacity of tier 3 services is vital to the support of the lower tiers as well as to the management of tier 3 practitioners' case loads.

We heard evidence about the current situation from a professor of speech and language therapy, who said that, since Hall 4 came in, delays to referrals for speech and language services have increased significantly—a survey was carried out over a wide range of areas that showed that that was occurring. When we talk about trying to move in the right direction, I wonder whether we are moving with sufficient urgency to ensure that the previous systems that were in place are not being

degraded. We have all signed up to GIRFEC—the previous Government was keen on it, too—but are people moving with sufficient speed towards the implementation of GIRFEC, or are they simply waiting for the pathfinders to report? Pathfinding exercises can sometimes have that effect. I have another question about the older age group, but I will ask it later.

Adam Ingram: It is true that people are waiting for feedback on the pathfinders' evidence and information in a distilled form so that they can absorb it easily. However, it is also encouraging that a number of learning partnerships have been established between the pathfinder areas and local authorities throughout Scotland. For example, there is a learning partnership between North and South Lanarkshire Councils and the Highland pathfinders—the Lanarkshire authorities are working in parallel with Highland and absorbing lessons as they go along. Something like 25 per cent of local authorities are engaging in that way, but I acknowledge that means that some local authorities are not. I hope that by this September we will have available the full evaluation of the Highland pathfinders. That would certainly give us extra leverage to promote the GIRFEC approach throughout the country.

At the moment, we are engaged in an exercise with all local authorities in Scotland to try to ensure that they all address the implementation of the early years framework. Others ministers and I are engaged in a visitation programme to stimulate that.

Shona Robison: Four boards are involved in the work that we are doing on the demonstration sites and increasing health care capacity in schools. What is provided will depend on the health needs in a school, but it could involve speech and language specialists being part of the health care team, providing additional support to schools. We are looking at other ways of providing quicker access to support, whether through mental health workers, speech and language therapists or physiotherapists—that will be determined by need. That is another way of exploring how we can provide access more quickly.

Dr Simpson: I understand that, but tier 3 practitioners have referred to what happens pre-school. Referral times used to be around two to two and a half years, but now they are up to four years. There has been a significant drift for the pre-school age group.

Having worked in the drugs field until I came back into the Parliament in 2007, I know that the intensity of workload for people in the drug and alcohol field who work with children has increased exponentially in the past four or five years since the publication of "Getting our Priorities Right", in which I was involved as a minister. I am not sure that there is sufficient recognition of the fact that those workers are taking on a massive extra burden within their existing case load. The case-load figures might not be changing, but the attention paid to the children has increased enormously, for example through attendance at case conferences, which did not happen previously.

On early identification, I understand that 300 children in Midlothian are now identified as being in families in which there is drug addiction, and they have to be assessed, which is a massive undertaking. We are identifying the problems—we have gone beyond strategy and on to identification—but an enormous challenge for the Government is coming down the line.

Adam Ingram: I do not know whether you are aware that we are running a getting it right for every child pilot in Angus that is focused specifically on children who are affected by parental substance misuse. I hope that the learning that comes out of that will inform how we proceed. I agree absolutely that the issue is growing at an alarming rate. That is why we have to move as rapidly as possible to an approach that is about prevention and early intervention. We have to choke off the demand that is growing, which could overwhelm services. That is a critical, key initiative, on which we have to follow through.

Dr Simpson: It might be worth our asking Angus Council for some evidence on where it has got to on that.

The Convener: It depends for how long the pilot has been running.

Boyd McAdam (Scottish Government Children, Young People and Social Care Directorate): It is just starting up. There is a proposal to carry out research and build on the work that Angus has been doing already on early identification of children's needs and how agencies come together to respond. It will be a year before the evidence is available from that work.

The Convener: There seems to be a lot of stuff happening. There would be no harm in our returning in a year's time to see what has happened with the pilots and so on to see how that matches up with the concerns that we will be raising in our report. That seems reasonable.

Dr Simpson: That would be helpful.

My final question is on the older age group. Professor O'Connor's paper in *The British Journal of Psychiatry*, to which I keep returning, suggests that one in five girls in Scotland aged 15 to 16 has self-harmed in the past year, which is a frightening statistic.

We heard in evidence from counselling specialists that, in Northern Ireland, counsellors are now attached to every school. I realise that we have link mental health workers, but do they undertake counselling or have counselling skills? If not, does the Government have any intention to introduce that early counselling to pick up problems in school, such as those to do with loss, bereavement or stress, and tackle them before people get to the point of self-harming?

