The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

FINANCE COMMITTEE

Wednesday 7 December 2011

Session 4

Wednesday 7 December 2011

CONTENTS

FINANCE COMMITTEE
13th Meeting 2011, Session 4

CONVENER

*Kenneth Gibson (Cunninghame North) (SNP)

DEPUTY CONVENER

*John Mason (Glasgow Shettleston) (SNP)

COMMITTEE MEMBERS

*Gavin Brown (Lothian) (Con)
Derek Mackay (Renfrewshire North and West) (SNP)
*Margaret McCulloch (Central Scotland) (Lab)
*John Pentland (Motherwell and Wishaw) (Lab)
*Paul Wheelhouse (South Scotland) (SNP)

COMMITTEE SUBSTITUTES

*Mary Fee (West Scotland) (Lab)
*David McLetchie (Lothian) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Tijne Berg-le Clercq (Netherlands Youth Institute)
James Dornan (Glasgow Cathcart) (SNP) (Committee Substitute)
Professor A J P Schrijvers (Julius Centre for Health Sciences and Primary Care, University Medical Centre Utrecht)
Merel Steinweg (Netherlands Youth Institute)

CLERK TO THE COMMITTEE

James Johnston

LOCATION

Committee Room 1

Scottish Parliament

Finance Committee

Wednesday 7 December 2011

[The Convener *opened the meeting at 10:00*]

Early Years Intervention (Netherlands)

The Convener (Kenneth Gibson): Good morning, and welcome to the 13th meeting of the Finance Committee in the fourth session of the Scottish Parliament. I ask members to switch off all mobile phones, BlackBerrys and pagers.

We have received apologies from Derek Mackay; James Dornan is here as his substitute.

We will take oral evidence on early years intervention in the Netherlands, focusing on the experience there in developing and applying an early years approach. I welcome to the committee via a video link Dr Berg-le Clercq, who is a senior international youth and family policy officer at the Netherlands Youth Institute; Merel Steinweg, who is an intern in the international department of the Netherlands Youth Institute; and Professor Guus Schrijvers, who is professor of public health at the Julius centre for health sciences and primary care at the University Medical Centre in Utrecht.

I invite the panel in the Netherlands to make opening statements.

Dr Tijne Berg-le Clercq (Netherlands Youth Institute): Good morning, ladies and gentlemen. I will tell you a little bit about the early years policy in the Netherlands.

I will start with prenatal care, as I believe that it is very important in giving children a good start in life. I will explain how prenatal care is organised in the Netherlands. In general, for uncomplicated pregnancies, primary care is provided by a midwife. Future mothers go to a gynaecologist only if there are complications. Prenatal care is very extensive, as during the pregnancy the midwife is visited 10 to 14 times. If the midwife notices risks, she can refer the mother to the gynaecologist and back to the midwife. As such, the service is very accessible.

The midwife and the gynaecologist focus on the medical aspects of pregnancy, but in the Netherlands prenatal care must also be offered by all youth and family centres, which I will focus on later. The main approach to preparing a mother for giving birth is pregnancy gymnastics. Women are provided with information about delivery and they are given physical exercises to do to prepare them for giving birth. The extent of home delivery is unique to the Netherlands. About 25 per cent of women give birth at home and about 75 per cent give birth in a hospital.

After giving birth at home or in a hospital, the mother stays at home or goes home, where she gets a universal postnatal service, which means that a nurse comes to the mother to take care of the mother and child. She gives the mother and father advice and assistance on how to care for the child. That lasts for eight to 10 days and is covered by the insurance system, so parents do not have to pay.

Once those eight days are over, a nurse from the consultatiebureau comes to talk about the services that it offers. My colleague Merel Steinweg will tell you more about that.

I will jump to the youth and family centre, which is a facility that has been created in the Netherlands in the past five years. Parents can go to the centre for advice about children growing up and about children's healthcare needs. The Dutch Government designed a basic model that must be implemented everywhere, but local authorities can decide themselves how they want to set up their centre. The model consists of several aspects that must be offered, which include preventive child and youth healthcare, well baby clinics and the prenatal education that I mentioned.

