# JUSTICE 2 COMMITTEE

Tuesday 16 November 2004

Session 2

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## JUSTICE 2 COMMITTEE
**† 32nd Meeting 2004, Session 2**

**CONVENER**

*Miss Annabel Goldie (West of Scotland) (Con)

**DEPUTY CONVENER**

*Bill Butler (Glasgow Anniesland) (Lab)

**COMMITTEE MEMBERS**

*Jackie Baillie (Dumbarton) (Lab)
*Colin Fox (Lothians) (SSP)
*Maureen Macmillan (Highlands and Islands) (Lab)
*Mr Stewart Maxwell (West of Scotland) (SNP)
*Mike Pringle (Edinburgh South) (LD)

**COMMITTEE SUBSTITUTES**

Ms Rosemary Byrne (South of Scotland) (SSP)
Cathie Craigie (Cumbernauld and Kilsyth) (Lab)
Kenny MacAskill (Lothians) (SNP)
Margaret Mitchell (Central Scotland) (Con)
Margaret Smith (Edinburgh West) (LD)

*attended

**THE FOLLOWING ALSO ATTENDED:**

Fergus McNeill (Adviser)

**THE FOLLOWING GAVE EVIDENCE:**

Nicola Hornsby (Fife Council)
Dr John Marshall (Greater Glasgow NHS Board)
Shabnum Mustapha (National Autistic Society Scotland)

**CLERK TO THE COMMITTEE**

Gillian Baxendine
Tracey Hawe

**SENIOR ASSISTANT CLERK**

Anne Peat

**ASSISTANT CLERK**

Richard Hough

**LOCATION**

Committee Room 4

**† 31st Meeting 2004, Session 2—joint meeting with Justice 1 Committee.**

# Scottish Parliament

## Justice 2 Committee

*Tuesday 16 November 2004*

[THE CONVENER *opened the meeting at 14:02*]

## Youth Justice

**The Convener (Miss Annabel Goldie):** Good afternoon everybody, and welcome to the 32nd meeting this year of the Justice 2 Committee. No apologies have been received so far, although I know that Colin Fox will be a little late in joining us. As far as I know, Stewart Maxwell intends to be with us, so I think that he will appear in the course of the meeting.

Item 1 is our youth justice inquiry. It is with much pleasure that I welcome Dr John Marshall, who is a consultant forensic clinical psychologist and the lead clinician in the forensic child and adolescent mental health service of Greater Glasgow NHS Board, and Dr Nicola Hornsby, who is a chartered clinical psychologist from the Fife youth justice team. We are pleased to have you with us this afternoon, and we thank you for making yourselves available.

Committee members have a range of questions that they want to put to one or other of you. In some cases, it may be a case of your deciding between you who will respond, so feel free to discuss with each other who will answer a question.

To get matters going and to set your evidence in context, could you both give a brief account of your background and experience in psychology in general, and in youth justice in particular? A brief résumé would be helpful to us. Ladies first, Dr Hornsby.

**Nicola Hornsby (Fife Council):** I have an undergraduate degree in psychology and a three-year postgraduate degree in clinical psychology. I should say at this point that I am not a doctor.

**The Convener:** Right.

**Nicola Hornsby:** I have eight years post-qualification experience as a clinical psychologist. Since qualifying as a clinical psychologist, I have worked in adult mental health and in learning disability. Latterly, I specialised in working with adults with learning disabilities who are at risk of coming into contact with the criminal justice system. I was involved in multi-agency service redesign for that group. I have been in post in the Fife youth justice strategy team since February 2001, and I assisted the team leader in recruiting other team members and setting up the service. I also have links to Fife child and adolescent clinical psychology department.

**The Convener:** That sounds very full indeed. We look forward to hearing more from you.

**Dr John Marshall (Greater Glasgow NHS Board):** I am a doctor of clinical psychology. I also trained in my work as a forensic psychologist, which is a different profession from clinical psychology, in that it emphasises offending behaviour. I have worked with children and adolescents who have mental health problems in a range of services in the community, such as community mental health teams and forensic community services. I have worked in the Scottish Prison Service in Barlinnie prison and in young offenders units. I have worked in secure accommodation and with looked-after and accommodated children. I currently head our forensic child and adolescent mental health service, which is unique in Scotland, and I am doing research on the subject. We will soon be among the first researchers to publish a study on predicting offending behaviour in a group of adolescents in Scotland.

**The Convener:** That is extremely helpful. On the general front, I am interested in the service in the Greater Glasgow NHS Board area that you describe as "unique". I ask both of you whether there is any opportunity for liaison with adjoining health board areas, or do you tend to work within your own health boards' remits?

**Dr Marshall:** I tend to work within the Greater Glasgow NHS Board area, although since the service started only a year and a half ago it has had an impact on focusing minds in other areas on the needs of young people who offend.

**The Convener:** Is it the same for you, Nicola?

**Nicola Hornsby:** Yes. We have focused mainly on establishing services in Fife over the past couple of years.

**Maureen Macmillan (Highlands and Islands) (Lab):** In its investigation into youth justice, the committee has been exploring the extent and effectiveness of multi-agency planning and multiprofession working across the field. What is the organisational context of your current practice? In particular, how do the different youth justice professionals work with you to address the needs of young people who offend and who have mental health problems and perhaps learning disabilities?

**Dr Marshall:** That is a big question.

**Maureen Macmillan:** I appreciate that.

**Dr Marshall:** There is a national policy framework. Of particular interest to us is the child

and adolescent mental health services framework, under the auspices of the child health support group, which is looking at implementation of the Scottish needs assessment programme and making services much more accessible to young people. That policy framework will have a big impact on how we deliver services to young offenders, because we are not accessible enough to that group. That is an important national context.

There is a multi-agency Glasgow youth justice forum steering group, with representation from the police, the children's hearings system, social work, the national health service and our service. Good examples of joined-up working have come from that steering group, for example getting people together from all relevant agencies in particular areas of Glasgow and considering persistent young offenders, flagging up who is and who is not a persistent offender, and drawing up action plans based on getting the relevant agencies together in one room. We have set up a steering group for treatment programmes, which is examining delivery of youth justice and NHS combined treatment programmes. The steering group is multidisciplinary and multi-agency and oversees the quality and implementation of youth justice treatment programmes. Those are two examples of useful activities that have come out of the Glasgow youth justice forum steering group.

**Maureen Macmillan:** What barriers have you found and has it been easy to overcome them?

**Dr Marshall:** Great challenges exist for joint working between mental health services in the NHS and social work services at various levels. There is a lack of understanding of roles and different language is used, but at the end of the day we are all working towards a common goal, which should make the work easier. Much of the time, the matter comes down to individuals' leadership qualities and whether people push the pace on a joint strategic agenda.

**Nicola Hornsby:** The population of Fife is much smaller than that of Glasgow and my post is fully integrated within Fife Council's youth justice service, which means that I have from the start worked alongside social work colleagues in considering how to address the risks of young people reoffending. The remit of our service is to provide structured risk assessments and to plan interventions for young people between 12 and 17 who are at moderate to high risk of reoffending. The team accepts referrals of young people who have had three or more offending episodes in the previous 12 months or who have committed an offence that has been referred to the procurator fiscal because of its severity.

