The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 12 March 2013

Session 4

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HEALTH AND SPORT COMMITTEE

8th Meeting 2013, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Mark McDonald (North East Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)
Drew Smith (Glasgow) (Lab)
*David Torrance (Kirkcaldy) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Anne Douglas (NHS Greater Glasgow and Clyde)
Dr Claire Fyvie (Rivers Centre for Traumatic Stress and Veterans First Point)
Kate Higgins (Children 1st)
Elayne McBride (NHS Lothian)
Paul McLaughlin (Miscarriages of Justice Organisation)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 1

Scottish Parliament

Health and Sport Committee

Tuesday 12 March 2013

[The Convener *opened the meeting at 11:06*]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning. I welcome committee members and the public to the eighth meeting in 2013 of the Health and Sport Committee. As usual at this point, I remind everyone to switch off mobile phones, BlackBerrys and other wireless devices, as they can often interfere with the sound system.

Agenda item 1 is a decision on whether to take in private agenda item 4, which concerns a proposal for a future external meeting. Does the committee agree to take that item in private?

Members *indicated agreement.*

Subordinate Legislation

National Health Service (Scotland) (Inquiry Benefits) Amendment Regulations 2013 (SSI 2013/52)

The Convener: Under agenda item 2, we will consider two negative Scottish statutory instruments. The first of those is SSI 2013/52. No motion to annul the instrument has been lodged. The Subordinate Legislation Committee drew the Parliament’s attention to the instrument—the details are contained in members’ papers.

If there are no comments from members, does the committee agree that it has no recommendations to make on the regulations?

Members *indicated agreement.*

Personal Injuries (NHS Charges) (Amounts) (Scotland) Amendment Regulations 2013 (SSI 2013/53)

The Convener: The second instrument for the committee’s consideration is SSI 2013/53. Again, no motion to annul the instrument has been lodged. The Subordinate Legislation Committee has not drawn the instrument to the Parliament’s attention.

If there are no comments from members, does the committee agree that it has no recommendations to make on the regulations?

Members *indicated agreement.*

Post-traumatic Stress

11:09

The Convener: Agenda item 3 is a one-off evidence session on post-traumatic stress. As this is a round-table discussion, we will carry out our normal procedure by introducing ourselves first.

I am the MSP for Greenock and Inverclyde and I am the convener of the committee.

Aileen McLeod (South Scotland) (SNP): I am a list MSP for South Scotland.

Nanette Milne (North East Scotland) (Con): I am a list MSP for North East Scotland.

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

Dr Claire Fyvie (Rivers Centre for Traumatic Stress and Veterans First Point): I am head of service at the Rivers centre for traumatic stress in Edinburgh.

Mark McDonald (North East Scotland) (SNP): I am a list MSP for North East Scotland.

Gil Paterson (Clydebank and Milngavie) (SNP): I am the MSP for Clydebank and Milngavie.

Kate Higgins (Children 1st): I am from Children 1st.

Paul McLaughlin (Miscarriages of Justice Organisation): I am co-project manager at the Miscarriages of Justice Organisation.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I am a regional member for Mid Scotland and Fife.

Elayne McBride (NHS Lothian): I am from the Meadows child and adolescent sexual trauma service, which is part of the national health service's child and adolescent mental health service.

Bob Doris (Glasgow) (SNP): I am an MSP for Glasgow and I am deputy convener of the Health and Sport Committee.

Dr Anne Douglas (NHS Greater Glasgow and Clyde): I am head of the trauma service for NHS Greater Glasgow and Clyde.

The Convener: Thank you for that. Our first question will be led by Bob Doris.

Bob Doris: I am delighted that we are having this round-table session. I just want to put on record my thanks to the Miscarriages of Justice Organisation, which took part in an informal session with some committee members before today's meeting. I know that there were other informal sessions before the start of the meeting that we found very helpful.

Regarding miscarriages of justice, I know from my constituency caseload and from working with individuals that those who commit a crime, are found guilty and serve a sentence sometimes receive more support than those who do not commit a crime, serve a sentence and are then found to be victims of a miscarriage of justice. There is definitely a service gap in the support that is available to victims of miscarriages of justice.

However, I want to widen the issue out. As well as hearing on the record what MOJO believes that service gap is—I would appreciate information on that—I want to ask what services are available not just for those who have been victims of a miscarriage of justice but for others who have had trauma in their life, such as those who have suffered child sexual trauma or our military veterans. Those are three very distinct areas, but I am keen to hear what the various groups feel about the services that are available and where the inadequacies are.

Paul McLaughlin: I will start on that, if you do not mind.

From our organisation's point of view, there is no uniform response—certainly on the medical side—to how a person who suffers a miscarriage of justice is treated when they are released from prison. In the public arena, people will see—we talk about this—the champagne cork moment on the steps of the Court of Appeal. Everybody thinks that that is the end of the story and, with a pat on the back, the person might be told, "You have been given your freedom, so now you can go and live your life." Well, that is not what happens. People may have a small period of euphoria after they have been released, but that is quickly followed by severe health problems.

We are currently dealing with 35 miscarriage of justice victims in Scotland who have all been diagnosed with post-traumatic stress disorder to varying degrees. The support that they get comes through our organisation, but there is no response from within the judicial system on their initial release to explain that, as a victim of a miscarriage of justice, they may find that certain things happen to their health. There is no recognition of that whatever—they are simply put out of a Court of Appeal door and sent hame. That is completely inadequate and is not how people should be treated in our society.

