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Pàrlamaid na h-Alba

Official Report

EQUAL OPPORTUNITIES COMMITTEE

Tuesday 29 May 2012

Session 4

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EQUAL OPPORTUNITIES COMMITTEE
10th Meeting 2012, Session 4

CONVENER

*Mary Fee (West Scotland) (Lab)

DEPUTY CONVENER

*Stuart McMillan (West Scotland) (SNP)

COMMITTEE MEMBERS

*John Finnie (Highlands and Islands) (SNP)
*Annabel Goldie (West Scotland) (Con)
*Siobhan McMahon (Central Scotland) (Lab)
Dennis Robertson (Aberdeenshire West) (SNP)
*Jean Urquhart (Highlands and Islands) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Lesley Boyd (NHS Lothian)
Linda Irvine (NHS Lothian)
James Lambie (NHS Lothian)
Kenneth Leinster (South Ayrshire Council)
Dr Iain McNicol
David McPhee (Perth and Kinross Council)
David Torrance (Kirkcaldy) (SNP) (Committee Substitute)
Joan Watson (West Lothian Community Care and Health Partnership)

CLERK TO THE COMMITTEE

Douglas Thornton

LOCATION

Committee Room 4

Scottish Parliament

Equal Opportunities Committee

Tuesday 29 May 2012

[The Convener *opened the meeting at 14:08*]

Interests

The Convener (Mary Fee): Good afternoon everyone and welcome to the Equal Opportunities Committee's 10th meeting in 2012. I remind everyone to turn off electronic devices.

We have received apologies from Dennis Robertson. Dennis is being substituted for by David Torrance, whom I welcome to the meeting.

We will start with introductions. At the table, along with committee members and witnesses, are the clerking and research team, official reporters and broadcasting services staff. Around the room, we are supported by the security team. I welcome the observers, in the gallery at the rear of the room.

I am Mary Fee and I am the committee's convener. I invite the other committee members to introduce themselves.

Stuart McMillan (West Scotland) (SNP): I am the deputy convener and a member of the Scottish Parliament for West Scotland.

David Torrance (Kirkcaldy) (SNP): I am the MSP for the Kirkcaldy constituency.

Jean Urquhart (Highlands and Islands) (SNP): I am an MSP for the Highlands and Islands.

Annabel Goldie (West Scotland) (Con): I am an MSP for West Scotland.

Siobhan McMahon (Central Scotland) (Lab): I am an MSP for Central Scotland.

John Finnie (Highlands and Islands) (SNP): I am a Highlands and Islands MSP.

The Convener: As this is the first meeting of the Equal Opportunities Committee that David Torrance has attended, I ask him whether he has any interests that he would like to declare.

David Torrance: I have no interests to declare.

Decision on Taking Business in Private

14:09

The Convener: Agenda item 1 is to decide whether to take in private item 4, which is on draft budget scrutiny 2013-14. Is that agreed?

Members *indicated agreement.*

Gypsy Travellers and Care

14:10

The Convener: Agenda item 2 is an evidence session as part of our Gypsy Travellers and care inquiry. We have with us representatives from healthcare and social work services. The members of the panel have first-hand experience of working with Gypsy Travellers in the context of care. What they tell us will help to inform our questioning of the Minister for Public Health.

I invite the panellists to introduce themselves and to give us a brief résumé of their background. We will start with Joan Watson—welcome.

Joan Watson (West Lothian Community Care and Health Partnership): I am a health visitor and I am based in Stoneyburn health centre in West Lothian. I have been liaison health visitor for Gypsy Travellers in West Lothian since 1992. My remit has changed over the years, but I have continued to act as the link for any Gypsy Travellers who come into West Lothian, whether to the local authority site—which, unfortunately, is now closed—or to any encampments in the area. I link with West Lothian Council as families move into and out of the area.

Dr Iain McNicol: Good afternoon. I have been a general practitioner in the Highlands for more than 30 years. I recently retired from my practice in Port Appin, but I still work as a locum in the islands and Highlands. I have worked with the west coast Travellers—they prefer to call themselves Travellers rather than Gypsy Travellers—and one family, in particular, for the past 30 years. Initially, through the 1980s, I did so in a fire brigade sort of way and then, in the 90s, we managed through a couple of public health initiatives to get more organised and tried to identify in a systematic way the problems that the families had. From the mid-1990s onwards, I have been involved in a number of initiatives.

I gave evidence to the Equal Opportunities Committee 11 years ago. The report that it produced was extremely useful in producing benefit for the travelling people. There has been a marked improvement in discrimination against the travelling people—in other words, there is less discrimination than there was 11 years ago. That is definitely directly related to the committee's work.

James Lambie (NHS Lothian): Good afternoon. I work in what is now called Edinburgh access practice, which was formerly known as Edinburgh homeless practice. My work with Gypsy Travellers—I, too, like to use the word "Travellers"—comes from leading an NHS Lothian service under the keep well umbrella since late 2009. The service that I led used an outreach model and engaged with local Travellers on council sites in Lothian and on any roadside encampments that occurred in the area. My local contribution has been to pull together a few evidence papers on the types of health presentation that involve Travellers and their experience of engaging with services. That involved looking quite carefully at the barriers to engagement and how we might overcome them, and collecting some evidence on the number of people with certain conditions and how best to look after them. The extent to which I will continue to be involved doing that in my new role is yet to be defined, but NHS Lothian's keep well team has some identified links to continue the work.

14:15

Linda Irvine (NHS Lothian): I am strategic programme manager for mental health and wellbeing for NHS Lothian. We have just developed a five-year strategy for improving Lothian's mental health and wellbeing, within which we have a huge focus on addressing inequalities. We know that Gypsy Traveller communities experience significant health inequalities. We are very keen to look at people's holistic needs, focusing particularly on mental health needs as well as physical health needs.

The Convener: Thank you. Committee members have a number of questions for the panel. John Finnie will start, followed by Annabel Goldie.

John Finnie: I thank the panel for coming along, and I thank James Lambie for his papers, which are fascinating reading.

When we were thinking about questions, we thought about the first engagement that a Gypsy Traveller—or Traveller, if you prefer—would have with medical services, which might be at childbirth. Will the panel comment on maternity and childbirth arrangements and on how engagement is perhaps lost? The evidence suggests that, after childbirth, there is a reluctance to engage with the medical profession.

James Lambie: I have experience of speaking with younger women, in particular, who have had babies. It is very rare to find a young Gypsy Traveller woman who has engaged with midwifery services.

Dr McNicol: In the 1990s, we saw a huge increase in interactions with pregnant ladies in the Traveller community. I had several patients who travelled 200 or 300 miles to attend antenatal classes. They did that in a very dedicated way, as I had a practice team that was user-friendly for them. That led to much better relationships and the introduction of contraception to the travelling

community in about 1997—I think I first gave contraception to a Gypsy Traveller lady in 1997. Very quickly, that spread. There has been a marked reduction in family size over the past 10 years. Within a generation, the average of six to seven children per family has gone down to one to four children per family. That is part of the issue.

We have been trying to get Gypsy Travellers to empower themselves and be in charge of their destiny, rather than be overwhelmed by children, which they had been doing for protective purposes—they felt that if they had six, seven or 10 children, they would be protected from the big bad community; they also got quite a lot of benefits, which was a secondary part of it. Unfortunately, due to the way in which midwifery services in Scotland have changed, GPs now have very little to do with midwifery. Women now go to midwifery services and, even in the small village where I live, having delivered, over 30 years, more than 300 children in that community, I can see someone walk in with a baby and wonder where they got it from, because they have had a baby on their own, with the services. They have gone to the midwife, but midwives do not think to tell us, although we may see the person with a bump and wonder whether they are pregnant.

That is a very sad reduction in services for young women, and it has repercussions, because that is when one gains the trust of young mothers to look after their children. The immunisation success we had in the 1990s and 2000s was because the mothers trusted us. The immunisation rates in the Traveller population went from zero in 1990 to more than 80 per cent by 2005. I suspect that it will slip back again.

Joan Watson: When we had the local authority site in West Lothian, I would visit it regularly, to see the children, the mothers and the pregnant girls. They linked in well with the GP practice that was attached to the site. Now that the site is closed, there are fewer opportunities to meet the girls who are static in one area. Families who come into encampments might see me—the health visitor—if the local authority advises me that they are there and they wish to see me, and most of the pregnant girls, who may have not seen their midwife for some time, will have their antenatal record with them. In my experience most antenatal mums guard that record. It empowers them—it is their information about their antenatal history. If they wish to see a midwife in West Lothian, I can arrange that quite quickly—we have a link midwife or I can arrange an appointment at St John's hospital for them.

However, I have to know where the families are to be able to speak to the girls to arrange an appointment. It is sometimes more difficult to attach people to a GP practice because of where an encampment is placed but, if the local authorities advise me that the Gypsy Travellers are there, I can get that link going. Often, it falls away because nobody even knows that they are there, and the girls might have difficulty getting an appointment with a midwife.

James Lambie: There is a central midwifery booking line in Lothian and I have successfully managed to get a couple of individuals along to appointments, but that is with a lot of on-going support prior to making the link and afterwards. A midwife visits the Edinburgh access practice once a week and I have managed to get a couple of women along to see her, but again support is needed before and after that encounter.

John Finnie: The philosophies and the practices that organisations put in place are relevant only if they can be followed through—the getting it right for every child approach suggests that there will be a plan that is followed through. If that engagement with the medical services is not there, are there any obvious follow-ons for the early years of a child in a Gypsy community, apart from in respect of inoculations?

Joan Watson: I attempt to engage with families when they come into encampments in West Lothian—unfortunately, we no longer have a local authority site there—and, if there are pre-school children or children who require immunisations, I can arrange that. We have a patient group directive in West Lothian that the clinical director is signed up to, which allows me to immunise the children on the site—they do not have to be registered with a GP practice. That initiative came about several years ago in West Lothian and means that I can offer the families immunisations for their children if those have lapsed. However, they do not always take place. The families have to agree to it and, again, it is about them getting to know me, and fewer families know me as well as families did in the past, because we do not have the local authority site.

Dr McNicol: One of our great struggles in the 1990s was to encourage the travelling community to accept that healthcare starts with primary care, not with accident and emergency. We realised that the fire brigade stuff that we did in the 1980s was not working. Travellers would turn up at the door at 10 o'clock at night, saying that they had a headache, and we would give them a couple of paracetamols and say, "Come and see me tomorrow," but of course they would disappear.