The youth and family centres offer information and guidance to parents, identify problems, guide parents to help if they have more specific needs and co-ordinate the care that is given. As such, the centres offer children not only healthcare but support with growing up. I believe that that is a very important development in the sense that it is an integrated approach, if that is how you say it.

Professor A J P Schrijvers (Julius Centre for Health Sciences and Primary Care, University Medical Centre Utrecht): That is correct.

Dr Berg-le Clercq: The centres also provide a link to extensive other services. In cases where they cannot deal with the problems themselves, they can refer parents to other services. That is a very important facility. Later I can talk about the lessons for the Netherlands, but now Merel Steinweg will talk about what the doctors and nurses do in the consultatiebureau.

Merel Steinweg (Netherlands Youth Institute): I am an intern at the Netherlands Youth Institute, but I am also a nurse and I have worked as a nurse at a consultatiebureau.

I will tell you a bit more about what a nurse's day looks like. First, I will tell you what a hypothetical day would look like, although it is never that way in practice. I would start with home visits in the morning. I would be able to do two home visits in the morning, which would take 30 to

40 minutes each. I would go on my visits by bike, given that I am in the Netherlands. The visits have three main goals: giving information about the well baby clinic, the consultatiebureau, and what parents can expect from it; giving basic preventative information on a range of topics, such as cot death, breastfeeding or general safety; and answering parents' questions.

After my visit I go back to the office and set up an electronic chart file, which takes between 15 and 40 minutes, depending on the family's situation. If the situation is complicated and extra help is needed, it is time to contact other professionals to address those needs. The questions that we ask the parents are leading. That is how we are taught to consult as nurses.

After a lunch break, I would have a consultation period in the afternoon. Parents would have an appointment with me. I would have 20 minutes per child, which would include the preparation—reading and updating the electronic file. I would see nine to 10 children in each session and discuss relevant subjects with the parents, depending on the child's age.

That is how a typical day looks at the consultatiebureau, except that appointments always last longer than expected, particularly where there are complications. Because we want the consultatiebureau to be a low-threshold facility, it should always be possible for parents to come without an appointment if they have questions. We do not have time reserved for that, so we have to be flexible. Parents do not always show up for appointments and, of course, there can be crisis situations in which I can be contacted by partner professionals asking me for advice, in which case I have to contact them immediately.

I stress that, to meet the needs of all parents, it is important for nurses to be flexible.

Professor Schrijvers: We are busy now with developing the centres for youth and family. I am one of the professors who created the concept in 2005. We like to give educated support to parents and children from minus nine months to 23 years. The ministry of health created special funding to set up the centres. More or less every municipality now has a centre. The municipalities put the emphasis on creating facilities; there are beautiful buildings and, if you are interested, I could offer you photographs of them. There are also beautiful software applications.

Merel Steinweg described the work of nurses. There is collaboration among the nurses, the doctors, the pedagogues and the social workers, but it is not easy to integrate those different disciplines, which have different norms. Having created the centres, we have to create better multidisciplinary pathways and norms. There will have to be guidelines, for example, on when to refer somebody to a social worker; on when to bring them back; and on how to do that within the referral system. There is a lot to be done, and we hope that we can get on with it. Meanwhile, we have the financial crisis to deal with. Do we stop in the middle? Or do we go on?

At the moment, the Government in Holland provides a stimulus, and there is debate over whether youth and family centres are to help parents, or whether the important thing is to detect violence at home, or violence against children. That is a dilemma. If you want to detect violence, that is a different thing from supporting ordinary families who need help because they do not know how to help their children and bring them up.

Why did we start the idea of integrated centres in 2005? A huge number of families required mental health services and psychopathologists. When a child had attention deficit hyperactivity disorder or education difficulties, he or she would be seen as having a problem and sent to a psychologist. However, in the philosophy of the youth and family centres, it is more likely that the parents have a problem. They have to bring up their children and not keep sending them back to the professionals if the children are too demanding or too stressful.

I work in Amsterdam, where committees evaluate the youth and family centres. At the moment, we are at a difficult stage. We need to educate everyone, from the front desk to the professionals, on what we are doing and we face delays from within the municipalities in the creation of a single funding system—with all the money going through the youth and family centres to the professionals. At the moment, some professionals are paid directly, not through the centres, and that is a difficulty. The Government has new programmes in which the integration at professional level is started after the creation of one building with one software system. Now we are waiting to have financing in one big lump sum.