We appreciate that the Scottish Government supports our organisation in doing its work, but that is a sticking plaster on a huge problem. As we said to MSPs earlier, the Government funds the work that we do, but that covers only maybe 25 per cent of the work that we are expected to do in dealing with our client group. What is missing is the effect that a miscarriage of justice can have on the family and community—the effects are not just on the victim but widen out in circles to include the family. There is no recognition of that. It is hard enough to get medical support for the miscarriage of justice person; there is no support for the families whatever and no recognition that there is a need for support.

I start from that point of view.

The Convener: Does anyone else wish to respond to Bob Doris's initial question?

11:15

Kate Higgins: Children 1st provides abuse and trauma recovery support to children who may have experienced trauma for a number of reasons—mainly child sexual abuse but also physical neglect and emotional abuse, particularly through the impact of living with violence in the home or domestic abuse. We provide that support in 10 local authority areas. In four additional areas, we also provide support for families where the children are affected by parental substance misuse. Quite a lot of that is trauma work dealing with abuse and neglect in children's earliest years. In two areas, we also now work directly both with women who have been affected by domestic abuse to help them to recover from that trauma and with adult survivors of childhood sexual abuse.

Our core abuse and trauma services across Scotland are mostly funded by us through fundraised income. It is difficult to source either statutory or trust funding other than for small projects or pilots or things that provide added value, if you like. We are paying for some of the most vulnerable children and young people in Scotland to receive services that are almost vital to enabling them to recover and go on and have normal healthy lives.

Another point to make is that, when we looked at all our services as part of our annual outcomes work, we were surprised to see that the waiting lists for those services are among the highest. There are more children requiring a service from us—either being referred to us through a variety of agencies or coming to us directly from their families—and we have not got enough workers or enough capacity to meet demand. Therefore, there is a service gap. We know that our services sit within a continuum or broader array of abuse services that are provided through the health service and through social work, but we know that there is a big service gap in terms of an unmet need for children and young people, particularly those who have experienced sexual abuse in childhood.

The work of our survivors group came out of working with families who had been referred to us because the children were at risk of moving into care. Quite often, there was substance misuse by the parents or violent relationships among the adults and that was all impacting on the children and young people. In working directly with the parents in those situations, we discovered that, in every single case that was referred to us, there had been unsupported childhood sexual abuse.

I think that the Scottish Government has done well in identifying the needs of adult survivors and setting up a fund, but that is small beer and there is not enough happening when children and young people are abused to support them to recover early by providing the right support at the right time both for them and for their families. We are now having to put in place services to try to address those problems as they manifest in other social problems later on in life.

Dr Douglas: Perhaps I could say something about the NHS response to PTSD. Trauma was identified as a priority in the recent mental health strategy, which was published at the end of the year. The aspiration is that all services should be trauma informed, but there should also be some trauma-specific services. Therefore, people such as those whom Kate Higgins has described should have the opportunity to be referred for PTSD, and that need should be recognised.

I want to say something about how services are organised in Glasgow. There is a distinction between what we call type 1 and type 2 trauma. Type 1 trauma relates to, for example, a car crash or a bang on the head and type 2 trauma includes, as Kate Higgins described, victims of childhood sexual abuse, domestic violence, trafficking and torture. That is lengthy, cumulative abuse and the mental health consequences of those traumas are different.

In Glasgow, we have specific services for asylum seekers and refugees. We have a specific service for survivors of trafficking, which is funded by the Scottish Government. We also have services for homeless people with histories of complex trauma, and some specialist sexual abuse services. In addition to that, it should be possible for anyone to be referred by their general practitioner to a primary care mental health team or a community mental health team to receive treatment for PTSD.

Paul McLaughlin: I can give you some examples of how that works. Billy Mills, who is sitting across the room, is a victim of a miscarriage of justice. He spent longer waiting for treatment than he spent in prison. On the service that we offer, if a client comes to us, we take them to their GP and we have to explain to the GP what is entailed in a miscarriage of justice—what that means. There is one study by Adrian Grounds into wrongful imprisonment and its effects, which we ask the GP to read. We then ask the GP, on the basis of what they have read, to try to get adequate services put in place for the patient.

To be quite honest, there is a scatter-gun effect. The patient may get a psychologist who understands and is willing to understand, or they may not. We have had clients who, once their case has been explained to the mental health team, sat down with a psychologist whose initial question was whether they would like to discuss their offence and how their victim felt. As soon as a psychologist starts from that point of view, our clients cannot work with them, and that is a common experience.

The common experience of our clients is that it may take a number of years before they find anybody with a clear understanding of what they are talking about and before they can begin to get treated. The problem is that, because of the nature of PTSD, the stress—the condition that the patient suffers from—is compounded when it is left untreated.

It happens that today is the 22nd anniversary of the release of the Birmingham six. We were set up by Paddy Hill, a member of the Birmingham six. Over the years, Paddy has gone to various services and has been told by some of the top clinicians in the United Kingdom that he is one of the most traumatised people that they have met, but he remains untreated. He remains in a situation in which his PTSD has never been properly tackled. There has never been a place where he can go where what happened to him can be properly examined.

Paddy and our clients are like square pegs fitted into round holes. It is difficult for our clients to take the first step towards treatment because there is no recognition of the condition, or of the circumstances that their PTSD comes from.

The Convener: There is a question as to whether that is a situation that is exceptional to your group, or whether it applies to those who have suffered sexual abuse or those whom I spoke to this morning, such as the mother of a murder victim and a police officer who had investigated sexual crimes over a long period of time and became a victim herself of the knowledge that she dealt with.