It is about winning the trust of people and about them understanding that by going to A and E, they will get an elastoplast or a couple of paracetamols but they will not get treatment. Travellers thought that they had been to hospital so nothing more could be done. A lot of the winning of people's trust came about through antenatal care,

immunisations, terminal care of travelling people at home and so on.

To this day we have the fire service. Travellers used to be quite happy to phone us when a child was not well but, more and more, as we lose contact with young mothers, they go back to going to A and E. They turn up to A and E in Oban and Fort William and get that emergency level of service again. There has been a break in trust and continuity because maternity services are drifting away from general practice.

James Lambie: I echo what Dr McNicol was saying. It is absolutely true that trust is the overriding element. In Lothian, immunisations were identified as a bit of a gap and were discussed within the public health team in Lothian. We possibly have a bit of a gap in respect of Gypsy Travellers' use of A and E and emergency care settings, because routine ethnicity recording of Gypsy Travellers is only very recent and our evidence and evidence from elsewhere suggest that it would have been relatively rare for Gypsy Travellers to identify themselves as such in an emergency care environment.

Annabel Goldie: I have three fairly simple questions. I am struck by the evidence that has come forward. The Gypsy Travellers conveyed to the committee a sense of being alienated by the system in trying to access healthcare. We have been told that a GP can refuse to see a patient without giving a reason—we were all intrigued by that. Dr McNicol can perhaps assist, although I am not suggesting that he has done that. When could a GP refuse to see a patient without a reason? Is that at the discretion of a GP?

Dr McNicol: Yes, I suppose so. One area of Scotland seems to be particularly bad at giving Gypsy Travellers access to general practice. I suspect that you are all aware of that area. The main issue is people being told that they are not resident here, so the GP does not have to see them or that they are outwith the practice area, because general practitioners have an area that they agree to look after. Some GPs know that they are in a position of authority and the Gypsy Traveller is not, so that if they say that they will not see them, they will not see them.

Sadly, over the years, many people have come to me and said that somebody would not see them. People have come 200 or 300 miles to be seen by me. One very vulnerable family, who live in Fife, are part of an extended family that I have looked after. They regularly travel to the west coast at their own expense, with pre-school children, to be seen for routine medical care.

Annabel Goldie: That leads me to my second question. Is there an issue with the national health service being at ease in dealing with the Gypsy Traveller community? Is there latent prejudice and an instinctive attitude that says, "We're not here to help them. They're troublesome and don't fit in with other patients"? I am trying to find out why Gypsy Travellers feel alienated by the system and why when they do something as basic as summoning up the courage to try to get medical help when they are not well, apparently it is shoved back in their faces. What is at the heart of that?

Joan Watson: There is quite a lot of ignorance within all authorities. I was involved in the launch of the hand-held records and the awareness-raising sessions that were conducted across Scotland in 2006. The hand-held records were designed to improve the continuity of healthcare, although whether that was achieved is debatable, because their use has never been evaluated. Iain McNicol indicated when I spoke to him that hand-held records are not being so well used in his area either. However, awareness-raising sessions were held alongside the launch of the hand-held records, involving not only health workers. I was involved in the sessions, which were done by Gypsy Travellers who were trained to speak to local authority staff, education staff and health workers across Scotland about the ignorance that exists about the lifestyle of Gypsy Travellers, the difficulties that they face and the inequalities that they perceive in health and education.

14:30

James Lambie: I echo that. I have also been involved in awareness raising for local council staff and healthcare staff. There was an issue last year with funding and capacity, but one thing that was top of the list was the need for cultural awareness raising within the emergency care setting.

I return to the point about registration at GP practices, which is obviously the first barrier that people experience. I would not say that different GP practices apply the rules in their own way but my experience locally is that, increasingly, some practices will, for example, stick rigidly to saying that families must be sure that they will remain in the area for three months before they can register.

For example, I have worked with families in roadside encampments in East Lothian that are less than half a mile from the local GP practice, but when I tried to assist with registrations there, I was told that if the families could not say that they would be there for three months, the practice could not register them. Everyone who works with Travellers knows that they live on a day-to-day basis and that their priorities and needs are experienced on that basis. Further, there have been issues with the documentation that must be produced in order to register with a practice.

Increasingly, for example, photographic identification is required.

Now, I work in the access practice, which by its nature is a lot easier to access. However, I experienced quite a bit of difficulty in trying to register a pregnant woman from one of our local sites at a local practice. I contacted the practice manager, who was fine with the fact that the lady could not produce photographic ID and was quite happy to go with a utility bill instead. They said that if somebody who worked with Travellers and knew the woman and could verify her identity could come down, the practice would be happy with that. I arranged to go and meet the pregnant woman and get her registered. Unfortunately, she did not turn up, but that was more a reflection of the fact that Travellers' priorities change.

On the culture of how primary care sees people, Travellers' needs are immediate. As we said just before the meeting, it would not be unusual for many members of the same family to turn up for one person's appointment slot and ask to be seen as well, because they are a very family-orientated community.

The Convener: Before I bring Dr McNicol back in, I wonder whether Linda Irvine wants to comment.

Linda Irvine: I have a couple of points on the question of stigma. For me, the main reason why Travellers do not access mainstream services is because they feel, with good reason, that they are stigmatised and discriminated against. All the statutory services should be committed to ensuring the provision of education and training in that area, and there is nothing more powerful than that being delivered by members of the Travellers' community. In Lothian, we have begun supporting that again because we recognise its value. However, I would like to see it moving to the next stage and our supporting Gypsy Travellers to become peer advocates or peer workers or buddies, so that they can work with their communities to encourage health-seeking behaviour.

Dr McNicol: I mentioned that, following my appearance before the committee 11 years ago and the committee's report, there had been a lot of improvements. Strangely, money seemed to appear and it was far easier to get than it had been previously. We had one initiative for Travellers called healthy together Argyll, which got £105,000 from the then Scottish Executive. There was quite a rigorous application process and for some reason we were asked not to bother to come to any of it, but we got the money and it was very useful.

The healthy together Argyll initiative was led by the Travellers and was totally multi-agency. We spent a huge amount of time on awareness raising with education, police, health services, hospitals and everybody. There have been tremendous improvements in the conditions in north Argyll and Argyll generally and a lot of the stigma has disappeared. There are still one or two families who have individual problems with individual council employees, particularly with family members who have severe handicaps. That is an on-going issue that is quite frustrating. However, I have spent quite a lot of time in the past weeks speaking to a number of Travellers and asking them how things have improved over the past 10 years, and they have said that they have improved tremendously in Argyll.

Awareness raising is therefore important, but so is getting children into education, which is also happening. A lot of primary school teachers are celebrating the fact that a different culture is coming into the school. They are saying, "Tell us about your culture"; they are not saying, "Oh, it's those dirty tinks who will be here for three days and then disappear." There has been a huge change in that regard, and in younger people's confidence, which is good. However, there are still problems.

Annabel Goldie: Dr McNicol, you talked about the difficulties that the centralisation of midwifery services have created, and about, as a GP, seeing someone with a baby and saying, "Where did this come from?", whereas in the past the mother would have been your patient and you would have known exactly what was happening. Is the system not helped when parts of the NHS do not speak to one another? Is that an issue, and if so, does it extend beyond midwifery?

Dr McNicol: Absolutely—

Annabel Goldie: And would you need two days to be able to give us the full story about what is not working?

Dr McNicol: The medical profession is as guilty as anyone else is in that regard, because when the new contract came in, the number of practices that simply jumped out of offering out-of-hours care—instead of gradually phasing out their service—was such that a new system had to come in, which was much more bureaucratic. That compounded problems for vulnerable members of society.

I have heard even a lawyer talking about how difficult he found it to get NHS 24 to get his wife treatment. She ended up in the Southern general hospital for three and a half months, although NHS 24 had said, "Take two aspirins and we'll see you tomorrow"—and he had not even been jumping up and down about it. If lawyers cannot cope with a centralised system, how can Gypsy Travellers cope? I have heard many great things about NHS

24, but it is a monstrous system if it is busy and the patient feels vulnerable.

James Lambie: Ms Goldie, were you asking about systems in the NHS that cannot communicate with one another?

Annabel Goldie: I was interested in Dr McNicol's illustration of the midwifery situation and I wondered whether there are other instances in which what happens in one part of the NHS is not known in another.

Dr McNicol: Mental health services have changed. As a rural GP, if I had to certify someone—I am thankful that I have not had to do so often—it usually happened in a fraught situation and it was good enough to write on the back of an envelope that the person needed a three-day admission for emergency assessment. If we did that now, we would be locked up ourselves. I totally understand that the changes are about the rights of patients, but we have almost gone too far. GPs, along with the police, are the people who are called out to deal with the guy with the shotgun—five times during my career I have been asked to go and disarm someone who had a shotgun. Usually it is we who say, "The person might have a problem that requires a bit of help"; nowadays, technically, we must phone someone 100 miles away to get a mental health officer to go through the process. The system is fine for the vast majority of people, but it does not make a lot of sense in remote areas and when we are dealing with vulnerable people.

James Lambie: On a small scale, in Lothian I have case-managed individuals who were moving to other health board areas, to try to ensure that the person's case was followed up, for example because they needed an investigation. That works if the other health board has the same attitude as we have and if the culture is there to support that, and it works if the individual who is moving understands why they need to attend an appointment and can be supported in doing so.

In NHS Lothian we have discussed at length with the Gypsy and Traveller health steering group whether there is a viable model for cross-health board work, to follow up people who move what can be great distances. There is no template for that other than the small-scale work that has been done, so it is difficult to comment. However, I have had good experiences when I have worked with healthcare staff in other health boards who care and who have the same attitude as we have in Lothian.

The Convener: I want to return to the issue of hand-held records, which we touched on briefly. Dr McNicol, of the Gypsy Travellers who present at your surgery, what percentage carry their own medical records? I do not expect you to give an exact figure.

Dr McNicol: Virtually none carries their own records. That is mainly because those whom I deal with I have known for 30 years. There were two problems with the hand-held records. I was involved in the set-up and launch of the scheme, which took a long time. I remember that at one meeting with Gypsy Travellers here in Edinburgh, opinion among them was divided. If I remember rightly, the vote was 60/40, with 60 per cent saying that the records were a good idea to improve healthcare.