I am involved at the assessment, planning and intervention stages and I work alongside social work colleagues in carrying out those processes. At the assessment stage, a social worker typically undertakes a risk assessment of the young person, based on risk and need factors. The social worker would ask me for an assessment if particular concerns were highlighted during that process. For example, a psychological assessment may be requested if the young person receives special education, if issues regarding the young person's level of understanding have been picked up, or if there are issues with the young person's reading or writing abilities. Similarly, if evidence exists of previous child and adolescent mental health services' involvement, or if there are existing diagnoses—such as conduct disorder, attention deficit hyperactivity disorder or autism spectrum disorder—the social worker will involve me. I may also be asked to carry out an assessment if there are concerns about particularly high levels of violence or issues that relate to more traditional mental health problems such as self-harm.

With social work staff, I have been involved in setting up and planning many of the interventions that we deliver for young people. Some of that work has been to develop community-based group work programmes for adolescents, but in the past 18 months, we have spent a lot of time developing family-based interventions that concentrate on family-based risk factors for reoffending. All the interventions are delivered on a multidisciplinary basis.

**Maureen Macmillan:** That gives us a full picture of exactly what happens.

**The Convener:** Dr Marshall, how is your group constituted? What gave rise to it and what are the component parts? Does it operate on an ad hoc basis, or are you accountable to the local authority or health board?

**Dr Marshall:** We are part of Greater Glasgow NHS Board's primary care division. We were set up through the child health investment fund, as well as with moneys from youth justice services. We are operationally managed by the NHS, but we have a multi-agency steering group that oversees our activities. We have a range of professionals in the team, including psychiatric nurses, and we provide psychiatry sessions, clinical and forensic psychology services and social work services. We provide input to youth justice services and secure accommodation units; in fact, we provide input for children and adolescents who are at high risk, no matter where they are.

14:15

**The Convener:** That is helpful.

**Mike Pringle (Edinburgh South) (LD):** From the written evidence that we have had, it seems that the work that you are engaged in on youth justice is quite unusual in Scotland. What can you tell us about how mental health and learning disabilities services are accessed by youth justice workers in other areas?

**Nicola Hornsby:** I have spoken to youth justice workers outwith Fife, so I know that they have great difficulty in accessing those services. That was also the case in Fife until my post was created, which was one of the reasons why the social work department has funded it.

There are several reasons for the situation in other council areas. Many of the young people with whom youth justice workers deal have multiple and complex difficulties within their families, homes, schools and communities. Research has shown that they are frequently less responsive to most types of treatment that are available from mental health services in the national health service. Child and adolescent mental health services are not really oriented towards the kind of intensive interventions that those young people need. Furthermore, priorities in the NHS are different to those in youth justice. Things such as waiting list targets are not conducive to delivery of the necessary interventions, which involve intensive input to a relatively small number of people and have much less hopeful outcomes than interventions that relate to other less serious problems. I do not think that that is a reason not to deliver those services, but it demonstrates that various services have differing priorities.

Another issue relates to the fact that many available services are not oriented to the practical needs of the young people, many of whom come from disadvantaged backgrounds and have difficulty attending clinic-based appointments and so on. The practicalities of getting to a certain place at a certain time when there are many stresses in the family are not always taken into account when people think of the accessibility of child and adolescent mental health services through the NHS.

**Dr Marshall:** There is a similar situation in Glasgow. We are giving evidence on a unique service today. The forensic CAMH service with which I am involved is dedicated to high-risk persistent offending. At the same time, however, we have to remember that the vast majority of children and adolescents are not high-risk or persistent offenders. The comments about accessing tier 3 or generic CAMH services should apply to minor and lower-risk offending. There is a difficulty for young people in accessing those services.

The issue is not simply about resources. In Glasgow, we are involved in an organisational process that attempts to pull together tier 3 generic CAMH services and the specialist teams such as the learning disabilities team and the forensic CAMH service. The process involves examining case studies to determine how individual cases are being handled in order to increase the linkages between the services within the NHS to ensure that there is much more joint working between specialist and generic teams.

Another issue is that the model that mental health services apply is a very psycho-pathological or diagnostic model. As Nicola Hornsby said, the young people with whom we are concerned have complex emotional needs that might not even reach diagnostic criteria. Nevertheless, they present with considerable emotional problems that require intervention. The necessary intervention might not be traditional mental health treatment; it might involve leisure and recreation services, substance-abuse intervention or vocational training. Interventions of that kind also impact on mental health and offending behaviour.

**The Convener:** Does that mean that a unit such as yours offers a degree of flexibility in identifying a wide range of individuals and making appropriate referrals?

**Dr Marshall:** Our service is geared around very high risk. We focus on and target small numbers of children and adolescents who are responsible for a disproportionate amount of offending, whether or not they have a diagnosable mental disorder. That is the key. We operate on a risk-and-needs principle, rather than a diagnostic principle.

**The Convener:** Is the experience in Fife similar? Do you find that you are the receiving point for young people with a problem, although it may not be a diagnostic problem, as Dr Marshall has said? Do you gather up such individuals and seek to determine what is appropriate?

**Nicola Hornsby:** I explained the team's referral criteria, which also apply to me. I become involved only with young people who have, using a variety of risk factors, been identified as being at moderate to high risk of reoffending. I agree absolutely that those young people usually present with a range of emotional–behavioural, relationship and developmental difficulties, rather than with specific diagnosable mental illnesses. Such illnesses are not the focus of my work.

**Mike Pringle:** You mentioned resources. Clearly, Greater Glasgow and Fife have decided to invest resources in the areas in which Dr Marshall and Nicola Hornsby work. Is it just about resources, or is it also about the ability to run the services? Clearly, the people with whom you are

dealing are not unique to Glasgow and Fife—they are to be found almost everywhere. Why have agencies in other areas of Scotland—for example, Lothian NHS Board—not taken up the idea?

**Dr Marshall:** I cannot comment on areas outwith greater Glasgow. Obviously, there are resource issues, but evidence-based practice is also important. We need to find ways to use existing resources and to train front-line staff, such as staff in residential care, to deliver treatment interventions in higher-risk cases. We need to help CAMHS professionals to become more aware of the early-warning signs that people show prior to their becoming persistent offenders. There are things that can be done with existing resources and services that would help considerably in reducing mental health problems and offending.

**Nicola Hornsby:** I agree. Increasingly, thought is being given in the NHS to developing more sophisticated services to meet the needs of children and young people. That means working out more specifically what types of interventions work for which families, at what stage and for which kinds of problems. Within that context, there is scope for redesigning services so that they can better meet the needs of young people.

**Bill Butler (Glasgow Anniesland) (Lab):** Dr Hornsby said that many of the people with whom you deal have multiple complex difficulties and that there is a need for intensive interventions. Should organisational arrangements be flexible, multi-agency and lateral in order best to facilitate meeting the needs of young people with such difficulties? Is there one model that fits, or is there a series of different models?

**Nicola Hornsby:** There is potential for a range of models. I strongly believe that a variety of professionals are required to develop expertise in the subject and to work together to achieve the same goals and outcomes for the young people, rather than try to fit them into the generic services that exist in the various disciplines.

**Bill Butler:** What is Dr Marshall's view?

**Dr Marshall:** Core models that are evidence based exist. For example, youth justice services provide cognitive behavioural treatment programmes for offending behaviour problems. People from CAMH services might be seconded or attached to youth justice services to allow increased flexible thinking and working. That may involve being extremely assertive in engaging chaotic young people who do not want to attend mental health services, and changing the language that is used so that it is much more young-person friendly.

**Bill Butler:** You both talked about the complexity of the young people's difficulties. What are the range and types of mental health problems and learning disabilities that you encounter in your youth justice work?