It occurred to me this morning—I will throw this out there—that what we are dealing with is a level of mental health problems. Those people are all suffering the same or similar anguish, loneliness and mental health problems displayed as physical problems. They explained how it is very hard to get their problems diagnosed and accepted and how, when they do, they wait a long time for an assessment. According to what we heard in the private session, after the assessment it can get worse for some people because, after waiting for a long time, they are sent to group work, which might not be appropriate if they need one to one. That can all take a very long time. Is there the capacity in the system?

Should we be describing it as post-traumatic stress? People were saying to me this morning, “That sounds as if I was in a war zone. I might not have been in an actual war zone, but I was in a personal war zone. This is happening here, not somewhere far away.” Anyway, I have prompted people to think about that.

Dr Fyvie: You are absolutely right. Miscarriages of justice need to be put in the context of trauma much more generally. There is a huge range of trauma reactions: they can be simple, complex, acute or chronic. Over the years, we have seen several cases of people who suffered from miscarriages of justice. You are right that the manifestations of trauma are far reaching and there are severe consequences of that type of trauma.

Paul McLaughlin put his finger on it when he said that the effects of trauma on his clients have not been recognised. However, that is the case much more broadly than just for miscarriages of justice or even for victims of sexual abuse as children. We see the whole range at the Rivers centre. We see survivors of torture, veterans of the armed forces, people who have suffered from domestic violence—the whole range of human misery. The problem is not so much a gap in services but the level of awareness of trauma: the effects of trauma are not being picked up. That goes for trauma in childhood as well as in adulthood. People are not making the connection between a trauma that may occur—whether it is a one-off or a repeated, prolonged trauma—and the physical or mental health problems that develop later on.

Dr Douglas: That is the point about a trauma-informed service. If you ask a person in the street, “Why do people have mental health problems?” they will say that it is because of what happened to them. However, the mental health service often says, “What is wrong with you?” If you ask someone what has happened to them, they can tell you, and that puts a different slant on your assessment of what is wrong. If we start by asking what is wrong, we might never get to what happened.

Paul McLaughlin: That is the main problem. When people go to get treatment, they all expect the person they deal with to be an expert on what the problem is. We know fine well that often that is not the case: many medical conditions remain a mystery. It takes research to find out how to treat certain problems. We feel that we are in that situation. Because of the lack of understanding, the lack of research and the lack of education of clinicians and everybody else who is involved in the system, we cannot get through the initial barrier to get the understanding that our clients need. It takes so long to get the understanding that that compounds the whole problem.

Elayne McBride: I speak from a child and adolescent point of view because I work in a specialist service in NHS Lothian that works with childhood sexual abuse and I also work in a larger child and adolescent mental health service, so I see what is going on in the general mental health teams. Everything that is not sexual abuse trauma goes to general mental health referral teams, on which my colleagues have a lot of experience of different kinds. However, there are huge treatment waiting lists. One of my bugbears is that some lists get hidden because the targets to get people seen in a certain amount of time mean that they are seen for an assessment but wait on a separate list for treatment. I do not think that it should become the clinician’s problem to insist, “Get them seen.” The longer the waiting lists, the higher the criteria for being referred. Therefore the tariff gets higher and it becomes very medical, which gets a lot of people out of it. Our team works in a very different way because we deal with sexual trauma, but we sometimes end up taking on non-sexual single-incident traumas because they will never get seen otherwise—not because of a lack of willingness but because of a lack of people to see them.

11:30

The Convener: Something similar is experienced in other areas, where the assessment process is more to do with managing the waiting list. Accusations have been made that the assessment process in social work care can be delayed in order to manage a budget or a waiting list because the demand is so great.

Elayne McBride: Services can guarantee that sufferers will be seen—that they will have eyes clapped on them—within whatever the waiting time target is. Some will not make that at all but, by and large, they will be seen. This is general mental health that I am talking about, not just trauma. However, they might be seen only once and considered not to reach the tariff to be seen for more sessions. If they are—I can speak only for NHS Lothian—there will be a separate waiting list.

The Convener: Is that common?

Dr Douglas: It is not unusual. That will change with the introduction of the new HEAT—health improvement, efficiency and governance, access and treatment—target, as the target will be the waiting time to psychological treatment. That will kick in in December 2014. The kind of treatment waiting list that Elayne McBride described should be a thing of the past with the new HEAT target.

The Convener: How will they do it?

Elayne McBride: I do not know how they will do it with the resources that they currently have. I talk to colleagues who are doing this day in, day out and I do not know how they could possibly see the number of patients whom they are seeing if they had to go on. I fear that the tariff will get higher again and more medical. With trauma, for example, there is a willingness. We are trying to expand into a full trauma team, but we cannot get the resources to do that and a lot of the type 1 traumas do not get a particularly good service or they have to wait for a service. The service that they get—when they get it—will be good, but they will have to wait for it.

The Convener: Do any of the other witnesses want to comment before I bring Bob Doris back in for his follow-up question?

Dr Fyvie: The difficulty is that the demand is always going to exceed the supply in this case. Trauma is such a big catch-all term that takes in such a wide range of reactions, including from children, adolescents and adults, that we are never going to have specialist services to meet the demand. That is why there has been a big push to roll out training, so that workers in the community, community psychiatric nurses and community teams can offer evidence-based treatments to people in those situations. There has been a big training programme aimed at treating people in the community. The situation is being addressed, but it is going to take time.

Kate Higgins: The demand is always going to be higher and services will struggle to keep up. It is reassuring that the figures from the NHS last year on the number of staff employed in CAMHS showed an increase. It would be interesting to track that to see whether, as Claire Fyvie says, there is a big investment taking place and what impact the new mental health strategy is having, to see whether that increase in the number of staff will continue.