The site in Aberdeen is called the beach. If somebody walks into a surgery to see a doctor and is asked, "Where are you staying?" and the answer is, "The beach," that is not the easiest thing to say. There is a real stigma. It sounds as if either the person has come on holiday and has swallowed their ice cream the wrong way or done something on the beach, or they are staying on the site. Some of the people at the meeting thought that it would be helpful to have something in their hand to give GPs access to the patient record. However, 40 per cent of the people thought that it would give the police the chance to ask them where their medical hand-held record was and who they were. They thought that it would become an ID card, which they were vehemently against.

When the scheme came in, at great expense and after a lot of hard work, including awareness-raising among doctors throughout the country, the vast majority of doctors thought that it was another bit of paper that they had to fill in. They had to fill in their records plus the hand-held one. The vast majority of GPs, even ones whom I would consider to be helpful and friendly and receptive to Travellers, said, "Don't give us more paperwork." Just because of the simple logistics of paperwork, the scheme was almost doomed to fail.

James Lambie: I echo that point. My experience of meeting Traveller families who have travelled across a considerable distance is that those records have not been used consistently. The records are where we legally record the interventions that take place. There are implications if they are lost or end up in the wrong hands, which is a danger. However, in my experience, the main issue is that the hand-held records have not been used.

Joan Watson: Unfortunately, their use was never evaluated. I occasionally come across families with such records and I still have a pile in my office. The scheme was a good idea, but the Gypsy Traveller community is a big one and, as Iain McNicol said, some were for it and some were against it. Even in the awareness-raising sessions that we did across the country, different views

arose and the scheme was not necessarily accepted by the families that we were delivering to. There was a lot of controversy over the records, although the idea was good. Often, as a health visitor, just having a contact telephone number can be the best thing, as it allows you to phone a colleague about a family to provide continuity of care for a child.

The Convener: I accept what you say about resistance from the Gypsy Traveller community. If there had been more buy-in from GPs and other medical people, might the system have been more of a success? From what Dr McNicol says, it sounds as if GPs did not support the scheme.

Dr McNicol: They were not against the principle, but they were not supportive of the practical side. I have often felt that there should be identified practices throughout the country that are willing to see Travellers on an open-house basis. They could have some kind of payment or whatever to do that, if that is what it takes. Travellers could then go to those practices, which would hold records for them. That would mean that we would not have to phone round when we are told, "I saw a doctor somewhere, but I do not know what the surgery is called."

A Traveller came to see me and said that, rather than drinking, he had taken up religion. I said, "That's great. Which church do you go to?" He said, "I don't know. The sign has fallen down." He did not know whether the church was Catholic, Protestant or something else because the sign had fallen down. How are Travellers supposed to know the name of a practice that they went to in Aberdeen, or in another big town or in Lothian? They will know where a practice was in a rural area; they will know that it was the Appin or Fort William practice—actually, there are three practices in Fort William. It is very difficult to pin down a practice, but there could be identified practices for Travellers, and they would soon get to know them. They could even say, "We'll choose the practices that we're interested in."

14:45

The Convener: Would a proper mapping exercise of the routes that Travellers take need to be done in order for that approach to work successfully?

James Lambie: Absolutely.

The Convener: It would be difficult to identify a particular practice or a health centre unless a mapping exercise was done. I am sure that Dr McNicol knows the Travellers who come into his area and move on, but not everyone knows them. Does a proper mapping exercise therefore have to be done?

James Lambie: One question that we had was how much information we could get from local Travelling families who use roadside encampments about their direction of travel. The answer to that question was none. Getting such information would be very difficult. Perhaps there were concerns that asking that question would be quite invasive.

Given what Dr McNicol has said about trust and the fact that certain Travelling families would happily travel a distance or a considerable distance, I agree with and support 100 per cent the idea of having identified practices in health boards. If Travellers in individual families are used to going to certain practices and have built up relationships with people, we need to capture that. That should inform the start of the mapping.

The Convener: Does Annabel Goldie want to come in on that issue briefly?

Annabel Goldie: My question has been answered. I was going to ask whether the hand-held records system is defunct but susceptible to revival, but I think that what is being said is that there is a better way of doing things. That is helpful to know.

The Convener: I have a question for Joan Watson. You are a liaison health visitor. If Gypsy Travellers move into your area, do you visit them, send someone out to visit them, or wait for contact to be made from their side?

Joan Watson: I go to visit the families. Unfortunately, I do not know where they will be in West Lothian, but I will receive an e-mail from a council representative that says that a family is in the area. I will then either meet him or go out to visit the family if they wish to see me, although families often do not wish to see health visitors. I will go out with the council worker, who is my link, meet the families and give any healthcare advice that they want, which usually relates to their children. I was well known in West Lothian for a long time because of the site, but perhaps I do not know families that move in and out of West Lothian. Again, it is very much about trust. Families have known me of old.

The families that I used to link a lot with in West Lothian live in the Lanarkshire area. In fact, a Gypsy Traveller family has opened up its own site there, which has very good facilities, and many families that naturally lived in our area before have moved to better facilities in Lanarkshire. More families are moving into housing, and they will be linked to a GP practice. The health visitor who is attached to the practice will tend to deal with the families.

Several Gypsy Travelling families have moved into my area and are part of my generic case load in the practice that I work with. They are offered

the same healthcare that my other families are offered. There is a very flexible approach. My biggest input into working with Gypsy Travellers involves flexibility. Any health worker who works with Gypsy Travellers must accept that such families will move on very quickly and we will not know where they have gone, although they will sometimes say where they have moved on to. If they want to help, healthcare workers need to take a very flexible approach to working with Gypsy Travellers. The same applies to my GP colleagues in West Lothian.

We have been quite fortunate in West Lothian as, when encampments have developed in a GP practice area, the families have temporarily registered with the practice if they needed to be seen for any healthcare interventions. We generally find that the families in West Lothian are registered—not permanently, because they will not be in the area for any length of time, but temporarily.

James Lambie: I echo what Joan Watson says. I have observed that individuals from the two sites in Lothian may be registered with a local GP, and one of the practices has historically had an excellent relationship with those individuals, but we need more consistent support for engagement with the practices.

Using the example of people with long-term conditions such as diabetes, asthma and coronary heart disease, my evidence is that engagement with GP practices to address those on-going needs is very poor.

My experience has been similar to Joan Watson's. Since 2009, I have found that, in Lothian, health links have come through the police. The intelligence on where roadside encampments are comes to us from a Gypsy Traveller liaison police officer, who contacts either me or a colleague. As Joan Watson said, we will be as flexible as we possibly can be to go out and engage with them.

Those are our local findings, but there is a substantial body of evidence from other parts of the country to back them up. The fact that we are comparing our findings with significant and robust evidence from elsewhere is interesting.

Stuart McMillan: A word that has come up quite a bit so far is trust. It is interesting to hear what has been said.

In trying to engage, you must, as practitioners, operate using a flexible approach. Joan Watson said that when a family moves in, she will go out to see them first. Given the need to adopt a flexible approach and a proactive engagement process—and bearing in mind what was said earlier about hand-held records being viewed as a form of ID card—how do you build up trust to help families with their health needs? It sounds as if it is a really challenging task that you have to undertake.

Joan Watson: It is about respecting who they are as people, and their children. Gypsy Traveller communities should not experience inequalities in health. It involves just being honest and friendly to families, so that we do not alienate them. Over the past 20 years I have experienced that trust, and I have just been honest with families. We are there to enable them to access healthcare and to discuss any options for childcare, antenatal care and contraception.

James Lambie: If we are to make any healthcare interventions and develop trust, one of the most important things is to have a regular presence, which is tricky, given our resource and capacity. We are increasingly working in a very target-driven and outcomes-driven environment. That is no criticism, but it is obvious from the work that Joan Watson and I have done—we have discussed this at length—that we need to be visible and contactable, and regularly visit the local authority sites and the roadside encampments. We need to be not too precious about what we are there for. I have spent half an hour helping people to fill in passport application forms because they have no literacy. As I am a healthcare professional, people think that I can help them. That is completely okay.

Joan Watson: I have been known to bring my baby clinic to a field, where I have had the baby scales out. Once one family has come along and grannies have seen that that is okay, before we know it, a whole group of families will come to get their babies weighed and to get general healthcare advice. People need to trust that we are there for good reasons.

James Lambie: We have talked about flexibility. We must be creative and think outside the box. That is one of the reasons why I became a healthcare professional in the first place.

Joan Watson talks about setting up scales in a field. I have taken prescriptions to people who were working on building sites when there was no other way to get prescriptions to them. I have ended up meeting people in vehicles at such places—the windows go down on my side, the windows go down on the other side and prescriptions are passed over. We must be creative and persistent. It strikes me that that is resource intensive.

Dr McNicol: Such approaches can be efficient. As part of the healthy together project in Argyll, we hired a marquee, took it to a site and had a barbecue. The gents all stood back and were fixing their cars; they would pop forward to grab a hamburger, but they would not sit down. However, we gave all the ladies champagne glasses with

fizzy water in them. They sat there in the sunshine, with a barbecue, and they blew into the CO_2 monitor. Within four weeks of that, 80 per cent of those ladies had come for smoking cessation advice. The barbecue took a couple of hours and a couple of hundred quid, but we got about 25 people to take smoking cessation advice. That was quite cost effective.

James Lambie: Absolutely. What I said related to how planning is done.

Dr McNicol: I agree.

James Lambie: I echo what Dr McNicol said in relation to brief interventions. We have quite a lot of local evidence about improvements in people's weight, cholesterol levels and the amount that they smoke and drink. That is because we have been consistent and persistent.

Dr McNicol: When I previously gave evidence to a committee, I said that the life expectancy of my group of Travellers was 55 years. A good result is that, when I repeated the research in 2008, life expectancy was up to 61 years. In 12 years, we managed to go forward six years. There is definite evidence that things can be improved.

The Convener: Given what you have all said, is it fair to say that any improvements and changes have come more from a personal commitment than any strategy that the Government has fed down from the top? You are all committed to and innovative in what you are doing. Is that the driving force that has made the change?

Dr McNicol: That is part of the driving force. Everyone round the table and lots of people throughout the country are committed. However, when the Government says that it can support an initiative with money, time or whatever, that makes a huge difference. People might think, "I'd love to do that," but they might have 15 other things to do, including their day job. That is where you guys at the top can come in and say that you will support people.

James Lambie: I agree. The work that was done in Lothian for about 18 months from late 2009 was, unfortunately, curtailed only because the budget was cut. We created more capacity through funding in that period, when a lot was accomplished.