Shona Robison: There is the potential to do that through the increased health care capacity in schools, of which mental health is a key component. That should not only support the staff in a school, but be a way of picking up problems at an early stage. The group that Richard Simpson identifies is a key group for attention. "Towards a Mentally Flourishing Scotland", which will be launched tomorrow, refers specifically to what must be done to provide better support for infants, children and young people. We heard earlier about e-health packages, some of which are designed very much with young people and teenagers in mind. Geoff Huggins might want to add something on teenage girls.

Geoff Huggins: Following on from the publication at the end of 2006 of "Truth Hurts—Report of the National Inquiry into Self-harm among Young People", which was produced by the Mental Health Foundation and the Camelot Foundation, we will have a commitment in "Towards a Mentally Flourishing Scotland" to set up a working group to develop guidance in relation to self-harm. The issue is complex. It certainly manifests itself in questions that teachers have about what they should do if they have concerns, as well as in questions of disclosure and trust. There are also issues to do with accident and emergency units and admission to adult wards—when there is a risk of significant harm to an individual, they will be admitted to an adult ward. We have put in place training on the A and E response. A graduated approach is necessary. Issues such as school ethos and bullying must be dealt with, but an immediate response is also required, with support for those who work with young people, including the professionals. The issue is challenging, but it will be a priority under "Towards a Mentally Flourishing Scotland".

Dr Simpson: That is helpful. We know the risk factors, but the issue is how many of them we can tackle. If possible, it would be useful to have more detail on the four boards that are increasing health care capacity in schools.

Ian McKee (Lothians) (SNP): I will follow up an issue that Richard Simpson and Geoff Huggins talked about by exploring some of the obstacles for older children in getting help. It is great news that more money is going into CAMHS but, from our investigations, it seems that a lot more is needed. However, not every young person immediately links up with a CAMHS team. It is important that young people can pick up help when a problem arises. If a young person comes to see a general practitioner, their confidentiality will be respected totally, unless the general practitioner comes to the conclusion that the person cannot make the decision that they want their confidentiality respected, perhaps because they have a learning disability.

We have received evidence from schools. One headmaster defined the term "in loco parentis" as meaning that teachers must tell parents everything because they are acting for the parents. A teacher who is responsible for guidance said that she warned the school that, if young people told her certain things, she would have to pass them on to the parents. Although on many occasions it is good to involve parents and the family team in the problems of their youngster, that is not always the case. For example, self-harm is often linked to a history of sexual abuse in the family, and feelings of despair and a lack of self-worth might arise because of things going on in the family. I am concerned that school, which is a wonderful place for picking up such problems, might also be putting in place barriers, either real or imagined, that prevent children from looking for help. What is your response to that?

11:00

Shona Robison: It is a complex area. We all hope that parents will be supportive in the vast majority of cases, but I understand the point that, in some cases, they will not be. I would expect a school to pick up on potential child protection issues relating to the child's home, and I would then expect the support systems around the school to kick in.

Services that have been effective in gaining the trust of young people have a major role to play. Some of those services are in the voluntary sector and involve projects for young people. Also important are the drop-in services that have been developing in schools—where young people can seek advice on a range of issues such as smoking, alcohol or bullying. When young people have any concerns, it is important that they can speak, in confidence, to someone whom they can trust.

Schools have always had to balance the issues and decide when a situation has become so serious that the school has to take advice—from the social work department, I would imagine. If child protection issues arise, the school will take advice on whether an intervention is necessary, or it might decide that it can have confidential discussions with the child but without the

intervention of other services. Such cases have always been a challenge for schools, and the decisions are difficult.

Adam Ingram: Concerns over child protection would override concerns over confidentiality. In the first instance, we would be looking for the teacher to check whether their concerns were shared by any of the other agencies that might be involved. If we are adopting a getting it right for every child approach, that would be the way in which things would be done. The GIRFEC approach is not embedded throughout Scotland at the moment, but we would like it to be.

We need to be a bit more proactive. As Ian McKee suggests, many issues may relate to young people's lack of aspiration or lack of confidence. We should take the initiative in identifying those young people and working with them. In an initiative that was taken in the Doon academy catchment area, in the Doon valley in my part of the world, schools, health services and social work put together a team to tackle the problem of teenage pregnancy in the area. There had been a significant problem, with something like 17 young people becoming pregnant each year in the catchment area. However, by taking a proactive approach of identifying the potentially vulnerable group of youngsters and working with them—expanding their horizons, and convincing them that life had more to offer than what they might have seen from their older siblings—the teenage pregnancy rate was reduced to zero. Such issues can be tackled.