Although that is reassuring, it is worrying when we look at the situation in a health board area. Some health boards have made active investment decisions to beef up their teams, which contributes to the overall totals. However, quite a lot of the staff are hospital based in acute trust settings rather than out in the community. In our experience, children who have experienced abuse and trauma in their lives tend not to come through the medical route so much as through social work, and if there are fewer staff based in the community settings they will perhaps find it harder to access services. It would be useful for the committee to look at how resources are being deployed and how health boards are making decisions about how and where to deploy their resources. Within that, it could look at the new Highland service, which is the first to integrate health and social care.

As we know from working with kinship carers, that group of families finds it really hard to access not just therapeutic services for the trauma that their children have received but support for themselves so that they can cope and have the capacity to support their children. All their interaction is with social work when they actually need to access CAMHS, and they find that quite a difficult bridge to cross.

Elayne McBride: I largely agree. Because many of our referrals come in from social work, we are trying very much to work alongside it, particularly where children are involved. Although the getting it right for every child approach is the only way to work with families, it is incredibly time consuming.

In response to Claire Fyvie’s point, I have found that, although a lot of training has been provided, my child and adolescent mental health service colleagues have found it difficult to secure places on those courses. Moreover, some say that the adult evidence-based nature of the training is not suitable for children, but the fact is that much of our trauma work with children is not evidence based simply because no research has been carried out on it. However, we know that what we do works. I simply do not think that we are getting enough training in that respect.

The looked-after and accommodated population also get a raw deal because the kind of long-term, neglected and complex trauma that they have to deal with consumes a huge amount of time. For a start, a huge system of people gathers around the child in question, and I simply do not think that they get the service that they require when they need it, which is when they are young, not when they are adults and have gone completely off the rails.

We also have a service that deals with the secondary traumatisation of non-abusing parents because, according to our research, they, too, can be traumatised by the abuse of their child if they are not implicated in it. Actually, there is no point in plucking a child out of that traumatised environment, doing work with them and putting them back into it, so that kind of service has to be available. Sometimes, if we can get in early with carers and parents, the child does not need to be seen. You can help to put the parent back in the driving seat; after all, they tend to feel quite disempowered when everyone else rushes in to do things for their child.

Paul McLaughlin: I could not agree more. For us, the failure is that there is no way to intervene early in our cases. If such early intervention were available—or even if it were explained to the person in question that they might develop post-traumatic stress disorder, that they might begin to have problems and what those problems might be—they might be able to cope better. Billy Mills, whom we mentioned earlier, said that he was a victim of state kidnapping. As we know, when the hostages in Lebanon were brought back to this country, they were instantly taken to proper medical centres and given appropriate treatment and all that was followed up to ensure that they reacclimatised to their communities and our society. Our clients need that kind of early intervention to give them some hope, to allow them to understand what might happen to them and to ensure that strategies are put in place to allow them to cope with the situation themselves. If you get in early, you might well not need to provide intensive long-term treatment, but the failure to act early is prolonging the need for treatment over time.

Bob Doris: We have heard many interesting comments, some of which are very helpful. With regard to Glasgow, I know from my direct interest in access to psychological services for children in NHS Greater Glasgow and Clyde that there has been a dramatic fall in waiting times from the shamefully high level of about a year and a half down to about 26 weeks or so. I am happy to correct the record if I have got that wrong, but I think that that is roughly the waiting time.

Nevertheless, I am keen to put additional pressure on services. We can discuss those who are already in the system and how long it takes them to get appropriate services, but the issue is the need that is not currently being captured, which is why I led on the miscarriage of justice situation. I got the positive impression that NHS Greater Glasgow and Clyde was developing a range of specialist trauma services that cover refugees and asylum seekers and sexual trauma, but I wonder whether consideration has been or might be given to the establishment of a specialist trauma service for victims of miscarriage of justice and how that might come about.

Of course, no matter whether we are talking about victims of miscarriages of justice, returning veterans or victims of child sexual trauma, if GPs are the first point of referral, they must be suitably trained and know the referral procedures.

In summary, therefore, should there be a specialist service? Secondly, how well informed and trained are GPs? I also want to chance my arm with a third question that I think ties everything nicely together. I know that specialists can design a bespoke service but we need to listen to what the victims of sexual abuse or miscarriages of justice or those who have suffered in war zones are telling us about what a suitable service might look like.

In that respect, I would like to hear the views of either Dr Douglas or Elayne McBride on the issue of specialist services, including those for victims of miscarriages of justice; how we ensure that GPs are suitably informed and trained; and how we ensure that people are prioritised in the system and are involved in designing such services. I know that I have asked a lot of questions, but the issue is not uncomplicated and we need a complex approach if we are going to get this right.

Dr Douglas: That is a big question.

Bob Doris: I know.

Dr Douglas: I think that all of us are providing on-going training to GPs to identify trauma. Indeed, I know that Claire Fyvie at the Rivers centre is involved in that work.

Dr Fyvie: The Scottish Government has commissioned the Rivers centre to carry out a three-year project on examining the level of awareness of trauma among GPs in primary care throughout Lothian and, after establishing that awareness, designing an intervention aimed at raising it.

Bob Doris: Do victims of miscarriages of justice fall within the scope of your project?

Dr Fyvie: Yes. Given that we are looking at trauma in its widest sense, they would come under it.

The Convener: What I was trying to make clear in my previous remarks about waiting times and other matters was that, in our conversation with three people who have been through the system, the waiting itself was a problem. It also emerged that it was not necessarily the GP who identified the problem; sometimes it emerged as a result of accidental engagement with a health visitor who might have been treating someone else or because of a referral to a CPN. In another case, the GP sent the woman in question straight to the Rivers centre. That shows how patchy the approach is and how people are having to battle through the system.