Joan Watson: I cannot speak for health visiting right across Scotland, but in my area, West Lothian, the continuity is provided by the fact that I have remained in post for all these years. I have had full support from my community management team to continue in my role. Jamie Lambie was right to talk about budgets. I cannot comment on how other health boards commit health visitors to working with Gypsy Travellers.

15:00

James Lambie: Blue-sky-thinking-wise, I cannot think of a better way of co-ordinating an approach than by resourcing it nationally and having personnel with the skills in each health board area. That need not be very expensive. It is about co-ordinating the work and linking with individual Travellers as they move between areas, which takes us back to what we said about having identified GP practices in each area. That is the ideal way forward

Annabel Goldie: Joan Watson has the advantage of having been in her role for a significant number of years. Does the fact that you have established a positive relationship with a family, who understand and feel the benefit of what you do, encourage them to strike up relationships with your counterparts in other areas when they move?

Joan Watson: Yes—I think that that happens. When the national resource centre for ethnic minority health was in operation, in Glasgow, it arranged a session for health visitors from all over Scotland. It was amazing to learn how many health visitors were doing similar work. No one had really known what we were all doing, but getting us together to talk about our links with families meant that we could take a note of who was doing the work, so that we could phone them if a family was moving to their area. We still have a network of health visitors who work with Gypsy Travellers, although it is maybe not as strong as it was several years ago. Once a family trusts a health visitor, I hope that they will feel the same way about the health visitor in the area to which they move.

James Lambie: In my experience, when we introduce new staff it is good to keep some continuity. We have to be careful, because sometimes people say, "Jamie, you're bringing in another new person," when in fact we are trying to keep an element of continuity. In my experience of supporting Travellers who have a new diagnosis of diabetes and who will be travelling to another health board area, I find it helpful if I can tell the individual, "I have talked to Mary in the other health board, and this is what she is going to do." People need to know that what the other person does comes with our backing. That is a plus.

Dr McNicol: Because we know GPs round the country, it is good to be able to say to a Traveller who is moving, "Right, go and see so-and-so and tell them that I said to look after you." It is amazing how often I get a phone call from a GP who says, "Oh, I saw your patient today and I did my best for them."

I once sent someone to a friend in Dundee—she used to be a friend; she is not now—who phoned

me and said, “Don’t ever send a dirty Gypsy Traveller to me again.” I have not spoken to her since. By and large, however, I get a positive response, and it gives the Traveller confidence to know that they have an intro.

James Lambie: In the context of adult physical and mental health, so much of what we are doing is about preventing bigger and costlier problems from arising further down the line. It is so much more cost-effective if we can prevent an in-patient admission for a heart attack or stroke, for example.

The general public is always being encouraged to be proactive about their health. When we started working with an anticipatory care approach in 2009, we thought that everyone who had worked with Travellers was being really negative, and that we had to be careful how we pitched it because the literature suggested that Travellers have a fatalistic approach and that their outlook is very now. In fact, we found a lot of individual buy in to the fact that you can prevent bigger problems from happening further down the line. That was quite an eye opener to me.

Siobhan McMahon: My question has been partially answered, but perhaps we can expand on it. I noticed that James Lambie’s briefing mentioned a particular GP practice in the Craigmillar area with good attendance levels. Do you have examples of what is a good practice to go to? Joan Watson mentioned the temporary registration at West Lothian. How do you increase attendance? Is that about how staff are trained or is it something else that we are missing out on? Will you give us examples of that?

As well as trying to get the attendance levels up and what has to be done to achieve that, after the appointment there are the follow-up calls, the letter writing and everything else that needs to be done. You have given some examples, but how feasible is it to roll that out across the country? If budgets are being cut, how do you get the staff to engage to ensure that everyone in society is represented equally?

Dr McNicol: In the 1980s, all our practice staff were trained not to push forms to anyone unless they knew they were literate, and that applied to everyone, including Travellers. In the old days, we had temporary residence forms, and people who arrived were told to fill in that form. We said to forget that, and that the staff were to fill in the form for anyone who came. If the person said that they would fill in the form, that was fine. I told staff that it would be gross misconduct for anyone to be in any way discriminatory or negative to Travellers—not that that ever became a problem, because the staff were very much on side.

One of the actions that we took in our project in the 1990s was to get hospitals to double-appoint people. Hospital staff sent, with the patient’s agreement, a copy of the outpatient’s appointment to the GP surgery. We then either found that patient or we telephoned the hospital and said, for example, that we knew that the patient was in Stornoway and would not be back for the appointment, that the appointment should be cancelled, and that the patient should not be put down as a did not attend.

If we thought that they were just frightened to go to the appointment, we tried hard to get a health visitor to go with them to the appointment. We had an excellent health visitor at the time, Margaret Black, who did a huge amount of work with Travellers. She told them what it was that they wanted out of an appointment, and wrote that down, ahead of time. We found that the Travellers suddenly found that hospital staff were saying that those people had a problem that they could help with, rather than describing them as non-attenders.

The Traveller father may decide that today he is going to move and he will hook up and go. The mother may say, “There are three hospital appointments for the children,” but the father will say, “We are going.” There is a strong culture in that and that has to be understood.

Cant is a birling language, and it is a pleasing language. That is how Travellers cope with society. If people in authority ask a question, they think that the person wants them to say yes, so they will say “Yes, doctor, I will do this.” You learn to read it and you know the way they say it. I might say, “You know you don’t have to say yes to me. You mean no, don’t you, and that you are not coming to the appointment. We will get on far better if you do that.” Then you get trust—again, we are back to trust—and they start realising that it is okay to say no. For example, I might say, “If I’m really asking you to do something that you don’t want to do, say no, or ask us to help you do it.”

Siobhan McMahon: James Lambie mentioned Craigmillar. What made people go to that practice?

James Lambie: An audit of attendance at a practice that is geographically close to one of the local authority sites and where a number of Travellers tend to go would be an interesting piece of work.

My impression is that the Craigmillar practice, which has known the Travellers for some time, is culturally a forward-thinking practice and understands well that other issues influence whether Travellers attend appointments.

I am sure that if Travellers' attendance at appointments were audited, it would be found that it is not as good as other people's. However, to support change in that would require quite a bit of work on the internal culture in health services. The "three strikes and you're out" rule and similar rules are prevalent in the health service and we know that Travellers do not work according to such rules.

Linda Irvine: With the focus on getting access to services such as psychological therapies, or on waiting times targets, the considered view is that there should not be a "three strikes" rule, particularly for vulnerable communities or people who are experiencing mental health problems and whose lives may be quite chaotic and vulnerable and who will not respond, for example, to receiving countless letters.

We have talked a lot about hand-held records, but it is now 2012 and we should be discussing how to use technology such as texting with mobile phones to improve communication within healthcare and with Gypsy Traveller communities. That cannot be beyond us, given that we are quite a small country. It would be innovative to consider how we could use telehealth initiatives to support some of our work with Gypsy Traveller communities.

Joan Watson: Hand-held records may not be used well, but most of my Gypsy Traveller mums will have the red book with which every family is issued for every new baby. The information in there will usually mean, for example, that I can get information about the baby's immunisation history, so that it can be checked. Nationally, the red book is used by all families. I find that the Traveller mums tend to retain the red books.

James Lambie: In addition, electronic patient records—such as TrakCare, which is used in NHS Lothian—are a good resource for information about individuals' attendance at emergency departments and any kind of alerts or urgent matters that I would not otherwise have access to. However, that of course means that we have to touch base to be able to pull up such information, and we must be aware of it before engaging with individuals in roadside encampments.

The Craigmillar practice is near the local authority sites. However, as I said before, people in roadside encampments find that that is a barrier to accessing and getting registered at GP practices. If Travellers receive the message that there is a barrier, they will probably come away with the attitude that health is not that important, which is the wrong message to give.

David Torrance: It is interesting to hear about the Craigmillar experience, because many sites across the 32 local authorities are isolated from communities, GP practices, education and social services and the Travellers themselves feel isolated. How important is it for the level of service that Travellers receive that sites are close to the service infrastructure and are easy to get to?

James Lambie: To be honest, if the Travellers' perception is that there is no trust, or they do not perceive the value of using a service, it would not matter that a site was just a stone's throw from services.

Joan Watson: One reason why the Bathgate site was closed was that it was underused. For years it was used very well, but for the last few years of its existence, it was not being used by the families.

I am not sure that local authority sites are the way forward for Travellers. Travellers themselves would agree that that is not the best way to live.

James Lambie: The site at old Dalkeith colliery is right underneath a massive electricity pylon.

15:15

David Torrance: Is the problem that local authorities have not spent any money upgrading the sites for a lot of years and so they have become unattractive for Travellers?

James Lambie: The amenities blocks that are on each pitch in the North Cairntow site at Craigmillar are in the middle of an upgrade. My understanding—although I could be wrong—is that the same thing is going on at the old Dalkeith colliery. I believe that money has been made available for maintaining and upgrading the sites.

Dr McNicol: Sites have tended to appear in places where local authorities find either cheap land or wasteland that no one else wants. For example, the Kentallen site was established in order to get rid of the new age travellers who had been there for 10 years. The council said, "The site is closing and is being updated. You'll get back in if you're a Traveller," and the police moved people on. The site is damp and dark. It is under a cliff and gets no sunlight, there is no television or mobile phone reception, and it is right on a main road. It is the most unattractive site imaginable. Above it is about 10,000 acres of forestry, which is on high land that has good visibility, is away from the main road and on which there could be a lovely site. About five years ago, we tried to set up an initiative to set up a sort of self-help Traveller site that would be run by the Travellers, with their own shop, their own hall—because they never have any public facilities to go to—and a museum of the culture of travelling people. The Scottish Government was willing to support it with some money, but one of the conditions that it set was that 24 Travellers would have to take responsibility

for it. I was to be allowed to be involved for three years, but 24 individual Travellers had to say that they would be responsible for the investment. However, we were talking about a budget of £5 million or £6 million, which was a bit of an ask for people who are not used to controlling anything other than benefits budgets.

There are things that could be done, with imagination and will.

Annabel Goldie: Joan Watson said that the Bathgate site had closed and seemed to suggest that local authority sites are not necessarily the answer. Did you say earlier that a new site has opened in Lanarkshire?