At the moment in Holland, the Government and the Parliament are in a hurry: they want to allocate money to youth and family centres for children who have serious problems. Up until now, the focus has been on low-risk kids. The centres are trying to reach integration, so that the front desk and the primary health professionals can work with children with smaller problems, but the Government also wants the serious problems to be seen and treated in the centres by 2013. Managerially, that is a difficult problem, because it takes time to integrate the different professions.

My two neighbours and I are quite willing to answer your questions. Thank you.

10:15

The Convener: Thank you. That was very enlightening. I look forward to my colleagues asking a number of questions, but I will start.

How were you able to overcome institutional opposition to the establishment of the centres? In Scotland, we find that there is a lot of support for the concept of sharing budgets and policies on prevention. How have you overcome opposition from people who agree with the policy, as long as their budgets are not directly affected?

Professor Schrijvers: That is not easy. We had a debate in some parts of the country about whether it was a network or a centre. A centre has a hierarchical structure; the money comes to the centre and is then divided among different professionals.

How do we overcome opposition? First, we create a safe atmosphere; we talk for as long as possible about quality, goals and aims. We try to create a collective ambition. That is one step.

In Amsterdam, we see good managers who are trying to reach compromises. It depends on the manager. Sometimes they have no knowledge at all; they are put in office as a manager in a municipality, but they have no feelings for the youth. Sometimes they are interim managers.

I would like to invite you to come over. We have some beautiful centres and we hope to roll them out. There are also centres where I think that I would prefer the old situation, because there is a bad marriage under one roof. Tijne Berg-le Clercq also travels around the country. If she thinks that I am wrong, she should tell me, but that is my impression from giving lectures everywhere in the country.

Dr Berg-le Clercq: I would like to add something. It is difficult to create an integrated service, but it helps that in Holland the money for the youth and family centres has been allocated to local authorities and ring fenced. Local authorities can spend the money on the health services and the other professionals working in the centres. There is a clear guiding role—as we call it in Dutch—for the municipalities; they are given a great amount of power. That can stimulate co-operation, because they have the money. I do not know whether that makes sense.

Professor Schrijvers: That is true—it is a good point. However, when I was in Amsterdam, we had a department for welfare and a department for health. There is no integration on the policy level. There are social services and health services. My problem in the big city of Amsterdam, which has been busy for 10 years with the youth and family centres, was how to create one policy within the centre from the medical side as well as the social side.

The Convener: Thank you for your invitation to come over to the Netherlands, but I do not think that the committee would be that keen—I am sure that it would be appropriate to send only the convener.

Do the developments that you have been talking about this morning have widespread political support within the Netherlands?

Dr Berg-le Clercq: Yes. The national, basic model is politically endorsed. It is set in law and is widely supported. Every municipality has to create a centre by the end of this year and I think that virtually all municipalities are ready to do that. It is seen as a valuable service.

The Convener: What has the public response been?

Dr Berg-le Clercq: The public are very used to the consultatiebureau and they have to get used to the idea of the centre for families. Parents very much welcome the fact that the centre for families offers not only health-related services but more practical parenting support services.

Professor Schrijvers: We have a new right-wing Government and we wondered whether it would continue the policy or whether it would say that education is for the parents, not for the Government, and abolish all the centres. However, it has provided the money and the centres go on, which is good. There is some hesitation about them among the public and in professional journals; people say that we have been busy in Holland for five years creating good centres and nice buildings but they ask where the integration is at a professional level. Sometimes, what is said in the newspapers or in interviews is not that nice.

Merel Steinweg: Perhaps I can share some of my experiences. For me as a nurse, it was very nice to have the pedagogical centre in the same building. I could take the parent—I could walk with them—to the pedagogical centre if they had a specialised question. For me as a nurse, that was very convenient.

However, I was less close to some other professionals, sometimes because they were not in our centre and sometimes because I had a hard time relating to them.

The Convener: Committee members have a number of questions that they want to ask. The first person to ask questions will be John Mason, who is the deputy convener, to be followed by Paul Wheelhouse.