Dr Fyvie: That is exactly the problem. Most of the patients we see at the Rivers centre will have taken quite a circuitous route—and therefore a long time—to get there. As well as having to wait after they have been referred, they have to wait before they get referred, because their problem has to be identified as being the result of trauma. That is the nub of the issue—the effects of trauma are simply not recognised and the training, the education and the awareness raising need to be focused on trauma reactions. Of course, that applies not only to GPs but right across the board to accident and emergency departments and mental health teams, health visitors and others in the community. We need to raise awareness and ensure that people can put two and two together and recognise that there has been trauma, that there has been a reaction and that the two things are linked.

The Convener: Some of this certainly complements and will be linked into the committee’s work on the integration of health and social care.

11:45

Nanette Milne: The convener has made the point about the patchy nature of initial referral. The point was also raised with us that, although there is a great deal of on-going traumatic experience in organisations such as the police service, those organisations do not seem to recognise it. I wonder whether there is a case in such organisations—it is not only the police—for raising awareness.

Dr Fyvie: The Rivers centre has had a contract with Lothian and Borders Police for about 15 years to provide psychological support services, and we have contracts with some of the fire and rescue services throughout Scotland too. It is recognised that emergency service personnel are exposed to such experiences. My feeling is that we need to look beyond emergency services to see the gaps in service provision.

Nanette Milne: The point was not so much about emergency services as it was about the on-going experience of someone who is dealing with traumatic issues throughout their working life, which then become a personal problem for them. There seems to be no recognition of that type of issue.

Dr Fyvie: You are right. One difficulty is that the media would have us believe that post-traumatic stress disorder is the only reaction to trauma, and that it happens only to veterans of the armed forces, such as those coming back from Iraq and Afghanistan who have been exposed to high levels of trauma. That is very misleading, as PTSD makes up a very small proportion—we reckon about 3 to 4 per cent—of the reactions to trauma. The most common reaction to trauma is depression, and second to that are anxiety disorders, panic disorders and other anxiety-based difficulties. PTSD is way down at the bottom of the list of reactions to trauma, which is why it is not recognised. Its manifestations are not clear-cut or obvious when people go to see their GP or a health professional, so people do not make the connections.

Paul McLaughlin: One problem is that there is basically a suck-it-and-see approach to dealing with PTSD—"This might work, and if it doesn't, then maybe you can try something else later." We need to listen to the experts in the field and see whether there is somebody available who can provide the necessary treatment.

Another difficulty is that much of the approach is based on localism. One health board may take one approach, and another may take a different approach. We need a uniform system so that people can fit straight into it. Once somebody is diagnosed as suffering from PTSD related to a miscarriage of justice, action must be taken from a very early stage to follow that through. We do not want to keep on going round and round the houses trying to find somebody and being told, "No, that is what you have to do. There is no other way of approaching it—you must go to the GP, who must refer you here, and that is the path that you have to follow."

Dr Douglas: My aspiration is for a clear trauma pathway. The situation is not too different for survivors of childhood sexual abuse, but it depends where they are. It would be great if GPs could identify PTSD and know exactly where people need to go, but that pathway does not exist at present.

Paul McLaughlin: The real problem is that to get support for our clients—

The Convener: I need to let other panellists in too—

Paul McLaughlin: Aye, but my point is important in response to Claire Fyvie's point of view—

The Convener: I have three committee members waiting who are desperate to get in.

Paul McLaughlin: In response to Claire Fyvie's point, this is important. If we could control the resources that were available, we could get the treatment to our people much more easily. We have a situation in which—as Kate Higgins said—the organisation is having to raise money to provide the service. We are having to put on fundraising gigs to pay for counselling for one of our clients, because the counselling is being discontinued. That is insanity—it is nae approach at all. The approach is simply, "Take what you can get where you can get it," and that is not acceptable.

Dr Simpson: I have some experience with PTSD, as I was a local GP at the time of the Dunblane incident and spent six months thereafter providing support to the GP practice there. To follow on from Dr Fyvie's point, I found it interesting that, initially, many people did not want to engage at all. Indeed, from the study that I did at the time—I was not particularly knowledgeable on trauma reaction—I found that early engagement and immediate application of psychological services to someone who has gone through a trauma can be counterproductive. People have their own defences.

Dr Douglas made the vital point that we need a trauma pathway. On miscarriages of justice, between 1999 and 2009, 982 people were successful in the appeal court. How many of that group were given a personal contact, although not necessarily intervention, at that point? How many were told when they came out of the court, along with the champagne, that they had a personal contact to whom they could turn? How many were told, "You might get on absolutely fine and put it all behind you, but if you have any difficulties, which might happen, you should phone this person"? Is there someone who keeps an eye on the situation?

Some people can handle traumas themselves and get through them, although issues might re-emerge in later years, triggered by something else. For example, I think that the reports this week relating to the firearms incident in County Durham will trigger issues for some of my patients who were involved in the Dunblane incident. For them, seeing once again that the firearms issue has not been dealt with properly will trigger problems.

I ask the panellists to give us an idea of how they see that trauma pathway. At the end of the day, PTSD is only the tip of the iceberg and the final reaction.

The Convener: What would a trauma pathway look like?

Kate Higgins: It is interesting that there were 982 victims of a miscarriage of justice in 10 years. To put that in perspective, every year, more than 300 children are put on the child protection register or referred to the children's hearings system either directly or indirectly because they have been affected by sexual abuse. More than 1,000 children every year are put on the child protection register or go through the children's hearings system because of emotional abuse. Those figures are absolutely staggering, but the number of those children who receive support from a service probably does not even come close. The official statistics suggest that, in 2011, the number of counselling staff who are employed in child and adolescent mental health services throughout Scotland increased from one person to 10 in one year. That is 10 people for the whole country in that one specialism.