Joan Watson: I believe that a lot of the families who lived on the Bathgate site now live on a site in the Shotts area that is run by a Gypsy Traveller who lives there with a lot of his family. I do not know whether Travellers are doing similar things elsewhere in the country on land that they own.

There was a private site in Stoneyburn; it is now a private chalet park that is used as a retirement village. I think that the owners of that organisation are, historically, Gypsy Travellers, but Gypsy Travellers do not live in the retirement village. I believe that that family has several such enterprises up and down the country. However, the site was originally a privately run Gypsy Traveller site, before the family moved on.

The families in the Bathgate site would go to one particular GP practice and would be registered with that practice even when they moved away—the model is probably similar to that which operates in Craigmillar.

Jean Urquhart: It has been fantastic hearing how positive you are about Gypsy Travellers. Until today, I did not know about the investment that was made in 2006. What has come out of that? How have we moved on, apart from in the area in Argyll that you mentioned? Was the money invested only in Argyll and the islands?

Dr McNicol: That was a health initiative to reduce cancer and coronary heart disease. We put in bids under both camps. A pot of money of about £7 million or £8 million was bid for, and there was about £2 million on the table. It was a surreal process, because Pat Tyrrell, the lead nurse in Argyll, and I took a camp each and we went to the meetings, which we came out of without having been asked to speak. We were just told that we had gone through to the next round, and then we realised that we had got twice the amount of money that we needed. We said that we wanted only one pot of money. The board had been willing to give us two pots but said that it would withdraw one.

That was an Argyll initiative, but it was Traveller led. We got about four young Travellers involved, one of whom—Charlene MacDonald—Siobhan McMahon's father will remember from the Equal Opportunities Committee in 2001. I know that John Finnie knows the family well. As a 16-year-old, she spoke eloquently at Parliament on the problems of dealing with healthcare professionals. I found it quite funny, because I had been a doctor for many years and she was wonderful at pointing out the deficiencies in the service. She got an Argyll and Clyde NHS Board—as it was at the time—badge, which she wore with great honour. She got £20 a week or something for a little session as part of the initiative. It gave those Travellers real confidence that they could get employment and that their contribution was valuable. They liaised with Travellers on site so that they could tell health professionals the direction in which they should move things.

We held some awareness-raising events and we did the smoking cessation activity that I mentioned. A country house hotel let us use it for a day and its Egon Ronay chef showed the Travellers how to prepare vegetables and so on. For £30, he prepared a wonderful meal and they all swanned around the country house hotel with champagne glasses full of fizzy water. There was also a crèche for the kids. It gave them confidence and allowed them to realise that there are all sorts of things that they can do.

The Spean Bridge site fed into us quite a lot, and we got quite a lot of people from the Heatherywood site in Kirkcaldy and the Double Dykes site one in Perth. Word gets round. The initiative had a three-year natural lifespan, then that was it.

However, there were lots of spin-offs. Careers Scotland's work with Travellers took off in the west. A lot of Prince's Trust money was used to buy computers and to provide driving lessons for the youngsters. There was activity on literacy and a lot of people went on individual programmes. The concept of people going to Careers Scotland to get advice on education, careers and self-reliance represented a move away from dependency. There has definitely been an improvement in the feeling among Travellers that, with support, they can do things for themselves.

Jean Urquhart: When we have taken evidence from Gypsy Travellers, they have made it quite clear that many general practices refuse to see them. Is the percentage of such practices much smaller in Argyll, where awareness raising has been done? I find it difficult to get my head round the fact that a surgery would refuse to see someone who needed its services, given that it is publicly funded. I do not quite understand why that is the case. Is it because seeing Travellers

generates excess paperwork or because the doctors in such practices do not like Travellers. If so, why do they not like them? American tourists with no permanent address in this country can be seen by a GP, so the fact that some Travellers cannot be seen is an issue for me. Do more surgeries in Argyll now understand Travellers as a result of the work that you did?

Dr McNicol: There does not seem to be any great discrimination in the practices in Argyll—not overtly, at least. It is a paradox that although Fife is deemed to be a real black spot, a lot of young Traveller women make their way to Forth Park hospital when they are due to have a baby. They go to that hospital more than they go to any other hospital in Scotland, because they feel that they are welcomed and get a good deal there. It is a real paradox that a Fife hospital seems to be the one that they prefer. Travellers vote with their feet—they know where they are welcome and where they are not. They are very astute in that way.

James Lambie: One reason might be that GP surgeries are open from 9 to 5, which might not suit some Travellers. It has become fairly apparent to me that priorities change. What we think might influence somebody to seek health advice or an intervention of some kind might be irrelevant or less important to Travellers. It may be that their travelling patterns mean that it is much more convenient to pitch up at an accident and emergency department for minor things, which is exactly what we are trying to get away from through the approach that we have shown has worked locally on a small scale.

Dr McNicol: Counter to that, in the 1980s I hardly ever saw a Traveller before 5pm, as they would usually turn up at the front door at 9 or 10 in the evening. However, nowadays it is very unusual for Travellers to put in an out-of-hours call. They know when surgery times are and tend to come very early when there is an open-surgery system, because they know that they will be seen quickly and will not have to hang around. They tolerate the opening times and, with a few honourable exceptions, they are very good at playing the system.

James Lambie: That is the case when you know them and have a trusting relationship with them. I am referring to individuals who are travelling around.

Dr McNicol: Yes, but they can cope fine with the 9-to-5 surgery hours once they know that the system is there and there is trust. They do not say that they are busy during the day or whatever.

Joan Watson: They often do not have transport during the day, because the menfolk are away out.

Jean Urquhart: What does the profession make of a surgery that will not see Gypsy Travellers? Gypsy Travellers have made it clear that their experience is that they are not seen. Does the medical profession have a view on that? Has the awareness-raising work penetrated the profession to the extent that it is recognised that it is not the right thing to do, or do you think that it is okay?

Dr McNicol: I and, I think, the professional bodies—although I am not particularly in tune with one or two of them—think that the situation is appalling. As Jean Urquhart said, the NHS is a publicly-funded system. This year is the centenary year of the Dewar report. I will not get on my hobby-horse, but we were in Parliament two weeks ago for a debate on the Dewar report. We were celebrating the fact that 100 years ago a system started in the Highlands whereby healthcare was made free at the point of need. However, 100 years on people in Scotland are still being denied that. I would say that that appals probably 95 per cent of the Scottish population, with doctors being included equally among that. It is very sad that some doctors behave in the way that Jean Urquhart described.

Stuart McMillan: Mental health has so far been touched on only around the edges of the discussion. Linda Irvine mentioned it in her opening comments and briefly touched on it later. Members are interested to learn more about the challenges that you face in addressing people in the travelling community who have mental health problems. How do you help such individuals to obtain the treatment that they require?

Linda Irvine: We had a project a couple of years ago that looked at how people from black and minority ethnic communities access mental health services. We assume that people will go to a GP to seek help, as that is the primary care system.

15:30

From our research, which included work with Gypsy Traveller communities, we found that people do not necessarily go to their GP. Obviously, we need to take that on board and ensure that we open up access to services in order to help people with common mental health problems such as anxiety and depression. We have therefore introduced measures such as self-referral for exercise or for guided self-help. The NHS living life telephone helpline, which has been rolled out across Scotland, provides cognitive behavioural therapy by telephone and has increasing referral rates.

For me, the biggest point is that we should not assume that the Gypsy Traveller population has different needs; they have needs similar to those

of the general population, but the difference is that those needs are coupled with stigma and discrimination, which also have an impact on people's mental health and wellbeing. The last thing I want to do is set up a specialist mental health service for the Gypsy Traveller community. I would rather work with people such as James Lambie and Joan Watson because—we have returned to this time and again—they have that trusting relationship. People are more inclined to talk about their mental health and wellbeing if they know the person whom they are talking to, whether it is a health visitor, GP or mental health practitioner. They are more likely to open up about the issues.

We need to be aware that, alongside the long-term conditions and physical healthcare needs of the Gypsy Traveller community, there are co-occurring mental health problems. Even with the general population, we are not always as good as we should be at recognising that. For example, if someone is diagnosed as having diabetes, we need to consider the impact of that on their mental health and wellbeing. In Lothian, we hope to bring together much more closely physical healthcare and mental healthcare to stop mental healthcare being such a specialist service. For some people, mental healthcare will need to continue to be a specialist service because they need that level of support, but we want to address the stigma that is attached to people talking about their mental health and wellbeing.

There are many opportunities, but it is absolutely key that we build on the trusting relationships that already exist.

Stuart McMillan: Are any particular mental health issues prevalent among the Gypsy Traveller community?

Linda Irvine: We have seen high levels of depression.

Dr McNicol: Particularly among Gypsy Travellers, but also among the general population, there is a high proportion of depression that becomes a condition that I would call despair, which is not responsive to antidepressants. That group of people are not particularly prone to committing suicide, so they are stuck in an absolute dead end of despair. We have to think in totally different ways for them.

On addiction to prescription medications—particularly benzodiazepines such as diazepam—a lot of work worldwide has shown that ethnic minorities do fairly well if they are kept on controlled amounts, which is different from what we do for the rest of the population, whom we try to get off such medication. Minority groups throughout the world, such as red Indians, Aboriginal Australians and various other groups can survive in life with an amount of benzodiazepines without which they will go into depression, suicide and despair. Therefore, we have to treat Gypsy Travellers slightly differently, although within the general framework.

There has definitely been an improvement in the association with alcohol. In 1997, I went to the funeral in Lochgilphead of the patriarch of a large family. It was a huge funeral. Before we went into the church at quarter to 12, there were cases of McEwan's export and lager. As we went up the path, I was asked, "Would you like a beer, doctor?", to which I replied, "It's a bit early for me and I'm driving, so no, thank you." A sort of parliament of perhaps a quarter of the men were drinking heavily. When the service started, the minister had a hard time, because the parliament would either agree or disagree with everything that he said. The poor minister was starting to shake badly by the end of it. That was fascinating.

Two years ago, I went to the funeral in Oban of the brother of that man. More or less the same people were there, but there was not a hint of alcohol at the church. After the committal, the people got into vans and disappeared. Twelve years earlier, more or less the same group of people were out of it, but that day they just went away. There has definitely been a change in the attitude to alcohol. There are a lot of mental health issues, which have to be treated slightly differently, but within the framework of all that we are doing.