John Mason (Glasgow Shettleston) (SNP): Good morning. I am afraid that we will have to

continue in English, because my Dutch is non-existent.

I noticed from some of the papers that we have received that this project, and youth policy generally, was started by central Government but is being transferred to local municipalities. Does that mean that different approaches will be taken in each municipality? Will they all do different things or will they all still have to do exactly the same?

Dr Berg-le Clercq: The basic model is a central model that has to be spread out everywhere, but how municipalities do it is up to them. On the one hand, there is central steering from the national Government, but on the other hand there are lots of possibilities when it comes to local implementation.

Professor Schrijvers: The Association of Netherlands Municipalities has models and runs workshops, which people from every municipality go to. They then try to adapt the models to their local situation. Of course, centres in an area of low population density are different from centres in a big city.

John Mason: Yes. I assume that the needs would be different, both because of the differences between rural areas and city areas and because some areas would have more people from ethnic minorities than others, for example.

Professor Schrijvers: Yes.

Dr Berg-le Clercq: That is true. Of course there is great diversity in populations in different parts of the country, but the basic model is so general that it can fit all kinds of municipalities.

Paul Wheelhouse (South Scotland) (SNP): Thank you for your evidence so far.

One of the issues that you have touched on is the relationship between different professions and organisations, not just in terms of funding and support for preventative spend and activity in general but on a one-to-one basis where professionals, such as Merel Steinweg, who is a nurse, are mingling with others. Have you explored improvements in interprofessional training and education while people are qualifying in the various social work and medical professions? Has that played any role in improving the situation in the Netherlands?

Professor Schrijvers: Not that much up till now, although my colleagues might correct me. A team in a centre might have in-company training, for example, and many congresses are held at which different disciplines are present—Tijne Berg-le Clercq does a lot of work on that sort of thing—but, in general, training could be done better, and there could be more training in company.

Dr Berg-le Clercq: I agree with Guus Schrijvers: the training of many professionals comes only from their own background—for example, medical professionals are trained in the medical training field, and social workers in their field. Things are slowly becoming more integrated but, as we are trying to make clear, it takes time to create good integrated services.

Professor Schrijvers: We co-operate now. Tijne, in the Netherlands Youth Institute, has all the social workers and pedagogues; I, in the medical service, get all the doctors and nurses in youth help.

Dr Berg-le Clercq: It takes four years.

Professor Schrijvers: Yes, it takes four years, and then people say that they should come together in training or in a congress. However, that is silo management. Professionals stay in their silos too much, and we are trying to break them open.

Paul Wheelhouse: You start your work from nine months prior to birth—so, you have very early intervention. In your work with local social services, is there any mechanism for identifying, as early as possible, the parents whose children's welfare might be at the greatest risk? Can you offer us some advice, based on how things work in practice in the Netherlands?

Dr Berg-le Clercq: Prenatal services have to be offered everywhere—there has to be a certain programme. In municipalities, midwives can identify mothers at risk—during their pregnancy—and refer them to specific programmes. In Holland, we have voorzorg, which is the Dutch version of family-nurse partnership. That service is offered to mothers at risk.

Professor Schrijvers: Mr Wheelhouse mentioned the minus nine months point. In our Parliament, there is debate now about pre-conception consultation appointments. Boys and girls, or men and women, with their children if they wish, can go to a nurse in the youth health centre, before the moment. As you probably know, the Netherlands has high perinatal mortality. We had a congress last week. We try to select pregnant women by risk—between low and high—to discuss, for example, home deliveries. There is social screening of pregnant women; we ask, for example, about their education, whether they have a house, whether they have a man, and whether the child was wished for. That is the way we work, and we are trying to develop it to select the women better.

Paul Wheelhouse: You have very helpfully set the scene, and I now understand the process in the Netherlands. However, do you ever find that some potential mothers slip through the net—either because they are out of contact with the

local authorities or because they are off the radar and not being picked up by any of your systems, and therefore that they present either quite late in their pregnancies or after they have had their children?

Professor Schrijvers: There are some mothers from ethnic minorities or from very low income groups who will slip through.