On the trauma pathway for children and young people, I echo Elayne McBride's point that it has to become part of the GIRFEC pathway. We are all clear about the impact of a poor start in life on child development, and about how that manifests itself in long-term impacts. The impact is not just on the child's emotional and mental wellbeing, but on how well they do at school. Those who have a poor start in life are more likely to end up not in education, employment or training once they reach young adulthood, and are more likely to become homeless and to end up misusing substances. We know about all that evidence. Harry Burns has done his job well; we know what happens when children are traumatised in their earliest years.

We are all working on things such as early years collaboratives and on how to ensure that children get the support that they need to recover from such early experiences. However, if our specialist trauma services are based in healthcare, a disconnect will remain between the GIRFEC pathway and the trauma pathway. We need to ensure that children and young people receive specialist trauma services where they need them and at the earliest possible opportunity, but we have a disconnect because of the artificial gap between health services and social care services. The ability to cross-refer and to wrap services around the child is improving and is good in many places, but we know that provision is inconsistent, as Paul McLaughlin said.

To respond to Bob Doris's point about victim-led services, Children 1st works in a child-centred and family-led way. Most of the organisations that are represented today take a similar approach. Members might have seen during the Christmas period a young woman called Jess who supported our child sexual abuse campaign by coming forward and telling her story. The interesting thing is not just what happened to her, but that she was given as much space as she needed and that she led the therapeutic work. Sometimes, that was about allowing her to do childlike things and to use art in a childlike way. Sometimes, it was just about allowing her to go out into the field next to the cottage where our Highland service is based and use a hockey stick and a ball to deal with her emotions and anger until she was able to come back in.

In our Moray service, we worked with a woman who had been seriously abused in a very violent situation and who could not talk about her experiences at all. Again, she used art and music to get some of her feelings out there, so that she could start talking.

Obviously, the experts and specialists such as the Rivers centre and other health professionals have huge skills, experience and expertise to bring, but sometimes there has to be a partnership approach if a service is going to work. That is about finding a way for somebody who is so traumatised that they cannot talk about their experiences to express how they feel and what is going on inside them.

Dr Douglas: To respond to Kate Higgins, we work closely with social work and we feel passionate about prevention. We know that children who leave care are particularly vulnerable to re-victimisation so in Glasgow we have set up a project to train staff to identify the children who are leaving care and are particularly vulnerable. We work closely with social work.

On the trauma pathway, as Claire Fyvie said, we need to increase identification at GP and health visitor level and we need to build capacity among social work and health staff to do what they can and to recognise those who require specialist treatment. We then need small specialist teams. We are looking for a triage-type pathway.

Dr Fyvie: I will mention a user-led service that demonstrates how different such services are from statutory services. Several years ago at the Rivers centre, we noticed that about a third of our patients were veterans of the armed forces. We felt that the service that we were delivering was not as good as it could be. Therefore, we got a group of veterans together and asked them what a brand-new service for veterans would look like if they could design it. They designed a one-stop shop where people did not need an appointment or referral and could just go in off the street. People could go with any problem—with debt, alcohol, relationships or housing—rather than only with a trauma or mental health problem. We were lucky to get the ear of Geoff Huggins in the Scottish Government's mental health division, who basically asked us how much we needed to do it. We put that together and it is now a service called Veterans First Point, which is just off Princes Street and has been running successfully for a number of years. It was designed by veterans and is run by veterans, for veterans and their families. It gets round the stigma that is involved for people in going to their GP with a mental health problem. People can turn up at the door and be seen under the same roof for any problem at all.

12:00

Elayne McBride: I am jumping back and forward between adults and children.

The Convener: Just go with the flow.

Elayne McBride: Another thing that goes unrecognised is that how children present with trauma symptoms is different to how adults present. We get some of the same symptoms, but we also get a lot of very disturbed behaviour, which can be put down to various reasons. For example, schools find it difficult to contain those kids; they are always in trouble and the situation is compounded because the symptoms are not recognised and the children are difficult to parent and to teach. We should understand that the child is not just a bad child or a child with attention deficit hyperactivity disorder, and that there might be other things going on. For some children, particularly those who have experienced abusive neglect early in life, in their first pre-verbal years, trauma affects brain growth—it affects everything and will have an impact.

Some early intervention and psychoeducational work has involved parents, carers and professionals working with people who have been through trauma—as well as the child, if he or she is old enough—to understand the impact that the trauma has. Some parents do not have the capacity, but many are interested in information about how trauma affects the brain, for instance, or how trauma might impact on them.

It is important to remember that a child's trauma might be triggered by something that has happened at any stage of his or her life. Psychoeducational work can happen quite early on. As Dr Simpson said, not all people want to come and talk about a trauma, but those people need to understand the impact it may have on them and what they can do about that.

Another point, particularly with sexual abuse, is that so many children feel responsible—they feel as if it is their fault. We know that the investigative process and everything that has to happen in the long run is good, but that process can in itself be very traumatic for children, who might have been threatened that if they tell, such-and-such will happen—and it does. Everybody falls out and the family falls apart, and all the things that the child has been threatened with by their clever and skilled abuser come to pass. We have to get better at that early bit, even before we do one-to-one work with children and their families.

Paul McLaughlin: I was interested to hear what Dr Fyvie said because I wish someone would approach us and say to us what they said to the veterans. It is certainly not our experience that we are reacted to in that way. It may be that there is not enough public awareness about miscarriages of justice, which would result in that sort of concentration on the problems of our client base.