James Lambie: It is interesting that, as far as I am aware, no Scottish research has been done on the prevalence of depression among Gypsy Travellers or their experiences of mental ill health in Scotland. Some research has been done down south, and there was a fascinating piece of work in Ireland called the "All-Ireland Traveller Health Study". There are echoes of the findings from that study in the Travellers whom we see—they are not the same individuals or the same groups, but the study is a fascinating read all the same.

With regard to mental health, I have noticed, over a couple of years of working with Travellers only, that it takes repeated contact and the realisation by a Traveller individual that it is safe to talk about certain things with you. That is the same for members of the individual's family: they will say, "Okay—I can talk to you about that person's moods".

A few weeks ago, I referred a lady on one of the sites to a physical health programme called healthy active minds, which is for people with depression or anxiety. I could see the penny drop for her as I was asking her certain questions. She realised that she had been living with depression for the past few years; she had not realised it before.

Joan Watson: Mental health issues are a very sensitive area for Gypsy Travellers, so we have to work at that very slowly. Families do not come forward with mental health issues, and it sometimes takes a bit longer for the rest of the family to accept an individual with mental health issues than it does for families of individuals in my generic case load.

Dr McNicol: We held a meeting with Irish Travellers at Pavee Point about 10 years ago, when the issue of hand-held records was coming up. I remember that a penny dropped in my mind that day, because we were talking about screening. We all know why we have to get screened for breast, cervical or bowel cancer, or for mental health issues, but the Travellers did not understand. They said, "I've been screened, so why do I need to be screened again?" They did not understand the physiology of the human body. They think that we live in a box, and that if you screen part of the box, you screen the whole box.

As part of the Argyll project, we held physiology and anatomy lectures for them. We said, "This is what the different systems do, this is why different things go wrong and this is why doctors screen", and we could see their reaction. That sounds patronising, but given that they are illiterate and that their access to education has been very limited and prejudicial, and that it has been based on what the father has allowed to be discussed, getting that information across allows them to understand the concept of things such as mental health. They begin to understand that their brain may not be working well, even though they are physically fit.

Joan Watson: Mental health is something that often they do not want to talk about.

James Lambie: That is also true for sexual health, sexuality, domestic violence and so on. Again, it goes back to trust.

The Convener: Unfortunately, I will need to bring this evidence session to a close. I thank you all for coming along and giving us your evidence. The information that you have given us has been very useful and will certainly help our inquiry.

I will just mention one particular issue that we must look into further, which is the need for a dedicated and named GP service, which would, it seems, solve the obvious problem. If a mapping exercise is done and we have dedicated surgeries and health centres, that would also solve a number of problems.

I suspend the meeting briefly for the witness panels to change.

15:39

Meeting suspended.

15:46

On resuming—

The Convener: I welcome our second panel of witnesses. I ask them to introduce themselves and give us a résumé of their involvement with Gypsy Travellers.

David McPhee (Perth and Kinross Council): I work in Perth and Kinross Council's housing and community care service. Part of my remit is to co-ordinate our response to the equalities agenda across our service.

Initially, my work with the Gypsy Traveller community was in the background—I arranged and commissioned cultural awareness training for our staff, which Gypsy Traveller community members delivered. However, in the past year, we have tried to move forward the theory of that training into a more effective approach in practice by staff who have received the training. We have tried to promote a more positive approach in the council to our community engagement activities with local Gypsy Traveller communities, in partnership with others—particularly the minority ethnic carers project for Gypsy Travellers that is run by the Minority Ethnic Carers of People Project, from which I know that the committee has heard.

That is my role. I was particularly interested to hear the issues that were raised in the first evidence session on engagement, barriers and trust. They are common themes and I hope that we can talk about our experiences of those issues in Perth and Kinross.

Kenneth Leinster (South Ayrshire Council): I am the head of community care and housing in South Ayrshire Council. I am responsible for co-ordinating and overseeing issues that relate to our permanent site and the unauthorised encampments in South Ayrshire. I am the local authority lead officer for housing matters and I liaise closely with colleagues on social work and education matters that relate to Gypsy Travellers. I am also the lead liaison person with NHS Ayrshire and Arran on health issues that relate to Gypsy Travellers.

Lesley Boyd (NHS Lothian): Good afternoon. I am the health inequalities manager at NHS Lothian. My role focuses on tackling inequalities that are experienced by people with protected characteristics. Since about 2001, I have chaired the Gypsy and Traveller health steering group, which picked up and carried on work by the Equal Opportunities Committee. We have looked at and

developed the role of health visitors in NHS Lothian.

Over the years, as money has dried up, we have tried to be creative in how we respond to the Gypsy Traveller community's needs. We have pulled together a group of agencies. It is not just health staff who attend health steering group meetings, because responsibility does not just lie with the health service. We have council representation from children and families services, we have housing staff and we have GPs. MECOPP has just agreed to join us and we have people from Article 12 in Scotland, who are considering younger Gypsy Travellers' needs.

Initiatives for working with Gypsy Travellers sometimes seem quite fragmented. By pooling our resources, we felt that we could make a more coherent response to the Gypsy Travellers in our community in Lothian, as well as look ahead to what a service for the community might look like. We cannot think of it only from a Lothian perspective. If we acknowledge that Gypsy Travellers necessarily travel around the country, it would be more sensible to think about a national service and to pool our learning from James Lambie's work, particularly the keep well project. We have a far better understanding of Gypsy Travellers' health issues. We would like to see the development of a national service. That was touched on in the earlier discussions.

The Convener: Thank you. Before I open up the session to questions from members, I have a question for Lesley Boyd. Do you have, or do you intend to have, a tailored health programme targeted specifically at the Gypsy Traveller community, because it has specific health issues?

Lesley Boyd: We do not have a decision on that. We are very aware of the particular health issues that Gypsy Travellers experience. We have seen the model that James Lambie was talking about, in which a particular, trusted health worker provides a cultural bridge into other services. We see that as quite a useful model. We have heard enough to know that Gypsy Travellers will not access normal health services. That just does not work, and it does not happen.

Someone asked for an example of good practice. There is a GP practice in Dalkeith that invited Gypsy Travellers to meet the GPs, reception staff, practice nurse and health visitors and talk about what kind of service worked for them. It helped to clarify a GP's expectations of somebody who uses the service and, similarly, what the Gypsy Travellers needed.

In answer to your question, there is not one way of doing this. We have to give Gypsy Travellers a better understanding of what is available to them. We want to enable them to have improved health and there are creative ways in which we can do that, but they need to be co-ordinated and to link into the range of other agencies—voluntary and public sector—that are involved with the community.

The Convener: Does anyone else want to come in on that issue before we move on?

John Finnie: I was going to ask Lesley Boyd what she is steering and where she is steering it to, but I think that she has answered that.

I have a couple of questions for the panel. What are the criteria against which you judge whether you are successful?

When your papers talk about Gypsies and Travellers, does that include Gypsies and Travellers who have settled—if that is the correct term—in the settled community? We often hear from the Gypsy Traveller community that they have been told that all their problems will be resolved if only they get a house. I do not think that it is as simple as that.

Lesley Boyd: Our interest would include Gypsy Travellers in houses. We are quite concerned about them because they are very much a hidden community. They do not necessarily identify themselves. Just because the census now collects that data does not mean that a person would necessarily identify themselves as a Gypsy Traveller. It is in the same column as identifying that you are Scottish, and being a Scottish Gypsy Traveller is quite important. Gypsy Travellers in houses experience many of the difficulties that Gypsy Travellers experience on sites and roadside pitches. We can certainly link them into GP practices but some of the same mainstreaming issues remain. They need additional support, when we can identify them.

John Finnie: What about the criteria for judging success?

David McPhee: Our starting point for our engagement activities was to recognise that if Gypsy Traveller community members have a poor experience or a perceived poor experience of a council service or their first point of contact with the council, it may put them off further attempts to engage with them. It does not matter how well written a policy is; if it is not put into practice and the first time that a person goes through the door they are met with what they perceive as a barrier, that will put them off having any future engagement.

Success must therefore be built up slowly and cannot be judged just by numbers coming through the door. If a service is put off by small numbers and immediately closes the doors, that creates the perception that people do not want to engage.

We have to persevere and acknowledge that although there is a big stigma about being recognised as a member of the Gypsy Traveller community at times, there is also a stigma about working for the council. As soon as someone who approaches the community is recognised as a council staff member, the members of the community become unsure about whether that staff member is there for the right reasons, because of their past experiences.

We have to keep plugging away and must involve partners who know the community and whom the community trusts. That is why we have worked so closely with MECOPP in the past year and why we have invested in appointing a development worker in Perth and Kinross for the year ahead. We want to continue that approach because sometimes having another agency between the council and the community can help to move things forward more successfully.

Kenneth Leinster: John Finnie asked a good question, which allows us to have a conversation about Travellers who have settled and those who have not. We have a site in South Ayrshire with eight pitches whose popularity means that it is difficult for people to get on to it. There is a differentiation between the people on that site and those on unauthorised encampments.

We have a site manager who is also the liaison officer and the face of the council. His approach is key to Travellers' engagement with the council. He is extremely successful in engaging with the residents on the site and the people who live on the unauthorised encampments. He builds up good relationships with people, which is crucial. He also takes a proactive role in engaging well with local health services, particularly through the liaison health visitor. Health visitor services tend to be universal, which allows access to a range of other services.

NHS Ayrshire and Arran is extremely good at providing services for Gypsy Travellers, who have no difficulty in accessing any of the GP practices. There might be difficulties in that regard in other areas, but not in Ayrshire and Arran, where the approach is very positive.

The key aspect for local authorities is to ensure that we have an open and welcoming approach rather than one that puts up the shutters and tries to prevent people from coming in. We think that our open and welcoming approach works in our favour and that it has been beneficial in building relationships with people who come back regularly, which is vital.

We can identify whether things are improving to a degree by looking at the take-up of services. Hand-held records were mentioned earlier. Such records are well used within the settled community—that is beneficial—but there is less take-up within the non-settled community.

Another question is how open other council services are to enabling Gypsy Travellers to access them. If the council has an open face, other aspects of the council will be open as well. For example, we have Gypsy Traveller children who attend school regularly, and we are able to provide literacy education not only for adults but for those children who do not attend high school, who can access that literacy education, which we provide on-site.

16:00

Siobhan McMahon: I am interested in what Kenneth Leinster said about there being no problems—or at least no perceived problems—in NHS Ayrshire and Arran. What data do you have on that, given that in the previous evidence session we talked about the need for an audit of GP practices? Is there some raw data that we can look at?