Dr Berg-le Clercq: It is a very small number.

Professor Schrijvers: Very small, and the midwives are very keen to send them to social services if they cannot anticipate, they do not buy things for the new baby or they have no money at all. We have a programme called voorzorg. I did a study in Amsterdam, where they have case management—one family, one policy, one manager—and if the mother has psychiatric problems or is retarded, we have professionals who can help them. However, that is a minor problem in the bigger cities.

10:30

Dr Berg-le Clercq: Also, in rural areas most mothers are identified and make use of maternity services.

Margaret McCulloch (Central Scotland) (Lab): Good morning. I have two questions. The first is, since the centres were set up in 2005 have you kept records to show the benefits of the initiatives that you have introduced? For example, has the number of cot deaths dropped as a result?

Professor Schrijvers: No.

Dr Berg-le Clercq: Well—

Professor Schrijvers: Yes? Okay, you take this.

Dr Berg-le Clercq: The national Government takes a distant role in relation to most of the data that have been collected on the youth and family centres. It monitors to check that centres are set up and created, but if the outputs of the centres are measured, it is at a local level. My medical co-workers will be able to tell you more about cot deaths.

Professor Schrijvers: Cot deaths are not registered better because of the youth and family centres, as there already was good registration. We registered what went on between minus nine months and plus two or three weeks. Cot deaths were registered, but that did not get an impulse from creating these centres. I think that there is now better screening after birth in Holland for educational problems and violence. There has been a big increase of 10 to 15 per cent or more in the consumption of care at special centres against violence. We think that that is because we see it better, not because we adults in Holland are beating our children more now than we did in previous years. There is better selection now and the norms are more severe.

Dr Berg-le Clercq: Perhaps Merel Steinweg can add something about how it works in practice and also about the decline in the number of cot deaths due to the consultatiebureaus.

Merel Steinweg: I do not think that this field of nursing has changed much with integrated centres, because it was always the task of a nurse from the consultatiebureau to educate about cot death and I believe that the cot death mortality rate was very low in the Netherlands.

Professor Schrijvers: It was much higher, but it has fallen, because babies are laid on their back and not on their stomach, and so on. I think that there are good guidelines for nurses.

Merel Steinweg: Yes.

Dr Berg-le Clercq: That is as a result of the consultatiebureaus.

Merel Steinweg: The change is not due to the integrated centres; what has changed is the communication with other professionals, making it easier to contact other professionals. However, that is not the most important factor in cot death.

Margaret McCulloch: Are all parents expected to attend the youth and family centres? If they do not attend, is there anything you can do legally about it, or is attendance purely voluntary?

Dr Berg-le Clercq: Attendance is purely voluntary but, as the centres also provide free shots, free vaccinations and free check-ups, the attendance rate is very high. I think that it is about 85 per cent.

Professor Schrijvers: In the week after birth, it is higher, at 99 per cent. After two or three years, it is a little bit lower.

Merel Steinweg: As a nurse in Amsterdam, I have noticed that parents with young children come very often. If parents did not show up and had not cancelled their appointment, we would do a home visit to try to find out whether they still wanted to visit the centre or were not interested any more. However, there has been a shift in the past years to focusing more on children who are at risk and less on children who are doing well but are perhaps not visiting the consultatiebureau. That has had less priority. There has been more proactive searching for children who do not visit the consultatiebureau but are possibly at risk.

Dr Berg-le Clercq: That leads to the increases that Guus Schrijvers was talking about.

Merel Steinweg: Does Guus agree with that?

Professor Schrijvers: I do. We have done research in the south of the Netherlands, where we noticed that the children of people who do not show up in the appointments system are more at risk than those in families who do show up.

Gavin Brown (Lothian) (Con): Good morning. The cost of setting up youth and family centres over the past five years has been talked about. Has the Julius centre for health service and primary care or the Netherlands Youth Institute done any work on potential savings through having youth and family centres? There is a short-term cost when they are set up and there are running costs, of course, but I would have thought that there could be quite big savings in the medium term if people got things right. Has any work been done on that?