We have to rely on the goodwill of specialists, lawyers and doctors who want to offer us their time and services. We have to go out every day and find that for ourselves, because nobody brings that together for us and there are no existing packages that we can tap into. We do not have support from the health boards or from social work departments; we are not even on their radar. We attempt to include ourselves as much as we can, but we have very limited resources. We have to do 101 things, but we do not have the time, resources or manpower—with two paid staff and 10 volunteers—to do even 10 per cent of the work that we would like.

We are a bespoke service for our clients. They can come to us because we offer a safe space for them. Iain Murray spoke earlier about his situation; he can walk into our office and be himself. He cannot do that in any other space anywhere in the world, but he can do it with us. We have to beg and borrow and pull things together, just to ensure that we can keep the door open. That is the difficulty that we face.

We need some appreciation; we have slipped through the cracks. Society does not want to recognise what has happened to miscarriage of justice victims, because there are too many questions that have to be asked. What is wrong with the system? How do miscarriages of justice occur? If those questions have to be answered, it opens up a Pandora's box, and people are reluctant to do that. We have to deal with the perception that there is no smoke without fire in relation to our clients and that "they should just get on with their lives"—all that sort of nonsense.

Dr Fyvie: May I make a suggestion? On the back of the contract we have with the Scottish Court Service, if a jury has been exposed to particularly traumatic material, judges have discretion to give those jurors access to services at the Rivers centre. They are given a leaflet that explains the kinds of psychological reactions that they may experience, and points to services they can access if their reactions become problematic. In the same way, it might be possible routinely to give people who have suffered a miscarriage of justice that information—material that says, "These are the problems you may experience. If you do, this is how to get help".

Paul McLaughlin: That is part of the application process for the Scottish Criminal Case Review Commission; our information is given to anybody who applies through that. Not everybody who passes through the court system necessarily acts on that or ends up at our door. We hope to be able to get to everybody, but unfortunately we do not have the capacity.

Mark McDonald: A couple of things have come up during the discussion, which has focused on the fact that there is a training and awareness need, whether it be for psychologists, GPs or social workers. My concern—I wonder what the panel's views are—is whether we are confident that individuals are, when they come into contact with the services, given appropriate diagnoses, particularly given Dr Fyvie's comment about how low down the order of trauma-related disorders PTSD actually is?

The wider public perception of PTSD tends to relate to military service personnel, because people have seen the news coverage and the documentaries about issues such as Gulf war syndrome, for example. Maybe there is not as much understanding of how trauma affects other sectors of society. I made the point earlier that often we are talking about continuous traumatic stress disorder, rather than post-traumatic stress disorder, because for many people the traumatic situation is not concluded, but is on-going. We may sometimes risk not so much misdiagnosis, but mislabelling and assuming that we are dealing with trauma that is over. An incident may have happened in the past, but the trauma related to that incident may continue.

Kate Higgins: Some basic training on recognition and awareness-raising among education professionals in relation to children and young people is vital, as well. That need accords with Elayne McBride’s point that some of the behaviours that manifest themselves in children and young people make them hard to teach. Quite often, children, young people and families are referred to our wider family support services because a child has been excluded from school, or are referred to our befriending services because a child is not socialising well or is having difficulties at school. Those issues can be the point of referral, but in fact that kind of behaviour is often telling us about something else that has gone on with the child.

There is also something about capacity. I would echo what Elayne McBride said. Not all the work that we do is about treating a young traumatised person; sometimes it is about supporting the whole family, because that level of intervention gives the parents the skills, resilience and knowledge to support the child themselves. The additional support needs framework is supposed to be about supporting more children better through universal education services. We need to build the capacity of all professionals who work with children and young people. I would definitely include education as well as social work.

Elayne McBride: I agree. A recent case involves a young person who has formed a really good relationship with their school guidance teacher. That young person does not want to come anywhere near other services. The guidance teacher is feeling a bit out of his depth, but he is keen to offer support, so we are supporting him to do so. That is good, but it would be good if more specialist training were given to guidance teachers and counsellors—or whatever we call them; there are counsellors in some schools.

School is where the child is; it is the place where they can be seen often, without feeling stigmatised. I guess that we lose a lot of young adolescents because they say, “I’m not coming to talk to you.” We come across that churlish adolescent attitude among young people, who do not want to come to the service at all, even though their behaviour is such that they need support.

I was at a child protection case conference the other day, at which the school said, “We have to exclude this six-year-old, because the disruption in the school is so great.” The little girl has been sexually abused and is very traumatised. She is being sexual in school, she is barking like a dog, hiding under tables and doing all kinds of things that scare the life out of the other kids. There are lots of neglect issues, parenting issues and so on. The headteacher is saying, “You have to do something about this kid, because I have to protect all the kids in the class.” The little girl will be excluded, because there is nothing that we can do fast enough to sort things out.

The Convener: Mark McDonald asked the important question, and I think that Kate Higgins alluded to it. The issue is not necessarily a shortage of resources. The committee has been considering teenage pregnancy—we concluded our evidence taking last week—and we have in this meeting touched on some of the issues that emerged.

A myriad of people run a school. Where is the counsellor? Where is the school nurse? We seem to be able to describe the pathway that will deal with the unmet need that we all agree exists, but which workforce will deliver what is needed? Is the approach going to be based on early intervention and prevention, or are we just going to keep sending in more people to deal with the crisis of the 300 sexually abused children and 1,000 emotionally abused children who have been reported to the children’s panel? What a legacy is being built up, given the predictions about how children who have experienced trauma go on to inflict trauma on others and perpetuate the cycle. It is scary.