You also said that liaison officers are a good thing, as they are the face of the council, with whom Gypsy Travellers can interact. However, in every evidence session that we have had, Gypsy Travellers have told us the contrary: that they do not like liaison officers. What evidence do you have for your statements?

Kenneth Leinster: I suppose the evidence is that, although our liaison officer—like every liaison officer—has a difficult job, there is a very high level of trust among the settled community, to such an extent that our officer carries out a semi-representational role for them. He would not be able to do that unless he had that level of trust.

Mental health was mentioned earlier. We are devising our mental health strategy and our liaison officer is a key part of that work. It would be ideal if members of the Gypsy Traveller community were able to contribute to the strategy, but they can do so through the liaison officer. We think that that role is beneficial.

With regard to unauthorised encampments, the liaison officer sees the same people year in, year out, and a degree of trust has built up between him and them. He is clear about what the council can and cannot do, and what it expects people to do if they are on our land on unauthorised encampments and what condition they should leave the site in. That does not always work out in the way that we would want it to, but the rules are quite clear. His first job is to explain the rules, and then he works with those people closely on an on-going basis.

The liaison officer's job is also to ensure that he is the access route to health services. He will say,

"I can get the health visitor to come and see you if you so wish". He takes on that role and liaises closely with the health visitor.

The evidence shows that there is a very close working relationship with the settled community, of whom a large number access mainstream services. With regard to the unauthorised encampments, the evidence seems to be the very fact that those people know the liaison officer and he knows them, and that everyone knows what the rules are so that we can build on that. However, it is difficult to provide any specific facts or figures in that respect.

Jean Urquhart: What are you calling a settled community?

Kenneth Leinster: I am describing as a settled community the site that we have with pitches for eight caravans, on which there are 32 residents at this point in time. That site, which is on the outskirts of Girvan, contains the main bulk of our settled community. As I said earlier, it is permanent and always full, and it seems to work very well.

There has been some discussion about the use of local authority permanent sites. In our experience, those sites work well if they are well managed and well planned, and if there is good liaison with the folk who stay there.

One other aspect relates to history. There may be historical reasons why some sites do not work very well; they may have a chequered past, which can mean that they are not particularly well used at all. That problem can go back over a long period of time, which brings me back to my point that sites need to be very well planned and managed, and to have a lot of attention paid to them.

Jean Urquhart: You said earlier in answering a question from John Finnie that the site that you mentioned is very popular. There are eight pitches for the whole of your local authority area. You also said that the site is so popular that people go back to it. That suggests that people leave it.

Kenneth Leinster: The arrangement is that people can stay permanently on the site, but they can travel for 12 weeks of the year and then go back to it. We will hold the place for them for 12 weeks so that they can travel and then go back to the site. We think that that arrangement is quite flexible.

Annabel Goldie: I want to ask about the terminology. I am grateful for the clarification on settled communities. Are the unauthorised sites of a temporary or permanent nature?

Kenneth Leinster: They are temporary. They are used by people who are travelling, particularly at this time of year. Many of those people are travelling to Ireland; they go through South Ayrshire on their way there. There can be small groups with two or three caravans who stay for one or two nights, or larger groups who stay for longer.

Annabel Goldie: Given that the permanent site is apparently very successful but pretty small, is there any provision for people in transit?

Kenneth Leinster: There is no provision for people in transit, but we are working with a neighbouring authority to see whether we can identify a transit site. That has proven to be quite difficult. One of the big issues is the size of a transit site. History indicates that we need more than one relatively small transit site rather than large transit sites. Identifying the appropriate places for all such sites has proven to be quite difficult.

David McPhee: Annabel Goldie mentioned the terminology. One of my bugbears is that, when the policy for unauthorised encampments is mentioned, a negative connotation is immediately given to the general public. I do not know whether you could consider calling unauthorised encampments something else. I know that they are not authorised, but the phrase has a very negative connotation that people immediately pick up on. That is what they hear about.

I echo what Kenneth Leinster said about transit sites. We, too, have set aside funding for a dedicated transit site in Perth and Kinross, and we have proactively sought a suitable location for it over the past year or so. Two prospective sites have been identified, but their suitability is being assessed. The process takes time. We must get the message out to the Gypsy Traveller community that such things cannot happen overnight, unfortunately. We involved members of that community in consultation and asked them what areas they travel through. We gave them a big map at an event last year to try to identify prospective areas that they would use more regularly.

When a liaison officer or health visitor, for example, first goes to somebody who is travelling through a local authority area, they give them information. People are probably given the same information in a different format in 32 local authority areas. There must be a common format. The emergency contact numbers will be different in different local authority areas, but if people are given information that looks the same, they will know where to look for the health phone number for Perth and Kinross or Ayrshire. The numbers will be on the same bit of the paper, which will lessen confusion. Perhaps that can be considered.

Annabel Goldie: I hear what you are saying about the connotation of the phrase "unauthorised

sites", but I was trying to use it in a fairly positive sense. It seems to me that Gypsy Travelling people in transit have a legitimate desire to stop somewhere for the night, but we have heard in evidence that it is very difficult for them to do that without their being asked to move on, shift or find somewhere else. If we all know that a community is a Travelling community that tends to have a pattern of travel, would not it be sensible to try to construct bases that it knows it can go to overnight without being moved on?

Kenneth Leinster: That is absolutely right, but two things have happened. First, the number of potential places where Gypsy Travellers can stay for one or two nights has been reduced significantly because local authority-owned land or private land has been configured in such a way as to prevent people from getting on to the sites. Secondly, when Gypsy Travellers come on to a site, we visit them and talk to them about how long they are going to stay there. There is a general understanding that, if they are there for two or three nights, we will let them stay there for that time and then move on, but if they are going to stay for longer than that there might be an issue.

Stuart McMillan: My question is about aids and adaptations but, before I ask it, I have a question about the site in South Ayrshire. Is eight an adequate number of pitches for the number of Gypsy Travellers who pass through South Ayrshire? If you could enlarge the site, what would your optimum number of pitches be?

Kenneth Leinster: It is a permanent site and there is not much turnover on it. Is it large enough? Probably not, but we do not have the opportunity to enlarge the site because of its geography. We would not prefer large sites anyway; we would prefer a larger number of smaller sites to a large site. Smaller sites are much easier to manage, it is easier to build up a sense of community in them and it is much easier to bring resources on to such sites with greater opportunity for those resources to be taken up. In particular, we bring adult literacy on to the site and we have a learning suite on the site that is very well used.

Stuart McMillan: When a family take up a pitch on the site and it looks as though they will be there for three, four, five or six months, are they charged local taxes? If so, is a fairly high percentage of those taxes collected by the local authority?

Kenneth Leinster: The average length of stay for people on that site runs into years and they are charged rent for the site by the council. They pay both rent to the council and council tax.

Stuart McMillan: One issue that has been raised with us concerns the adaptation of accommodation for a family who care for a disabled family member—a disabled child or an elderly person who has physical health issues. How does South Ayrshire Council work with such a family to provide the aids and adaptations that are required?

Kenneth Leinster: People who access the services through South Ayrshire Council are entitled to exactly the same services as anyone else. There is a single, shared assessment and we then look at the specific needs and identify what can be done for them. That is the theory; in reality, it is a wee bit different because people are not keen to have social workers coming round. We approach the matter through the liaison officer—or, potentially, through the health visitor—and an occupational therapist is involved in the process.

I do not think that we are particularly successful in the area. One of the challenges in occupational therapy terms lies in adapting the interior of a caravan and providing a ramp to the outside. We have been looking at that, and recently we asked the occupational therapist to make contact with the caravan providers. If we have a large number of off-the-shelf adaptations for mainstream houses, we should be able to provide exactly the same service for people in caravans. To date, we have not done particularly well on that. I have asked my staff to look at that much more closely, to ensure that everyone has the right opportunities and an equal opportunity to access the service. As you said, Gypsy Travellers pay council tax and rent, so they are perfectly entitled to such services.

16:15

Stuart McMillan: Going to the manufacturers is a good idea, particularly because caravan doors tend to be a lot narrower—I suggest that trying to get a wheelchair through them would be impossible.

What is the average time for an assessment for someone who requires assistance?

Kenneth Leinster: I return to the point about having a trusting relationship. People do not have a strong trusting relationship with someone who comes along from the council and says that they are a social worker, but they are much more likely to have a trusting relationship with a liaison officer, who can work with a social worker or an occupational therapist to build a relationship.

The key aspect is not how long an assessment takes but how long it takes to build an appropriate and trusting relationship that allows a local authority to ensure that people get what they need. We must be flexible enough to accommodate the needs of people who are on our site—that is the approach that I would tend to take. It is up to us to be flexible enough to do that.

Stuart McMillan: From speaking to your colleagues in neighbouring local authorities, do you have an indication of the time that they take to assist someone who needs aids and adaptations?

Kenneth Leinster: I cannot speak for other local authorities. You will be aware that the demand for occupational therapy services is huge. Most local authorities have waiting lists for those services and have different ways of managing their lists. Being a member of the Gypsy Traveller community should have no bearing on how someone is treated—they should be, and are, treated in exactly the same way as everyone else is. If a service has a waiting list, the fact that someone is a member of the Gypsy Traveller community should have no bearing on that.

Stuart McMillan: If you as the head of the service in South Ayrshire Council could do one thing to assist people in the Gypsy Traveller community to obtain aids and adaptations, what would be your top priority? If there were no barriers to accessing finance or equipment, what is the top thing that you would ensure happened to assist people?

Kenneth Leinster: There are not necessarily barriers to accessing finance or equipment. People in Gypsy Traveller communities have exactly the same rights as everyone else has. My key point is that occupational therapists need to be sufficiently skilled to deliver the services that people need. Whether someone lives in a tenement close, a ground-floor house, a bungalow or a caravan should make no difference to the service that they receive—they are perfectly entitled to exactly the same service that everyone else has.

Annabel Goldie: When was an adaptation for an elderly or disabled individual last installed on your authorised site?

Kenneth Leinster: I cannot say off the top of my head, but I imagine that such instances are extremely few and far between.

Jean Urquhart: I want to pick up on the point about universal services being available to Gypsy Travellers just as they are available to everybody else. What we have heard suggests that Gypsy Travellers often need a different service, which requires an understanding of their culture and how they live. For example, I have learned that being in fixed housing can bring its own health problems for Gypsy Travellers, although we might like to live in such housing.