Professor Schrijvers: In 2005, my colleagues and I did a literature study in Dutch on the savings, but there is no original study about what we have saved. We are saying that we have impressions. Things could be more expensive in the short term because more high-risk cases are detected. I have noticed that nurses are happy that they see children who are at risk early in their life. Perhaps after 20 years, there will be less of an inflow into mental health institutes and people will be happier, but a good and robust evaluation has not been done in the Netherlands.

Dr Berg-le Clercq: The Government believes that the centres play an important role in preventive services. It sees them as the first service point that parents go to and, as such, as a way of saving money and putting that into more extensive and targeted services. However, that is an assumption.

Professor Schrijvers: We have a shift in financial flows for 2012-13. The Government is trying to switch money from more intensive therapies for youths and children towards less intensive therapies. It says, "If we are early, we will provide less intensive treatment in positive parenting programmes or other programmes. It will then not be necessary to bring children into an intramural institute." The Government believes in that idea and takes conclusions from it. In the coming years in the Netherlands, a third of a million euros will be switched to primary health services instead of more specialised services. However, there has not been a robust evaluation. If such an evaluation existed, it should be known about in our institutes.

Dr Berg-le Clercq: Unfortunately, we still have a lot to learn in the Netherlands about focusing on outcomes instead of outputs from having centres.

Professor Schrijvers: I am always asking for money for more PhD students and so on, but that does not work.

Gavin Brown: I have a separate but simple question about prenatal care. If I heard right, the midwife visits the expecting mother 10 to 14 times over the nine-month period. Is that right?

Dr Berg-le Clercq: The mother goes to the midwife 10 to 14 times.

Gavin Brown: I think that you have answered my question, but I just want to make sure. I take it that that happens in a clinic as opposed to in the family home.

Dr Berg-le Clercq: Yes, that is correct, but specialist interventions such as the voorzorg family-nurse partnership are offered at home. Targeted services are offered at home.

Gavin Brown: That is helpful. Thank you.

James Dornan (Glasgow Cathcart) (SNP): Good morning. Dr Berg-le Clercq referred earlier to money for services being ring fenced to the municipalities. Outside of the union of municipalities, how do you monitor it? Is it only the social services part that is monitored, or is the health service part monitored as well?

Dr Berg-le Clercq: Go ahead, Professor Schrijvers.

Professor Schrijvers: In the Netherlands, each municipality has a municipal health authority that is not only for youth services. It monitors children from the age of five or six and produces an annual youth health monitor that shows what the children's quality of life is and includes some physical data. In some municipalities, the monitor gives information about the consumption of care. It has some influence. For instance, one municipality noticed that many young children were overweight or obese, so it set up a programme to do something about that via the schools and primary healthcare general practitioners.

There is some monitoring in medical faculties, such as public health, but it is more about special diagnostic groups. The union of municipalities is collecting more logistical data on, for example, how many family centres we have, what is done there and the characteristics of the centres. Dr Berg-le Clercq does a lot of work in the Netherlands Youth Institute, which she can perhaps tell you about.

Dr Berg-le Clercq: It is being developed at the moment. Quality criteria are being developed for the youth and family centres, but they are very much focused on what I would call process criteria—what is going on, what is being delivered and what services are provided—and not on the output of the services that are offered.

Professor Schrijvers: No.

Dr Berg-le Clercq: I am not sure whether that answers your question.

James Dornan: Further to that, is there what we would call here a postcode lottery, in which some areas get better services than others? If there is, what moves are being made to equalise the service across the country?

Professor Schrijvers: The answer is yes and no. Nurses and doctors for youth health services are financed by the municipalities. They are not financed by a special grant but are funded through the municipalities' general income, which pays for traffic facilities, youth services, housing and so on. It is a general grant that is not earmarked for particular services. In the resource allocation formula, the bigger cities with lower-income groups and those with lower economic and social status get more money per citizen than the richer suburbs. There is no special allocation for youth services. Historically, there have been more problems in the bigger cities, so they get more money. However, the Government is now thinking about changing the allocation formulas because its view is that there are also big problems outside Amsterdam. That has created a lot of problems and debates within professional practice and the union of municipalities.

Dr Berg-le Clercq: As local authorities have a lot of power, it is hard for national Government to steer on equal provision across the country. That is why there is a model to ensure that basic services are being provided everywhere.