**Dr Marshall:** Not many research studies cover the prevalence of mental health problems in Scotland, but large-scale studies have been conducted of adolescents and young people—15 and 16-year-olds—who have been remanded to prisons in England. Those studies recorded anxiety problems and post-traumatic stress and substance abuse problems was common. In one study, 2 per cent of the sample had a mild learning disability.

Our study examined children and adolescents who were looked after, accommodated or in secure accommodation and who offended. About 7 per cent of the boys and 14 per cent of the girls were depressed, but many other problems such as impulsive thinking, substance abuse and complicated emotional difficulties that are perhaps non-diagnostic were apparent.

In my practice, I encounter a range of cases. The rare cases are children and adolescents who are mentally ill in the traditional sense—they are psychotic, delusional or have hallucinations and may have been admitted to in-patient wards at Gartnavel or Yorkhill hospital in Glasgow. We respond flexibly to that group when they may have been involved in much violence. Much tier 3 generic service input is given, as well as input from our team, to help with offending behaviour.

More often, I encounter young males between the ages of 12 and 16—our average age of contact is about 14—who have complicated emotional problems, anger-management problems, impulsivity problems or substance-abuse problems and who may have highly antisocial beliefs and attitudes, which are targets for treatment interventions to reduce offending. It is important that the committee knows that mental health factors do not predict offending behaviour and that traditional mental health treatments do not necessarily reduce offending behaviour. However, that is not to say that they are not important. They are important, because they help young people to maintain themselves on the treatment programmes that are effective in respect of offending behaviour. Mental health treatment is almost a way to support treatments for offending behaviour problems.

**Bill Butler:** Would Dr Hornsby like to add anything?

**Nicola Hornsby:** I agree that key aspects are understanding young people's difficulties and vulnerabilities in themselves and in their wider social and familial networks, and understanding how those factors interact with traditional evidence-based risk factors for offending.

I agree with Dr Marshall on mental health issues. Since our team was created, a large number of young people who have been referred to the service have had specific learning disabilities that had not been picked up but were having an impact. Those learning disabilities are verbal and intellectual. There is a significant difference between their non-verbal abilities and—

**Bill Butler:** I am sorry to interrupt, but what percentage of young people are affected in those ways?

14:30

**Nicola Hornsby:** I am aware of one study that showed that up to 25 per cent of young people with serious conduct difficulties also had those other difficulties. That certainly comes across among the young people who are referred to us—which, if they are going into the criminal justice system, has implications for their understanding of procedures, police interviews and so on.

**The Convener:** You have indicated that you are not a doctor but, to help the committee, how would you like to be addressed.

**Nicola Hornsby:** Ms Hornsby would be fine.

**The Convener:** I thought that my colleague was struggling a little.

**Bill Butler:** You are always one for etiquette, convener.

**Nicola Hornsby:** Call me "Dr" if you like!

**Jackie Baillie (Dumbarton) (Lab):** I want to pursue some of Dr Marshall's points. It is welcome that a needs-based approach is being taken and that people do not rely on a diagnosis. However, I would like some insight into the balance of emphasis in your work. How many of the young people whom you see have a diagnosed mental illness or learning disability? How many fall into the category that you might describe as "other problems"?

**Dr Marshall:** That depends on what you describe as a diagnosis. Traditionally, "conduct disorder" is a diagnosis, but it involves a cluster of antisocial behaviours. Carrying a knife is described as a symptom of a conduct disorder, but that is nonsensical. How can it be a symptom of an intrinsic mental disorder? There are also contextual factors and attitudinal factors. If we set those arguments aside, all our young people would probably meet the criteria for severe conduct disorder. The majority present with behaviours and problems that are consistent with mental disorders.

**Jackie Baillie:** I want to pursue another of your comments. The research that you are about to publish sounds fascinating; I am sure that the committee will want to have a copy, because I think that it will be instructive. If I picked you up correctly, you said that mental health problems are not a predictor of offending behaviour.

**Dr Marshall:** That is right.

**Jackie Baillie:** If that is the case, what are the main factors that show a high risk of future offending behaviour? Are you allowed to share that with us?

**Dr Marshall:** Absolutely. If we consider the issue from an offending angle and try to pick up people with mental health problems and make predictions, we will not find that mental health factors are predictive. Even if we consider people who have been diagnosed with a mental disorder, we still will not find mental disorder as a good predictor of offending behaviour.

Instead, we are looking at people's previous antisocial behaviour; at family problems, such as a father or older brother who is very pro-criminal in his beliefs and attitudes; at educational attainment problems and truancy from school; at association with delinquent gangs or antisocial groups; at substance abuse problems; at leisure and recreational difficulties; and at anger management problems or impulsivity problems. There is also the big factor of antisocial beliefs—when people believe that offending behaviour is a good choice to make or that being violent works. Some people have beliefs that support their violent behaviour.

Those issues cut across mentally disordered and non-mentally disordered offenders. Even when we consider massive studies, such as the McArthur study, which are based on people who have been diagnosed with schizophrenia and depression, we still find that those factors that I have mentioned—which are known as criminogenic needs, because they are directly related to offending behaviour—are predictive of offending behaviour in groups of people who are diagnosed with mental disorders. That should come as no surprise, because many people who have mental disorders do not commit crime.

**Jackie Baillie:** I want to pursue the idea that the main predictor is antisocial beliefs. Where does that come from? What is it rooted in? How do we understand that idea?

**Dr Marshall:** I do not think that we understand the development of antisocial thinking very well. That is an important area of new research, particularly into how we can provide treatment interventions to interrupt those kinds of pathways and to reduce and change antisocial thinking. However, we know that such thinking is difficult to change.

**The Convener:** I am interested in early intervention and would like to find out at what

stage you become aware that someone in the client group ought to be referred to you. I realise that our witnesses might answer from different perspectives. Dr Marshall, do you feel that you have an opportunity to get involved early enough or could that be improved?

**Dr Marshall:** We have other services in Glasgow that are specifically involved in much earlier intervention. A new service is being set up through West Dunbartonshire Council to look at children between the ages of 10 and 12 who are potentially at risk of developing future offending behaviour. We also have a looked-after and accommodated team that supports the looked-after system. Members of the team train staff and provide universal assessments of emotional health for children and young people in the system. There are other good examples in Glasgow of early intervention services, perhaps not specifically related to offending, but nevertheless concerned with the early risk factors associated with offending behaviour.

Our service tends to be caught up with the existing group of persistent and serious offenders. We have to be realistic and focus on small numbers of people. A good example of that comes from the multi-agency forum that I referred to earlier. We were trying to target the most persistent offenders in the north-east of Glasgow and we found that two young people were responsible for up to 13 per cent of offending in that area. We also found out that they had previously been referred to CAMH services, had not attended and were discharged. That was a great forum for getting together and saying, "Let's make another referral here; let's try to support them and get them back into the services. Let's increase the level of mentoring and supervision levels. Let's look at leisure and recreation." We were considering mental health interventions as well as the other interventions. We have to laser in on the small group of persistent high-risk offenders.

**The Convener:** At that point, diversion might be one of the approaches.

**Dr Marshall:** Absolutely.

**The Convener:** Ms Hornsby, is your experience similar, albeit that you are dealing with a slightly different client group?

**Nicola Hornsby:** Not necessarily. One of the predictive factors for on-going offending into adulthood is that the earlier the antisocial behaviour starts, the higher the risk of its continuing.

We have a clear remit to work with young people of a certain age group who have a moderate to high risk of reoffending and who have committed three offences in the previous 12 months. However, there have been attempts to refer to us young people for whom there are major difficulties at home and school and for whom it is clear that difficulties are starting in the community, but who do not yet fit our referral criteria. That is a source of frustration.