Ian McKee: I appreciate that the issue is difficult and that there are measures to try to tackle it, but we definitely heard evidence from people who work in the field that deciding when they should disclose and to whom they should disclose was a problem. There was also confusion, because not every professional would agree that being in loco parentis means that they have to tell the parents everything. Sometimes, it probably means the opposite: that they can take parental decisions because the parents are not present.

Is there not some way of sorting this out? For example, a general practitioner will not break a person's confidence unless he or she believes that there are very good reasons to do so. Could we press for the establishment of a guidance set-up in schools where those decisions could be made, perhaps with advice from a more experienced person, so that someone could take upon their shoulders the decision about whether to disclose? My concern is that, if a young person thinks that there is even a chance of making a situation worse by discussing it with someone, they will not discuss it. If they think that their parents will be told, they will simply not talk about something until they are ready for it. If their parents will have to be told even if the young person is not ready for it, they will not go for advice.

Geoff Huggins: The discussions that we had following the "Truth Hurts" report certainly showed us that teachers would like there to be clear rules on what they should do. Unfortunately, I am not sure that that would be terribly helpful. There are probably clear rules at either end of the spectrum, but it is mostly a grey area, which requires some degree of judgment. Teachers are conscious that, when things go wrong, it is generally the case that many people had small bits of information that did not get put together. One of the on-going outcomes of critical incident reviews and risk assessments is that, if information that was held by six or seven different individuals had been seen in one place, it would have given a different story from the one that any of those individuals had.

That probably means that we need to do two or three things. We need to be clear about how much of the matter is a grey area. We also need to be alive to the risks not only of confidentiality but of disclosure—you eloquently identified the reasons why young people would not share information if they were concerned about that. Beyond that, we need to have a degree of confidence in our professionals' ability to make judgments. Sometimes, their concern comes from the fact that we do not have the confidence that they will get it right, which leads them to ask us to pre-take the decisions, in effect.

Ian McKee: We must not make rules that take their professionalism away from them.

Geoff Huggins: That is right. We are looking for a balance between guidance, strong rules and weak rules to get the best results.

Boyd McAdam: One of the work themes that we are taking forward under getting it right for every child involves promoting the electronic sharing of information in a secure environment through the e-care framework. One of the concepts of getting it right for every child is that if a teacher, social worker or nursery worker has a concern, they should be able to find out whether other professionals who work with the child share similar or other concerns. If there is a clear child protection issue, there is a responsibility to ensure that action is taken. However, we need to understand that we can share information on lower-level concerns that, on their own, might not be considered child protection issues.

The Government has a work stream to build a privacy impact assessment into the development of the requirements for the electronic information-sharing system. We are working with practitioners to test out what we can do. Part of the getting it right for every child approach is always to secure consent from the young person, explain why the

information that they give might be used to help them and respect their views. We face that issue in the domestic abuse pathfinders: a child or mother may not wish the alleged perpetrator to know their school address or where they are staying. Part of our work over the next year or 18 months will be to decide how to manage that information. There are no easy answers.

Ian McKee: An example that was given to us in evidence concerned the fact that, under the Sexual Offences (Scotland) Bill, sexual activity will be a crime for a girl under the age of 16, but we know that precocious sexual activity can be a sign of mental disturbance. If a girl of 14 confides to a guidance teacher that she is having sexual intercourse and that becomes an illegal activity, will the teacher need to pass on information about the illegality? In that case, will the 14-year-old decide not to confide in the teacher because the information will be passed on? That is the sort of judgment that will need to be sorted out, but I do not know how that could be done under that set-up.

The Convener: Everyone has fallen silent.

Shona Robison: Those are very valid points. Perhaps we can come back to the committee with further information on the pathfinder project that Boyd McAdam described. We can also reflect on whether more needs to be done to ensure that things are as clear and as supportive as they can be for those on the front line who need to make such decisions. We should perhaps have a think about what more could be done.

Ross Finnie (West of Scotland) (LD): Like others, I welcome this morning's announcement by the Minister for Public Health and Sport that additional resources will be provided. Certainly, the need for that is reflected in many of the problems that the committee has heard about in evidence. On how that cash will be converted into people, how confident is the minister that health boards can relatively easily recruit additional psychiatrists and nurses with the appropriate qualifications? Will she take the opportunity to elaborate slightly on the welcome announcement that she made?