10:45

Paul Wheelhouse: I was intrigued by a table—I imagine that you do not have it in front of you, as it was provided by our committee clerks—in the United Nations Children's Fund assessment of children's wellbeing in the Organisation for Economic Co-operation and Development countries. The Netherlands is at the top of that league table, and is particularly strong on aspects such as family and peer relationships, behaviours and risks, and subjective wellbeing. Unfortunately, the United Kingdom is at the bottom of the same table, ranked 21st out of 21.

Given your research at the Julius centre and the Netherlands Youth Institute, do you have any views on why the Netherlands is doing so much better than the UK? What are we doing wrong? If you have any particular knowledge of what is happening in Scotland, do you have any views on what measures should be taken here?

Professor Schrijvers: I did some research that compared health services in England with those in the Netherlands. Holland is richer than the UK. I believe that Scotland is richer than England—is that right, Mr Wheelhouse?

Paul Wheelhouse: You will not have any disagreement from me on that.

Professor Schrijvers: There is a problem with income, because we are richer per capita, so there is more money to be spent on youth health services. We have created the family centres because of an increase in the consumption of care, not because of the health status of the children.

It is a little bit of a paradox—it is a dilemma. The health of children in the Netherlands is high ranking, as you saw from the table. However, the consumption of care is also very high. I know of one study—by one of Dr Berg-le Clercq's colleagues—that compares England, Germany, Holland and Norway, but it did not include the state; it just compared organisations. Perhaps Dr Berg-le Clercq knows more about the table.

Dr Berg-le Clercq: Yes, I know about the table, but it is very hard to explain why Holland is doing so well. It helps that we have a lot of universal services in place for parents, such as the youth and family centres and the universal child health services, which are increasingly picking up on the signals of children in need. You should focus on creating a universal service for everyone that is able to refer children to targeted services if necessary.

Paul Wheelhouse: Thank you—that is very helpful. We have had a big debate about the universality of benefits, so it is a helpful message for us in Scotland that that is an important feature of why the Netherlands is doing so well.

Professor Schrijvers: I would like to add one point. You should not forget that we have a social insurance system that pays for general practitioners and youth mental health services. Only the preventative services and interventions are paid for by the municipalities. Youth mental health services such as psychiatry, and care in children's hospitals, are all paid for by the insurance companies. We do not have your national health service system that is financed by tax money.

John Pentland (Motherwell and Wishaw) (Lab): Good morning. In evidence that various organisations have given to the committee, much has been said about the lack of leadership. Professor Schrijvers mentioned the silo approach in the Netherlands. Who takes the lead? Is it the Government or is it the organisations?

Secondly, the Scottish Government has set aside a significant amount of money—£500 million—for preventative spend. What kind of allocation has your Government made for intervention and prevention?

Professor Schrijvers: The union of municipalities is taking the lead in this—it has the brains and it sees things well. The union of municipalities in the Netherlands is trying to put

emphasis on good leadership. The Government does not like to be too involved with leadership; it is creating the conditions within which leadership can be developed. That is the point that we have reached in the Netherlands. Dr Berg-le Clercq's institute and our group are trying to run workshops to train better leaders. That is working, but it is long-term work.

Dr Berg-le Clercq: At a local level, the definition of leadership varies in who takes the lead in the youth and family centres. Most often, it is the municipality that takes the lead, but it varies. We are looking at other countries to see how we can improve our leadership. Merel Steinweg wants to write her thesis about leadership in integrated services. We hope to learn from you in that respect.

Professor Schrijvers: I could not understand your second question because my Scottish English is not that well developed.

The Convener: Neither is John's.

John Pentland: Neither is mine, Professor. I come from Motherwell and Wishaw.

The Scottish Government has set aside £500 million, which is a significant amount of money, for preventative spend. How much has your Government set aside for intervention and prevention?

Professor Schrijvers: I do not know because we have no data on it. We would like to shift from curative intervention to prevention, but we have no data that I can mention.

Dr Berg-le Clercq: Unfortunately, I have to agree with Guus Schrijvers.

Professor Schrijvers: In our country, it is often used as a weapon when local politicians want to change something, but we have no good data on it.