It seems to us that there is a gap in services in the provision of the kind of intensive support that such families need. The CAHM services that we spoke about were not able to meet the needs of those children, despite the fact that they provide a high-tariff service. Over the past 18 months, we have tried to develop the family interventions that we can offer. We have also had some additional funding, which should come on stream in February next year. That funding will allow us to offer such services to young people who might be displaying antisocial behaviour in the community but who have not reached the tariff that the youth justice team offers. The situation in Fife is slightly different from that in Glasgow.

**Maureen Macmillan:** Dr Marshall, you talked about mental health treatments supporting other treatments, interventions or services, but quite a lot of the evidence that has been sent to the committee suggests that those other treatments, services or interventions are not always available, that they are underfunded or that they are not quite developed yet. The Association of Directors of Social Work gave us a long list of what it thought should be available but perhaps is not. In the health service, for example, there is a lack of in-patient facilities for young people with mental health problems, a lack of services to support emotional well-being, a lack of dual diagnosis in cases of substance misuse and mental health problems and a lack of health and housing support for youngsters with mental health problems who are perhaps trying to achieve some independence from their families. What priority would you give those interventions?

**Dr Marshall:** You mentioned in-patient care. I presume that you are referring to children and adolescents who are diagnosed with a mental illness under mental health legislation and are perhaps detained.

**Maureen Macmillan:** I am aware that there are some young people who, because of substance misuse, are now in psychiatric care and that there are perhaps too few facilities for that.

**Dr Marshall:** I must emphasise that I am dealing with a very unusual group in that there is a tiny number of people with severe mental illness who are also high-risk offenders.

**The Convener:** Earlier, you mentioned Gartnavel and Yorkhill. Did you mean Gartnavel royal hospital?

**Dr Marshall:** Yes. There is a west of Scotland adolescent in-patient unit there; most of the young people in the unit are placed there due to mental illnesses such as anorexia, bulimia and schizophrenia. They are very vulnerable children. The unit tends not to cater for or plan for adolescents who are violent, who are serious offenders, who are at very high risk or who perhaps need an element of security.

I emphasise that we are talking about a tiny number of adolescents who may need psychiatric in-patient secure care—it is important to get that across. In the past year in Glasgow, only one patient, I think, has been referred to the English in-patient psychiatric secure NHS service. We have managed to provide a lot of intervention and community support in other cases in which patients may have gone down that route. It is important to emphasise that there are no in-patient facilities in Scotland that would cater for very high risk mentally ill offenders. The forensic network children and adolescents sub-group will be considering the needs of that tiny group in respect of interventions and responses.

**The Convener:** Ms Hornsby, do you have a different perspective from Fife, where you are dealing with a more general and broader client group?

**Nicola Hornsby:** On the need for in-patient facilities?

**The Convener:** We do not want to get too sidetracked by in-patient facilities.

**Maureen Macmillan:** The lack of in-patient facilities was one of the matters flagged up by social workers.

**Nicola Hornsby:** I am sorry, are you asking about the priorities?

**Maureen Macmillan:** In its evidence to us, the ADSW said that it was concerned about a lack of in-patient facilities, among other things—I listed various services and treatments that would go alongside specific support, such as housing and help with substance misuse. Youngsters with learning difficulties or mental health problems need other support as well and the ADSW felt that such support was perhaps not available and needed to be developed. I wonder how crucial you think such support is and what your priorities would be.

14:45

**Nicola Hornsby:** I agree with the main factors that you listed. However, without getting sidetracked on to the in-patient issue, I should explain that in Fife we have not required an in-patient facility since our team came into existence. Such a facility would apply to only a small group of young people.

On other priorities, there has been a lack of attention to developing meaningful, structured, family-based interventions for young people. Various aspects of family functioning are key risk factors for whether young people offend. If some kind of bond is maintained between young people and their parents, that is a major protective factor. There has been insufficient work on developing innovative interventions that would bring together health and social care services to develop family-based interventions that would be responsive to young people's needs. That must be given much more attention throughout Scotland.

A further concern about priorities is how education links with youth justice services. Like health, education has priorities, goals and targets that are not always consistent with those in youth justice. However, maintaining young people in education is a key protective factor against long-term offending and it is also key to building more positive outcomes for young people. I suggest that, in addition to the involvement of more specialist health care professionals in youth justice, it would be of value for education to have a more direct involvement with the youth justice service and to share goals with it. For example, there could be secondments from education.

**Maureen Macmillan:** You said earlier that is was possible in an education situation to pick up potential problems well before they were evident in the community.

**Nicola Hornsby:** Yes, that is right.

**Maureen Macmillan:** I found that interesting.

**The Convener:** I want to clarify something and either of the witnesses may want to answer my question. I realise that, by its very nature, risk assessment can never be a precise science, but it seems to me that it is important for early intervention. Can you give us a little guidance about how well developed risk assessment is? For example, is there a danger that a risk assessment simply involves judging whether youngsters are likely to do something again and that such a judgment determines whether they are brought into the justice system? Am I being naive about that?

**Dr Marshall:** No. The research on risk assessment is far in advance of what happens on the ground. There are new, structured risk assessment systems for early identification of risk. For example, the early assessment risk list for boys—the EARL-B—is designed for boys from 8 to 12 and involves the early identification of high-risk pathways to criminal behaviour. There are also systems such as the youth level of service case management inventory—the YLS.

The list that I gave the committee earlier of crimonogenic needs that are associated with offending has been shown to be substantially better than chance but far worse than perfection in predicting offending behaviour. The crimonogenic needs are described as fair predictors of offending behaviour. However, the point of risk classification is not to predict but to identify needs and the level of service response. We have a long way to go on that and on how we deal with the implications of an assessment. It is easy to do an assessment, but the issue is what that translates into in terms of action plans.

**The Convener:** That is helpful. Does Ms Hornsby want to add anything?

**Nicola Hornsby:** No. I think that I will leave that issue to John Marshall.

**Jackie Baillie:** I want to pick up on a couple of points that my colleague Maureen Macmillan was pursuing. I address myself to Nicola Hornsby specifically. People have suggested that there is a need for non-specialist youth justice workers, whether they are in education or are primary care health workers, to be better trained in identifying and responding to mental health problems and learning difficulties. I take it from their nods that both witnesses agree with that. What kind of training should be put in place?

**Nicola Hornsby:** I think that my colleagues in the youth justice team would agree that it is important that there is a variety of training. The witness from the National Autistic Society Scotland will talk to you about autistic spectrum disorders. A small but significant number of young people who are referred to our service have a diagnosis of Asperger's syndrome. It is important that workers on the ground understand those people's needs and how their particular difficulties or array of problems impact on their offending behaviour and their understanding of the situation when they come into contact with different agencies.

Many of the interventions, such as the family interventions that we talked about, need to be of a high quality if they are to be effective. Practitioners must be well trained and have on-going supervision and easy access to support if they are to maintain high-quality services. I emphasise those key issues. People also need a basic understanding of the nature of learning disabilities and the various ways in which such disabilities present.

**Jackie Baillie:** How much of that training is going on? Is there still a long way to go?

**Nicola Hornsby:** I hope that I provide that service in Fife. I cannot comment on areas outwith Fife.

**Jackie Baillie:** Dr Marshall's expression is inviting me to ask him the same question.

**Dr Marshall:** I will have to be careful not to get into trouble with my colleagues.

The situation is gradually improving. For example, generic child and adolescent services are becoming more aware of the early risk factors that are associated with future offending behaviour. However, there is a long way to go. We could go right back and consider the pathways in very early childhood that can lead to offending behaviour and we could systematically identify much younger children who are at greater risk.