Shona Robison: The work that NHS Education for Scotland is doing on the workforce development plan will be critical in ensuring that the phasing in of that new workforce is achievable. That will ensure that boards at local level have achievable workforce plans in order to recruit the right people in the right numbers so that the money is used effectively. Such work was happening anyway for the £2 million-plus of investment by health boards, but it will now be stepped up to ensure that all the new investment money is used to maximum effect. Of course we want that phasing in to happen in a way that builds capacity. Perhaps Geoff Huggins can say something about the mechanics of that.

Geoff Huggins: For the funding that is focused on the psychology workforce, the resource that we have identified will be used both to create training places and to fund posts within boards. We are acutely conscious of the pressures that boards are under at this stage. We identified that boards would be hard pressed to create the new posts in the absence of a resource to meet the costs.

The psychiatry workforce has been growing steadily year on year over the past 10 years. We expect that a proportion of the new psychiatrists who qualify over the next five years will specialise in child and adolescent mental health services. That will probably give us an additional 50 such psychiatrists over the next five years. Over the same period, we expect that about 15 psychiatrists will retire. That will leave us with a net gain of about 35, which should increase that part of the workforce by about 50 per cent overall. Part of the strategy in making the specialism more of a priority is that it will then be more attractive to people to enter. That is intended to change behaviours both among those who create the posts and among those who are deciding on which career they want to persue within the larger profession in Scotland.

Ross Finnie: That is helpful. What are the timescales and the profile for continued workforce planning in that area?

Geoff Huggins: Over the next three to four years, we currently have funding for around 36 training places for clinical psychologists. Of those, traditionally about a third convert into child and adolescent specialists. We now plan to increase the number of training places annually by about 10. Those will be targeted on CAMHS, so that should result in about 22 specialist CAMHS people qualifying each year.

We know that on average, within three to four years, most new posts are less than full time, because the workforce is predominantly female and takes on other responsibilities. We plan for retirements and the likelihood that many people will work part time. By about 2012, we estimate that, in the system as a whole, we will have an additional 60 clinical psychologists with a focus on CAMHS and between 45 and 50 masters-grade psychologists and applied psychologists, who tend to be more directly involved in the delivery of more straightforward therapies and who tend to work in a supportive role, rather than in an assessment and clinical lead role.

11:15

Shona Robison: It is worth adding in relation to CAMHS nurses that work is being done to give

CAMHS a higher profile in pre-registration training. It is important to remember that health boards are planning in their local workforce plans how they will use investment to create new CAMHS nursing posts. Allied health professionals also come into the mix.

Ross Finnie: That response is helpful. The Minister for Children and Early Years said properly and honestly that GIRFEC has not yet been rolled out across Scotland. What is the thinking on how and when it is likely to be rolled out?

Adam Ingram: As I said to Richard Simpson, one key event will be receipt of the evaluation report from the Highland pathfinder, which will be published in September. That will be a trigger that kicks the programme on to parts of the country that it has not reached yet.

Momentum is building behind the getting it right for every child approach. A lot of interest has been shown and I hope to stimulate that through the engagement exercise with local authorities on the implementation of the early years framework, because GIRFEC is the mechanism that will deliver that. We are trying to expedite the embedding of the GIRFEC approach throughout the country. I cannot give you a definite timescale for that, but I assure you that we pursue the objective with urgency.

The Convener: I have a final question that is on a subject that we have not discussed today: the transition from services for young people to those for adults. We have heard evidence that if someone is diagnosed with a particular mental illness, such as schizophrenia, that transition is not a problem, but a submission from psychologists said that when people have something non-specific, the transition requirements should be specific to each individual, in contrast to a bleak cut-off. Is that transition covered in the document that we have all heard about and which you have had to tell us about today, although it will be published tomorrow?

Geoff Huggins: The transitional issue is not a particular focus in the document; it is being picked up more in the core group's work and our work with clinical leads. Part of the challenge that we face is that the transition between child and adolescent services and adult services falls at different stages for different problems. For example, the transition for psychosis might be placed at a different age band from that for eating disorders—one transition might be earlier and one might be later. That makes designing services less than straightforward.

We are beginning to consider the development of a care pathway for CAMHS. As with adult care pathways, we will seek to address assessment and admission to and discharge from that pathway. That is probably the best place to tie CAMHS to adult pathways.

The Convener: The evidence was about individually tailored services.

Geoff Huggins: The intention would be to reflect an individual's experience and needs better than the current system does.

The Convener: That is helpful.

As members have no more questions, I thank the witnesses for their evidence. I thank the committee, as we are on time to within five seconds.

Item 3 is consideration of our draft report on our pathways into sport inquiry. As agreed at our meeting on 14 January, the item will be taken in private.

11:20

Meeting suspended until 11:25 and thereafter continued in private until 12:55.

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