Is there an understanding that Gypsy Travellers' needs can be different? You used the word "trust" a number of times. We all have to trust the people who give us advice about health or whatever, but I appreciate that you acknowledged that trust is a particular issue for Gypsy Travellers, particularly when we talk about delivering health services.

Kenneth Leinster: You are right. I was saying that Gypsy Travellers' entitlement is exactly the same as anyone else's; it is how services are delivered that might be slightly different. It would not be right just to turn up with a social worker and say, "I'm here to complete your single shared assessment"; the right approach is to go through people with whom the Gypsy Traveller has a relationship of trust. In my experience, that is one of two people: the liaison officer or the health visitor. We use those people as a conduit, to ensure that Gypsy Travellers get the right services. I certainly would not send anyone to see a Gypsy Traveller unless they were accompanied by the liaison officer or the health visitor—that is, someone in whom the person has a high level of trust.

David McPhee: I am no expert in aids and adaptations, but in a conversation with our occupational therapy team leader I was led to believe that there is a slight difference in policy in relation to the awarding of grants for adaptations in caravans or chalets, which can mean that the process takes slightly longer. The situation with regard to the legislation might need to be verified, because what I have said is based on a brief conversation. I accept that it sounds as though I am saying that Gypsy Travellers are treated differently, because they are more likely to stay in a caravan or chalet than in a fixed house.

We need to take a more flexible approach, through the engagement process that we have started. The council funds a range of voluntary sector services, such as independent advocacy and carers centres, but if Gypsy Traveller community members are not accessing such services we need to work with them to make the services more accessible.

We rely on organisations such as MECOPP, which are close to the community and are trusted, particularly with regard to carers issues, which is MECOPP's area of expertise. If MECOPP tells us that something is not working for a community, we need to consider how to make it work better. There is a move towards personalisation and self-directed support, which is a prime target area that could benefit the Gypsy Traveller community, as long as we do not allow the bureaucracy to get in the way of the policy—if the system becomes too bureaucratic, it will not be personalised.

The Convener: Is the very nature of the Gypsy Traveller lifestyle a barrier to access to self-directed support? How will people maintain a service when they are moving between local authority areas? As self-directed support is rolled out, will people have one set of paperwork or will they have to go through some sort of assessment

and application process with each local authority? I agree that self-directed support could benefit Gypsy Travellers, but there are barriers that might limit the community's access to such support.

Kenneth Leinster: There are difficulties. There is a difficulty with the concept of portability of care. There is a desire to have a single shared assessment that people can take to any local authority to get exactly the same service, but that has not been agreed or finalised, which will without a doubt present a distinct barrier to accessing care. There might be ways round that. I understand that the Social Care (Self-directed Support) (Scotland) Bill team is still working on a number of issues, and that is certainly one that needs to be taken up.

To return to the point about occupational therapy services, one interesting issue is that Gypsy Travellers on a settled site pay rent to the local authority for the site, but they own their caravan. That is potentially a slight issue. Anyone else in the community either owns their house or rents it. A person who owns their house can go through a grants system for OT adaptations and a person who rents can go a slightly different route. People who are on a site come somewhere between those. However, that should not mean that they are not entitled to the service. When such bureaucratic issues arise for people, it is the officers' job to ensure that they get what they need.

The Convener: I will certainly check out David McPhee's point about the differences in legislation for people accessing grant funding, and we will copy any information that we get to him.

John Finnie has a question.

John Finnie: The point has been covered, so I would be raising a new point, but other members might want to ask about the current issue.

The Convener: Okay.

What awareness training have the panel members been involved in? I know that David McPhee has been involved heavily in that, so it would be useful if he gave us a flavour of that work and his involvement with the Gypsy Traveller community in rolling that out.

For our other witnesses, what involvement have you had with awareness training, how far is it rolled out in local authorities and what involvement is there with the Gypsy Traveller community in delivering it?

David McPhee: As I intimated at the start of the discussion, my first involvement in our work with Gypsy Traveller community members related to awareness-raising training. Since 2007, we have been commissioning Gypsy Traveller cultural awareness-raising training for staff, which is facilitated by an independent person. Currently, that is Michelle Lloyd, who works with MECOPP. She originally worked with Save the Children to provide similar training but, a number of years ago, Save the Children dropped Gypsy Traveller issues as a priority area of its work. However, we continued to commission training through Michelle Lloyd independently and, latterly, when she took up the role with MECOPP. The reason why we have continued to commission the training is that the feedback is always positive. It is facilitated by Michelle and delivered by Gypsy Traveller community members in a way that is at times forthright and humorous but which challenges service providers and members of staff who are attending. The training opens the eyes of many staff members.

The trainers now tell us that the people who are attending are perhaps not the ones who should be attending. People attend because they are interested and they want to improve their knowledge and learn, but the staff who do not come along are perhaps the ones who should be targeted for training. We perhaps need to try a more targeted approach in certain council services.

At times, we have opened up the training to other partners, particularly our health colleagues. On one occasion—we know that it was only once, as it was particularly noted by the trainers—a police officer attended. We are keen to continue that training and to build on it. We also have buy-in from the person who is organising the induction training for all the councillors who were elected recently—an element of such training will be part of their induction over the coming weeks.

16:30

On the other side of the coin, we have a long-standing and extremely positive relationship with Show Racism the Red Card, which delivers out of site anti-racism training to schools. It focuses specifically on racism that is targeted at members of Gypsy, Roma and Traveller communities. Show Racism the Red Card chose Perth as the venue for the launch of the out of site materials in 2010 because of the working relationship that we had with that organisation. During the current school year, we have used those materials in local schools for the first time. As part of an annual programme of Show Racism the Red Card workshops, nine primary schools have received out of site workshops, which 347 pupils have attended. In addition, we have had general Show Racism the Red Card workshops, which have involved another 27 primary schools and which more than 750 pupils have attended. That work has been done in partnership with the St Johnstone community coaching team.

We think that such work will have a more positive influence on the message that goes out to our young people than negative media reports or "Big Fat Gypsy Weddings"-type sensationalist television programmes and that, in time, that will permeate our local community.

Kenneth Leinster: South Ayrshire Council has an extensive programme of equalities training that deals with a number of issues. Our liaison officer has run some limited training for a number of staff across the council who have had or who are likely to have significant levels of contact with the Traveller community, but most of our training is done through the general equalities training that is organised corporately in the council.

Lesley Boyd: NHS Lothian provides equalities training. In addition, at various times over a period of several years, Gypsy Traveller-run training—in which Michelle Lloyd and Save the Children have been involved—has been provided, which has been very well received. The training on hand-held records that has been mentioned has also been provided, which, again, has been led by Gypsy Travellers. Although such training is not built in on an annual basis, it is open to anyone to attend it and people are strongly encouraged to do so. It is always well received, and it has always been multi-agency training.

The Convener: We understand from the dialogue that we have had in the past with the Gypsy Traveller community that particular cultural issues arise when Gypsy Travellers access care and support services. Does the training that you do highlight that? Has it facilitated Gypsy Travellers accessing the personal care services that they need?

Lesley Boyd: Our experience is that that has certainly been raised in the training. In an effort to work in a personalised way, we would ask a Gypsy Traveller patient how they would like to be cared for and how we could meet their needs while they were in hospital. We would be involved in a dialogue.

David McPhee: Specific care training is now delivered, as well as more general cultural awareness training. The case studies that are used as part of the care training are focused on specific care issues that have been identified, and they relate to real cases involving members of the Gypsy Traveller community.

Jean Urquhart: I have a quick question for Lesley Boyd and David McPhee. Were you surprised to hear that there was not a problem with Gypsy Travellers accessing GP practices in Ayrshire, or were you surprised to hear that there was such a problem in other parts of Scotland?

Lesley Boyd: I was surprised to hear that there were no problems in Ayrshire. I am aware that, even within Edinburgh, some practices are easier for Gypsy Travellers to access than others.

Jean Urquhart: What is the situation in your own health board area?

Lesley Boyd: There are practices that are easier to access than others.

David McPhee: It is probably a common theme, as was highlighted in the previous evidence session. Although I do not know about it specifically, I am sure that it is also common in our area.

Lesley Boyd: That is why I brought up the example of the Dalkeith practice, which met Gypsy Travellers to check out what their expectations were, so that GPs could provide a better service and Gypsy Travellers would know what to expect. Such a dialogue is helpful.

John Finnie: Given your title of health inequalities manager, do you know of any other group that encounters similar difficulties? For example, I know that homeless people are refused access to GPs in the Inverness area and that the health board there has provided a dedicated GP. Are you aware of groups other than Gypsy Travellers that encounter difficulties in your health board area?

Lesley Boyd: In Edinburgh we have an access practice that is specifically for homeless people, so that would be their first port of call. They would be linked into other practices when they get into housing.

The other group that is currently causing us most concern is the Roma community, which is small in number but has many of the same issues as Gypsy Travellers when it comes to accessing health services. They come from the accession 2 countries, so they have slightly different rights. Like Gypsy Travellers, they find that a particular practice is easier for them to access, so they all tend to go to that practice. There is again a mismatch of ideas about what they can expect from the practice. Their understanding of healthcare is quite different from what we deliver in Scotland, so we must ensure that we do not make assumptions about their needs and that they do not make assumptions about what we do or do not deliver.

John Finnie: Of course, general practitioners are commercial businesses that are outwith the direct control of the NHS.

Lesley Boyd: Yes, most of them are.

David McPhee: I believe that the University of Salford is doing research on Roma issues across the UK. I completed a survey yesterday with one of the BME organisations that we work with. A common theme is perhaps emerging, as that

organisation said that the Roma in our area are not necessarily identifying themselves as Roma first; they are identifying themselves as Polish or Slovak Roma. Stigma is still associated with being a member of the Roma community, so they identify themselves in such a way that the Roma bit is hidden. There might be a bigger issue than we think there is, because they identify themselves according to their country of origin, rather than as Roma.

The Convener: As committee members have no further questions for the panel, I thank the witnesses for their attendance. The information that they have given us is very useful and will help us with our inquiry.

Annual Report

16:38

The Convener: Item 3 is consideration of the committee's first annual report of session 4. Paper 4 is the revised draft annual report. Members will have noted that paragraph 25 is an additional paragraph. Can we agree the final version?

Members *indicated agreement.*

The Convener: As we previously agreed to take item 4 in private, we now move into private session.

16:39

Meeting continued in private until 16:46.

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