That is not to label or stigmatise such children in any way, but to ensure that the right kinds of services are in place for them. There is concern that risk assessment is about classifying people in a negative way, but it should not be about that. We could provide much better and more targeted parenting and family interventions in relation to a much younger age group. For children in early adolescence, we could consider much more individual-focused interventions about the development of antisocial beliefs that support offending behaviour, regardless of whether the child has mental health problems.

**Jackie Baillie:** I understand that a number of local authorities and local strategy groups are busily trying to recruit mental health professionals to work in youth justice teams. Is that a sensible approach? Is there the capacity of trained staff to make the approach a success?

**Nicola Hornsby:** There is increasingly the capacity, so such recruitment should be successful. I am employed to do that job, which I think plays an important role. However, mental health professionals would benefit from additional training and expertise in the area, because not many people have that expertise—we need to build it up.

**Dr Marshall:** I am not sure that the answer is simply to use more mental health professionals—that would be overly simplistic. The existing generic mental health services need to be much more flexible in relation to the lower-risk, minor offending that makes up the bulk of the problem and concerns communities. We must also emphasise much earlier, evidence-based identification of risk and evidence-based interventions that are associated with reduced offending. Sometimes such interventions might not be mental health interventions.

There are problems with the mental health model, which emphasises confidentiality and focuses on the individual rather than on systems or communities. Often a pathology model is used and there can be an obsession with diagnosis among some clinicians. In my experience, young

people have real difficulty with the language that is used in mental health services. The services need to be more flexible, but they also need to change substantially.

**Jackie Baillie:** Do I detect in what you have said a desire to shift funding away from treating the problem after it occurs to trying to prevent high-risk offending behaviour? As I understand it, that is not the way in which your system is currently set up. Is that too simplistic a summary?

**Dr Marshall:** The system is improving, but it is not currently set up to prevent high-risk offending behaviour.

**Nicola Hornsby:** The earlier the intervention starts, the easier we can effect change and, possibly, the more cost effective the intervention is. There will always be a need for interventions at various stages in young people's development, but the kind of interventions that John Marshall offers—and that I offer a step before him—ought to be one end of a care pathway for young people who, as they develop, are vulnerable to developing the range of problems that we have been discussing. We can now quite accurately identify those young people at a very early age.

**Jackie Baillie:** So it might be more sensible to invest in the next generation.

**Nicola Hornsby:** Yes, especially given the intergenerational nature of the problems.

**Mr Stewart Maxwell (West of Scotland) (SNP):** I enjoyed your diplomatic answer earlier, Dr Marshall. In response to one of Jackie Baillie's questions, you referred to the problem of labelling. I am sure that you understand the reluctance of many parents—particularly those with younger children—to be sucked into the system when they are extremely concerned about their children being labelled in a certain way at an early age and do not agree with some of the suggestions that have been made about their children. How do you try to help those families and children without doing exactly what they fear—labelling them and sucking them into a system that seems never to want to let them go?

**Dr Marshall:** In fairness, I should add that the NHS, particularly in Glasgow where I work and where my experience is based, is taking a good look at itself and its services—a series of organisational development processes are under way to consider how we deliver services. We cannot necessarily go on offering clinic appointments to people who are highly chaotic and might never turn up. That is a simple example of the need to think much more assertively and to consider needs and risks rather than labelling people. However, we must also remember that some families welcome a diagnostic label. For example, some families have told me that it has been helpful to have a diagnosis of Asperger's syndrome, because that opens up new services and options for them.

**Mr Maxwell:** I accept that, but some parents are obviously concerned about labelling.

**Dr Marshall:** We need to configure services so that they are much more child and family friendly. I tend to work more with 12 to 16-year-olds who are extremely chaotic, do not want to see me and do not think that they have a problem. If that is the baseline, we start to work out strategies and ways of motivating them, such as using text messaging to remind them of appointments and using befrienders with whom we meet the young people so that we get to see them where they are rather than expecting them to turn up to some sort of mental health clinic. We are taking a good look at ourselves and thinking about how we can be much more child friendly. The SNAP report also has a big impetus in that direction.

**Mr Maxwell:** From the evidence that you have given this afternoon and the written evidence that we have received from other organisations, it is clear that mental health clinicians and mental health services in general can make an important contribution to youth justice and to the development of best practice, which you have mentioned a number of times. Will you summarise what you think are the most important and most distinctive contributions that mental health services and, in particular, mental health clinicians—given that we are talking about a one-to-one area—can make to youth justice?

15:00

**Dr Marshall:** It is useful to think of examples of young people's cases. The support that we give to many young people who go through evidence-based treatment programmes for offending behaviour—which look very different from mental health interventions—is critical. We assess and support their mental health needs. For example, a young person who was on an offending behaviour programme became very depressed as a result of his disgust with what he had done in the past. He was prone to low moods and became very depressed. It is important that the mental health services come in at such a stage, to support the youth justice services' good intervention. The mental health services need to understand the evidence on offending, to take into account risk and need, and to know when to intervene. The timing of intervention relates to a subtle sequence of events.

**Nicola Hornsby:** That is definitely true. Clinical psychologists, for example, have a distinct range of specialist skills that can be adapted and applied to the young people in the group that we are

talking about, to reduce the risk of their reoffending and to produce better outcomes for them. Although the evidence shows that such input is best provided in a multidisciplinary context, we have a distinct set of assessment skills and an understanding of how to deliver interventions that could be modified to apply to that group. As I have said before, that should be part of the care pathway, with the various gaps being filled in.

**Mr Maxwell:** I agree with you. I think that the multidisciplinary aspect underpins the whole process.

**The Convener:** I am keeping an eye on time.

**Mr Maxwell:** I have one final point. I want to pin down the most important contribution that mental health services provide. Dr Marshall spoke about providing support and intervening at the right point and it is true that a multidisciplinary approach is important. Is the key issue the fact that, when young people are receiving other services and are being helped with their offending behaviour, depression and self-disgust or self-loathing may kick in at the point at which they begin to confront their offending behaviour? That is when mental health services have a distinctive role to play in supporting the young people concerned and allowing them to carry on.

**Dr Marshall:** Yes, because young people will respond individually. Some might be so depressed that they find it difficult to get on to an offending behaviour programme, whereas others might become depressed halfway through such a programme. The key is to take an evidence-based approach to offending behaviour. If we get things wrong and we intervene solely in cases involving traditional mental health problems, by reducing people's anxiety, improving their moods and treating their depression, we will risk increasing offending behaviour, because we will not change people's impulsiveness or their antisocial attitudes, for example. We need to have a flexible and sophisticated response that comprises assessment, formulation and treatment. That involves having a flexible link between mental health and youth justice services.

**Nicola Hornsby:** Mental health professionals can do much more than tackle specific issues such as depression. That is apparent in the treatment of offending behaviour. We are becoming more aware of the investments that young people have in their families and their wider communities; their relationships with people are very important. Much of the work that we have been developing on that front has involved building on and improving reciprocal relationships, particularly within families. We are well equipped to do that and to train other people to do that. A relevant example is that when we started doing multiple-family group work treatment in Fife, for which five families attend together, we suddenly did not have a problem with getting young people to attend because their parents had to come with them. I emphasise that there is a broad range of interesting examples.