John Mason: Looking to the future, do you have specific targets for what you are trying to do? The paper that we have been given says that 15 per cent of Dutch adolescents have problems and may need additional support, and that 5 per cent are structurally at risk. Is there a specific amount by which you want to reduce those figures, or is it quite general?

Dr Berg-le Clercq: As Guus Schrijvers pointed out earlier, there has been a big increase in the use of specialised services. The national Government is keen on bringing those numbers down, but I have never seen the percentage specified. It wants to bring the numbers down and hence decrease the spending on specialised services, but it is not a very Dutch thing to set a specific target.

Professor Schrijvers: In the town where I live—Utrecht, which is in the middle of the Netherlands—there is a neighbourhood in which 150 different kinds of professionals are working for 1,000 families. There are professionals in addiction care, psychiatric care, case management for the elderly, and so on. We are trying to make them neutral—to say that there are problems with children in those families, but to go back from specialised care to general care, general educational care and general youth help. That is the idea. There is going to be a switch in money to general care. People are hoping for a reduction in these figures, but I should say that the culture in the Netherlands is not the same as the culture that I have noticed exists in England. We do not have the same sort of targets. The students I teach say to me, "We should have these targets," but we are still a long way from that kind of approach in the Netherlands.

Dr Berg-le Clercq: Politicians are also scared that they will have their heads cut off if they do not hit such targets.

The Convener: The more things change, the more they stay the same.

The Netherlands has 431 municipalities. Does each of them have a youth centre? Clearly, some will be larger than others. As far as prevention is concerned, we are interested in the issue of scale, particularly in the rolling out of family-nurse partnerships. Roughly how many youth and family centres are there in the Netherlands?

Dr Berg-le Clercq: There should be at least one in every municipality, but the bigger ones have more. Merel Steinweg might know how many there are in Amsterdam, which I think—this is a ballpark figure—contains about 400,000 people.

Merel Steinweg: I do not know about that, but I think that there are 22 centres in Amsterdam.

Dr Berg-le Clercq: Depending on the size of the municipality, there will be more than one centre, but there has to be at least one in every town. The big cities try to have one within walking distance for parents.

The Convener: How many citizens does each centre serve? Is there one for every 5,000, 10,000 or what?

Professor Schrijvers: In smaller villages of 5,000 people, there is often one small consultatiebureau. However, various smaller villages can come together to create a bigger organisation. For example, seven municipalities in the south of the country have come together to provide every village with a small centre—like a supermarket—that acts as a point of contact and to establish a bigger back office for paying salaries, providing subsidies, making policy and

creating protocols and guidelines. In Holland, we call that being small within a big organisation. Instead of creating big youth and family centres, each of which serves 40,000 inhabitants, we might have one organisation serving 40,000 with eight points of contact. Otherwise mothers might face a long walk with their buggy, or having to take a bus or whatever, and that is not the idea in the Netherlands.

Dr Berg-le Clercq: I agree. I have nothing to add.

The Convener: Given that Scotland's population is 30 per cent of that of the Netherlands and that its land mass is twice the size, it would be difficult for all our people to walk to such centres. Nevertheless, the important message from the model that you have put in place in the Netherlands is that every citizen who needs these services can access them.

On behalf of the committee, I thank the witnesses for the time that they have given us this morning. You have given us plenty of food for thought and, in the weeks ahead, we will certainly deliberate on the information that you have provided.

As previously agreed, we will move into private session.

10:59

Meeting continued in private until 11:44.

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

Members who wish to suggest corrections for the revised e-format edition should e-mail them to official.report@scottish.parliament.uk or send a marked-up printout to the Official Report, Room T2.20.

Available in e-format only. Printed Scottish Parliament documentation is published in Edinburgh by RR Donnelley and is available from:

All documents are available on
the Scottish Parliament website at:

www.scottish.parliament.uk

For details of documents available to
order in hard copy format, please contact:
APS Scottish Parliament Publications on 0131 629 9941.

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@scottish.parliament.uk

e-format first available
ISBN 978-1-4061-7948-4

Revised e-format available
ISBN 978-1-4061-7960-6

Printed in Scotland by APS Group Scotland