**Dr Marshall:** I second that. Organisations at the front line—such as the Includem project and organisations with a high frequency of contact—and people such as befrienders, mentors and those in residential units could receive training in specific assessments and interventions that would have a huge impact on young people's lives.

**The Convener:** I have a final gathering-up question, although I am not sure whether you will be able to answer it. Do you have an opinion on whether the services that we have been discussing this afternoon in Scotland are well developed and well resourced compared to similar services in England and Wales?

**Nicola Hornsby:** The youth offending teams in England and Wales receive a lot of support from the Trust for the Study of Adolescence and I am not sure whether the youth justice teams in Scotland receive support from a similar academic body.

**Dr Marshall:** I have worked in the northern forensic mental health service, which is based in Newcastle and which provides services that do not exist in Scotland, such as in-patient psychiatric secure units for adolescents with mental illness who require security. However, the youth offending teams in England face similar problems to those that we face. Their linkages with CAMHS are patchy and although good examples exist of strong links where CAMHS are seconded into youth offending teams, there are also poor examples.

Another example is the intensive support and electronic monitoring—or tagging—service, which the Executive is considering. In England and Wales, the tagging and educational elements of that service have been emphasised, but not the treatment programmes. We are trying to enhance substantially the treatment elements of that new service.

**The Convener:** On behalf of the committee, I thank Dr Marshall and Ms Hornsby for being with us. I am sure that all members found the evidence invaluable—it has been extremely interesting.

I welcome to the meeting Shabnum Mustapha, who is the policy and campaigns officer for the National Autistic Society Scotland. We apologise for keeping you waiting. I noticed that you were in the public gallery and I am sure that you would agree that what we were listening to was helpful to our inquiry.

**Shabnum Mustapha (National Autistic Society Scotland):** Absolutely.

**The Convener:** I am sorry that we kept you waiting while we pursued those issues, but we are glad to have you with us now. We have received written evidence from the society, which was helpful, and members have a variety of questions to put to you. We will just fire ahead.

**Bill Butler:** Ms Mustapha, your written evidence provides very useful data about the prevalence of ASDs in the general population and develops some of the likely implications for youth justice. Has any research been carried out into the prevalence of ASDs among those in prison, on probation or involved in youth justice?

**Shabnum Mustapha:** No comprehensive study has been carried out in Scotland into the prevalence of ASD among children, young people and adults who have been involved in the youth justice and criminal justice systems. One limited study, called "On the Borderline? People with Learning Disabilities and/or Autistic Spectrum Disorders in Secure, Forensic and Other Specialist Settings", was published by the Scottish Executive this autumn and specifically examines secure settings in state hospitals, prisons and secure accommodation units for children. The report managed to identify only one child with autistic spectrum disorder in secure accommodation, but anecdotal evidence suggests that that is not accurate.

**Bill Butler:** Given that, what kind of study is required to assess better the extent and nature of ASDs among young people involved in youth justice?

**Shabnum Mustapha:** As the report pointed out, staff in those settings, no matter whether they were for children or adults, knew that the figure was an underestimate, because no formal diagnosis was made even of the people whom they had suspected of having an ASD. As a result, even though they might have had such suspicions, they could not record for the purposes of the report that those people had an ASD. People might also have slipped through the various identification and assessment processes.

For a more comprehensive study, academics and experts in psychology such as John Marshall and Nicola Hornsby need to go into those settings and carry out some screening themselves. Indeed, in England, the NAS sent experts into special hospitals such as Broadmoor, Rampton and Ashworth to look at case notes and histories in order to ascertain who was suspected of having an ASD. After further investigation, the NAS managed to identify that between 2.4 and 5.3 per cent of the prison population in those three settings had an ASD. However, those people were diagnosed with schizophrenia when they were admitted. We need a more comprehensive approach that involves experts going into such places.

No formal study has yet been carried out on people involved in the youth justice system and those who are going through children's hearings. Indeed, I understand that children's hearings do not record the number of children and young people involved in the system who have an ASD. Only learning disability and mental health figures are recorded.

**Jackie Baillie:** Your submission mentions the need for investment in services for people with ASD. Indeed, you explicitly link such investment with a reduction in people's contact with the youth justice system. You now have a chance to outline those services and the specific ways in which they would reduce people's contact with that system.

**Shabnum Mustapha:** Our holistic approach is based on our work over the past 40 or so years with children, young people and families who have been affected by autism. We have found that providing appropriate services at the earliest possible stage helps that child, young person or adult to participate in society and adhere to the normal rules of social behaviour. The key areas are timing and diagnosis, because once we make the diagnosis we know what services to provide for the child or young person. Agencies must recognise that specific services must be provided; we cannot provide these children with mainstream services and it might not be appropriate to provide them with generic disability services.

We also need to provide a wide package of services covering elements such as education, going to the general practitioner and social skills training. Such an approach should be aimed not simply at trying to train a child not to behave antisocially but at helping the child to develop their social, communication and interaction skills to ensure that they do not run the risk of offending. Given that little things can often trigger these young people off, we need to minimise the chances of that happening by providing them with proper services and giving them the social skills to ensure that they do not do certain things.

**Jackie Baillie:** You spoke about getting a diagnosis first, yet Dr Marshall and his colleague took the opposite approach and talked about a needs-based assessment that ensured that risks were identified and so on. Would you sign up to that approach?

15:15

**Shabnum Mustapha:** In an ideal world, anyone with any kind of need should get the appropriate services. Unfortunately, the problem for children

and young people with autism is that, without a diagnosis, the door to appropriate services is not always open. Some people have their needs met—we are aware of families that have not needed to go for a diagnosis—but, in most cases, people's needs are either not being met at all or not being met to the extent that is required. That means that the diagnosis is necessary. We need professionals who have expertise in making such a diagnosis.

**Maureen Macmillan:** I was interested in what you said about training and social skills. I know that youngsters with Asperger's syndrome see the world differently, respond to the world differently and do not have the same kind of social interactions as other people. Could you enlarge on the idea of the training in social skills that you envision? Could you talk about the training that is received by all youngsters who come into contact with the youth justice system? Regardless of whether they have an autistic spectrum disorder, such youngsters lack social skills. Would they receive the same kind of training?

**Shabnum Mustapha:** The kind of training can vary. Various models can be used and they need not all be geared towards addressing the needs of a child who might be at risk of offending. We provide various models, such as a befriending service, which involves someone befriending a child or young person with autism and taking them out to take part in social activities with other people. That enables them to develop the skills that are necessary if they are to engage with other people and not be offensive towards them or hit them and it can enable them to have a degree of independence and gain the skills that they need to make choices. Similarly, we run another scheme called teenscene, which is funded by East Dunbartonshire Council and which takes a group of teenagers with Asperger's syndrome out and about in Scotland to take part in various activities. That gives them the skills that they need to communicate and interact with one another and develop the appropriate skills to ensure that they do not misread social cues, offend people or say and do things that can be misinterpreted by people who are not aware that the young person has a disability. The children get a lot out of it. They develop their skills, make choices and take part in activities that they might not otherwise be able to take part in. It is an holistic approach in that the children get something out of it and society benefits as well.

**Maureen Macmillan:** I get the impression that the schemes that exist are fairly patchy. Can you give me an indication of how patchy they are? How many schemes exist? What parts of the country do they cover?

**Shabnum Mustapha:** The befriending scheme operates in Glasgow and Edinburgh. We will be expanding it to cover Aberdeen in conjunction with the Grampian Autistic Society. The teenscene project is funded by East Dunbartonshire Council and so takes on children only from that area. In the greater Glasgow area, the Scottish Executive funds our transition programme for children in education that is designed to enable them to develop their social skills so that they can make general choices about their post-school life, whether that involves going into employment or whatever.

Provision is patchy. Local autism organisations can provide only what they have the funding for in a specific area, although some of the funding relates to national projects.

**Maureen Macmillan:** Have you any idea of how many youngsters are falling through the net?

**Shabnum Mustapha:** The work that my colleagues are doing and the information that we are getting through our branches and our helpline suggests that there is a great need for services such as teenscene, particularly for people who are at the age at which they do not want to be seen hanging around with their parents all the time or have their parents mind them and watch over them. Those young people want to be independent, but not all of them have access to schemes that will assist them in that regard. Parents have been crying out for such schemes for teenagers.

**Mr Maxwell:** We have been talking mostly about services for children who are not in secure care. Your submission notes that young people with autistic spectrum disorders who are in secure care or custody of some sort need services that are appropriate to the nature of their conditions. What sort of services would be appropriate?

**Shabnum Mustapha:** Because of the complexity of the impairments that children and young people with autism have, we cannot expect them to interact with or understand mainstream or generic disability services. Programmes that are being used in secure settings will need to be adapted to meet the needs of every individual with an autistic spectrum disorder because their needs will differ. For example, people need structure to their day and their day needs to be planned out with rules and routines, because they find it difficult to cope with sudden or unexpected change, which can trigger anxiety. Anxiety in turn can trigger antisocial behaviour if the person does not understand what is happening. Even basic things such as adapting people's environment and ensuring that they have routine and structure in their day can help, and educational programmes must be adapted in such a way that they understand what is happening. Language must be

used in a way that they can understand, and the child or young person may find it easier to communicate using signals or visual symbols.

Staff also need to be aware of the complexity of need of people with autism. Even asking an open-ended question can result in a person with autistic spectrum disorder repeating the last thing that the person asking the question said, but that does not necessarily mean that that is what they want or that that is how they are feeling. One needs to understand the complexity of the condition in order to ensure that the needs of those people are being met.

**Mr Maxwell:** That is a very complicated answer. I am sure that you are right, but I just wonder how the system can adapt to deal with that situation, which is very much driven by the individual.

**Shabnum Mustapha:** Various approaches and therapies are available, and I referred to two of them in our written evidence. One is the SPELL—structure, positive approaches and expectations, empathy, low arousal, links—framework. The other is the TEACCH—treatment and education of autistic and related communication handicapped children—programme. Both approaches are aimed at working with individuals with autism in a mainstream environment, so they can be used in a secure setting and can be tailored to each individual within that setting. All that is required is a bit of understanding and flexibility to create an environment that is right for that person.

**Mr Maxwell:** This is a bit of a leap of imagination, but is it feasible or practicable for all institutions and secure centres to be able to have that level of individual approach?

**Shabnum Mustapha:** In all honesty, I think that it will have to be if children and young people are going through the system and ending up in secure settings. The risk is that if their needs are not met within the system, it will not be possible to address the underlying causes of the behaviour that led to their offending. When they come out of that setting, if their behaviour has not been addressed and if their experience has not been a positive one, that could lead to their re-entering the system because of further reoffending. We must recognise that some children with autism offend and the system needs to gear itself up to meet their needs.

**Mr Maxwell:** How close we are to the ideal world that you have outlined—or how far away are we, if that is a better way of putting it?

**Shabnum Mustapha:** We have a long way to go. There are positive approaches at a local level, through multi-agency groups, steering groups and working groups involving local authorities and health, social work and education departments. At Scottish Executive level, working groups have been set up to make recommendations in various reports to address the gaps in services and to meet the needs of people with autism. For example, the Executive has been developing standards for a quality diagnostic service for ASD. There are positive developments at the moment, but it will take a wee while for those developments to feed through. At a local level, some services will be patchy, because some local authorities do not have autism working groups whereas others do and are doing wonderful things.

**Mr Maxwell:** The same patchiness was mentioned earlier. How do we take best practice from one area and spread it through the system?

**Shabnum Mustapha:** There might be a need for the Scottish Executive to do something to bring together various policy strands and initiatives and to establish a minimum standard. It could tell local authorities and health boards that people with ASD form a client group whose needs are currently not being met, or are not being met to the necessary extent. The Executive could set up multi-agency working groups and give pointers in their guidance to examples of good practice that already exist in some councils.

**The Convener:** Have services for young people with autistic spectrum disorders secured youth justice funding?

**Shabnum Mustapha:** I do not think that they have secured specific youth justice funding. I am aware that the Grampian Autistic Society gets a lot of referrals from hospitals and secure settings because the society employs John Forrester, who has great expertise in criminal justice, but I think that he works primarily with adults. I am not sure where his funding comes from. I do not think that we or other societies receive such funding.

**Mike Pringle:** In response to Stewart Maxwell, you talked about the two programmes, SPELL and TEACCH, that are mentioned in your submission. Will you tell us a bit more about them? We have been talking about the patchy nature of provision; are the programmes widely available? Where are they available?

**Shabnum Mustapha:** The NAS runs a training consultancy service and trains people in the programmes so that they can implement them in their own services. A service does not need to come to the programmes; the programmes can be brought to the service.

The principle behind SPELL and TEACCH is that flexibility rather than massive change is required. The underlying aims are the promotion of the social skills of people with autistic spectrum disorders and the provision of structure to such people's environment and daily routines, to minimise levels of anxiety that could lead to distress or antisocial behaviour. The programmes are about introducing flexibility to the mainstream

environment to allow a child or young person to cope however they are able to cope. The young person might be in a mainstream classroom; they would not necessarily be in a secure setting.

I appreciate that people might be put off the model, because they think that it requires a lot of work. However, in all honesty, it does not require a lot of work—it is about being flexible, so it might involve making small, simple changes. For example, little Johnny might have an obsession with trains and disrupt class time by talking incessantly about his obsession, but the situation could be defused if Johnny was allowed to talk about trains for five minutes at the end of the day. Johnny would know that that was the routine, so he would not disrupt the class because he would know that he could talk about his favourite subject before the end of the school day.

**Colin Fox (Lothians) (SSP):** A key conclusion that is highlighted in your submission is that people who are involved in the youth justice system would benefit from autism awareness training. Will you say a little more about what such training should involve? In response to a question from Stewart Maxwell, you said that there is a need for a greater understanding of the complexities of autism. Would staff benefit from training in other aspects of the condition?

**Shabnum Mustapha:** Ideally, all the professions that are involved in the criminal justice system—police, social workers and reporters and panel members in the children's hearings system—should have an awareness of autism and should know how to adapt what they do to meet the needs of a person with autism, so that the person can understand what is happening. For example, children's panel members or the police can be given tips on how to communicate effectively when they come into contact with someone with autism. They can be told to use simple, clear, concise language, to avoid asking ambiguous or open-ended questions, to use short sentences and to avoid irony, sarcasm and metaphors, which confuse people with autism. They should give people with autism extra thinking time to process information and they should understand that the fact that a child or young person makes no eye contact—or inappropriate or fleeting eye contact—does not mean that they are being disrespectful, but is just part of the condition. If professionals understand how people with autism communicate, the experiences of people with autism who go through the system can be a bit better.

**Colin Fox:** I accept that you would like everyone to undergo such training. Should we give priority to a particular group that would benefit more from such training?

**Shabnum Mustapha:** It would be difficult to single out such a group. Children with autism live in the community and we cannot predict when they might become involved in the system. A child might be picked up by a police officer who does not understand why the child reacts in a certain way. Children's panel members might have a similar experience. In our written submission to the inquiry, we gave the example of a 10-year-old boy called Mark who came before the children's panel and did not understand any of the questions he was asked. The case eventually went to court, which might not have happened if the panel members had been more aware of the nature of autism and how to communicate with someone with autism. Mark could not communicate the fact that he did not understand the questions. It would be difficult to single out a profession that needs urgent training on autism awareness, but front-line professionals such as social workers and the police are the key.

**Colin Fox:** So it really depends on who the youngster comes into contact with first.

**Shabnum Mustapha:** Absolutely.

**The Convener:** As there are no other questions, I thank you very much for attending the meeting. Again, I am sorry that we were late in taking evidence from you, but it is clear from the interest that members have shown that we were pleased to have an opportunity to ask you questions and to hear from you. What you have said has been extremely helpful in a wide range of aspects.

The next item on our agenda is the fact-finding visit in Edinburgh that Maureen Macmillan and Colin Fox made in connection with the youth justice inquiry. Members should have a paper that details what happened. I hope that they have had a chance to read it. It certainly seemed to be a full visit. I do not know whether Maureen Macmillan or Colin Fox wants to say anything more about it. Perhaps members want to ask them questions.

15:30

**Jackie Baillie:** I am keen for us to stay focused on what works and, although there is a full description of what is going on, I got no sense of whether what is being done is more effective than anything else, what the results were of the activity and whether it reduced high-risk offending, repeat offending or anything like that. I wonder whether we could have a statistical base for the visit and for future visits, so that we can compare and contrast.

**Maureen Macmillan:** We talked to people about that, but the strategy is so new that they do not have any outcomes yet, although they want to measure outcomes. Members will see at the start of the report that people realised that there was a

scatter-gun approach at the start, with all the money going into projects without children being assessed to see whether they were suitable for them. Children are now being assessed to find out which projects fit them and they are going through the projects, but there is not yet the data to know whether what is being done is successful, although people think that it is.

**Fergus McNeill (Adviser):** It might be helpful to say that one of the Executive's initiatives is to introduce an evaluation toolkit, but it has been delayed. I think that it is just about due for publication. The intention is that it will be used to evaluate practice in the youth justice teams. I do not think that anywhere that we visit will have anything like robust data to address the question of what works; at this stage, outcomes will be anecdotal. We should ask and we might well need to ask for data, but there are difficulties about expectations of what will come back.

**The Convener:** I am sorry. It was remiss of me not to welcome our adviser, Fergus McNeill, to the meeting. I thank him for his contribution.

Jackie Baillie made a good point, which we must not lose sight of on visits. It would be helpful to know whether there is any capacity to measure.

**Mr Maxwell:** I want to say something on the same matter. We do not know the outcomes for the projects, so I wonder whether Maureen Macmillan or Colin Fox have any impression of why those projects receive funding. How is it decided which projects will be chosen if we have no idea of outcomes? That is a back-to-front question, but some projects are being funded and some are not. What does the selection process involve?

**Maureen Macmillan:** I got the impression that the projects were there anyway and that they were not the problem. The problem seemed to be that children were being put on projects that might not always be the right ones for them. I think that people were concentrating on assessing the children for projects that were already there. They seemed to think that the projects were good, but obviously they will have a better idea about that once they measure the outcomes.

**Fergus McNeill:** As far as I am aware, different ways of doing the same thing will be seen. Projects are usually funded in broadly similar ways. It is not a matter of people having been spectacularly successful at securing additional funding; it is simply about how people have chosen to cut the cake locally.

I think that Nicola Hornsby's post is funded as a result of a successful application to secure additional funding to address particular needs, but by and large, I presume that the Executive deals with requests for additional funding on the basis of whether a project has a robust basis in evidence, so that it has a chance of being successful and of demonstrating positive outcomes. Evaluation will come later. Again, that is a question that the committee might want to direct at the departmental civil servants in the final session.

**Mr Maxwell:** At the moment, I do not have a clear impression of the situation. Projects just seem to appear out of the blue. I do not understand how or why that can happen.

**The Convener:** As Fergus McNeill said, the Executive officials are the appropriate people to answer the question. I agree that there is an apparent lack of rationale. Again, as Fergus McNeill said, certain themes are pursued in different ways in different areas.

**Mike Pringle:** The other thing we need to talk about is the question of funding beyond 2006, which is an issue that I have highlighted. When we visited the youth justice strategy group, we were told about the lack of certainty in funding. If we want to improve services, it is crucial that we assure people that their funding will continue—after all, 2006 is just round the corner.

**Colin Fox:** I agree that it is early days for robust data. That came through in the Edinburgh experience, as Maureen Macmillan will agree. What also came across was a sense of greater confidence. When we met Neil Bruce, he spoke about the present system being more effective than the previous one and his confidence was palpable. Mike Pringle is right to highlight the anxieties that were raised in the final multi-disciplinary meeting. People were quite optimistic about the approach that the council is taking and value it. The only anxiety that they expressed was about how long the project will be funded for.

The project was wonderful. It is one of those projects in which one woman can make all the difference in the world: her enthusiasm and commitment are critical. I got the impression—certainly over lunch—that there are an awful lot of groups and projects. I also got the impression that there was a strong desire to effect change for all of them.

I spoke to a guy who is involved in the rural and urban training scheme project, which tries to get young men and women who have been stealing cars to become involved in motor mechanics and maintenance. The project involves the young people in something that fires them up and tries to turn that into a positive. I sense that people are trying anything that will work or that seems to be effective. Those sorts of workable project applications will always be listened to.

**The Convener:** As there are no other questions or comments, I thank Colin Fox and Maureen Macmillan for undertaking the visit and for

reporting to us so fully on it. In due course, we will hear back from the other three visits.

# Petition

## Public Bodies (Complainers' Rights) (PE578)

15:37

**The Convener:** We move to item 3, which is further consideration of petition PE578. When it came before us previously, we deferred our consideration until we could see what the Scottish Executive had to say about the issue that it raises. We have now received a helpful letter from Hugh Henry. His letter of 11 November is also very positive. The minister recognises the difficulties and also the sensitivity of the issues. As members can see from the letter, the Executive takes the matter seriously. Hugh Henry's officials are now in discussion with Education Department officials to see how the issues can be progressed.

**Jackie Baillie:** I suggest that we note the minister's letter and continue petition PE578 until we receive the more detailed response that the minister has promised. Given the length of time since the petition was submitted, it might be helpful for us to write to Donald MacKinnon, the petitioner, indicating that we have had a response from the minister, enclosing a copy of the response and giving him an idea of what the committee has decided to do.

**Mr Maxwell:** I agree with Jackie Baillie's suggestion. The last sentence of the letter says that the minister hopes to be able to give us a more detailed response

"in the reasonably near future."

The matter is not being kicked into the long grass for any great length of time. We should get an answer reasonably soon.

**The Convener:** Is the committee agreed that, in the light of the minister's response, we should continue the petition for further consideration once we receive the minister's more detailed response?

**Members** *indicated agreement*.

**The Convener:** Is the committee also agreed that we write to Mr MacKinnon to confirm that decision.

**Members** *indicated agreement*.

**The Convener:** That brings us to the end of our agenda. I thank members for their attendance. I also express my appreciation for the helpful way in which members made an early appearance before 2 pm, as that let us deal sensibly with all the questions.

*Meeting closed at 15:39.*

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