Paul McLaughlin: It is an endless cycle.

Dr Fyvie: The consequences are not just to do with mental health.

The Convener: Mark McDonald asked what the workforce that we need would look like. There was talk about education. It is not simply up to the health service.

Dr Douglas: Work is needed across all agencies. Everyone can play a part. Parenting programmes and early intervention programmes can play a part. I think that it needs—

The Convener: But are agencies working together effectively? I think that that was Kate Higgins’s challenge.

Elayne McBride: There is a lot of will to work together, but people can be very protective of their remits. They have their own waiting lists and all kinds of things to do. Even the whole GIRFEC initiative can cause upset about who is going to be the lead professional and so on. The definitions of people's jobs and their remits add another layer to the problem and it is not right to expect them to do more without additional resources or the right training. Working together and taking a systemic approach to individual work with people is the only way forward, but it is quite hard. People would resist taking on another part to their job without proper backing. They might say that they have enough to do and the new part is not their remit.

12:15

Mark McDonald: Elayne McBride has highlighted some of the difficulties and challenges that are faced in many areas. For all that we are approaching an integration agenda and trying to get services and agencies working together, there is still a silo mentality out there. People still say, "It's not in my remit—someone else should be picking this up." I guess that there is a challenge to us all to break down those barriers. Something new might not be in a particular individual's remit, but that person should have a role in making sure that the situation is dealt with and not simply wait for another agency or organisation to pick it up.

The convener made a good point: there is a role for early intervention and it has to be the key. We need to think about prevention; we do not want miscarriages of justice to happen and we want to be able to identify children who are at risk before they are harmed.

However, people will always suffer from traumatic incidents in certain situations. That is just how life goes, but we hope that we can reduce that trauma by taking an appropriate approach. Whether it be a fireman arriving at the scene of a road traffic collision and having to cut a dead body out of a car, a child who is suffering from abuse, a person who is wrongly convicted of a crime and is later cleared, or someone in the army who is injured overseas, how do we ensure that they get the help and referrals that they require at the earliest possible point?

Dr Fyvie talked about how PTSD is only a small proportion of reactions to trauma and how depression, self-harm, and suicidal tendencies can also result from unmet need. How do we ensure that we make appropriate interventions at the earliest possible stage? That has to be the focus.

Bob Doris: Mark McDonald made an important point about capturing trauma early. We need to take preventative action, but when people suffer trauma, we need to get to that trauma, work with the victims at the earliest opportunity and provide an appropriate service.

Elayne McBride mentioned initial assessment and waiting times, and Dr Douglas mentioned triage. We need to talk about how we prioritise assessing everyone as quickly as possible. Rather than waiting 18 weeks for an initial assessment, there needs to be a recognition that some people might have to wait quite a long time because, relative to others who have significant trauma, theirs is a milder form—although I do not want to downplay it. Are we good at early assessment and prioritisation?

Elayne McBride: We can be. Lothian CAMHS is not just a trauma service: it is a mental health service, although the specialist team is for sexual trauma at the moment. There are competing needs because people are coming in to be assessed for all kinds of mental health needs that are not particularly related to trauma. Psychosis, depression, self-harm and so on can result from trauma, but can also result from many other problems, and even within those criteria, there can be priorities. Trauma can present through a variety of symptoms and my fear is that it might not hit the top of the ladder.

Kate Higgins: I want to respond to Bob Doris's question about how we ensure that people who have been traumatised get access to help as quickly as possible, and to raise awareness of a particular group with which we work. We support children who have been sexually abused to recover, which often involves supporting them right from the beginning of the investigation of a case and all the way through court proceedings to its conclusion. Because of the nature of our justice system, that can take years and can dominate years of a child's life. Having to go through that process and be prepared to relive what happened in giving evidence is a trauma in itself.

We have developed a national therapeutic service to support children and young people who are going through court proceedings. Also, and in particular, the aim is to train our support workers, therapeutic workers and practitioners in skills to work their way through those proceedings.

One of the biggest issues is that, in some areas, the prosecuting authorities—the procurators fiscal—are, for obvious reasons, still very resistant to beginning therapeutic work to help a child to recover before the case is concluded. There is a fine balancing act. However, some cases can take two years from start to finish. That is two years in which a child who has been sexually abused has not only had that happen to them, but has to relive that trauma without getting any therapeutic support.

We have long campaigned for a child witness support service to be set up across Scotland, in which specialists would provide children with the information that they need and specific support so that they can give their best evidence. We will continue to campaign for that as part of the process for the Victims and Witnesses (Scotland) Bill. That service should weigh the therapeutic support that children need to recover from their trauma against the need not to jeopardise proceedings.

Sadly, that specific group of children and young people is increasing. There is simply not enough specialist support to help them to get through court proceedings, although things have improved generally through victim information services. However, they need a specialist support service.

Elayne McBride: I agree. The child witness guidance says that, if a child requires therapy or counselling, that should be paramount. I do not know whether the PFs take that on board differently in different areas. If a court case is pending, we tend to inform the PF that we are seeing the child, as we know that the case can go on for a long time, that it might be put off on the day and that there can be other delays. Sometimes, that is not the right time to see a child, so we support the system and the family. At other times, if the child needs to be seen because they have many worrying symptoms, we always inform the PF about what we are doing, so that a defence lawyer or whoever cannot accuse us later of having contaminated evidence. We will say what is happening, even if that is just a containing exercise with the child while they await court proceedings.

The Convener: We have about 10 minutes remaining. Gil Paterson would like to come in.

Gil Paterson: My question is about access. I do not want to personalise the matter too much, but my question relates to the three people to whom we spoke this morning. Each of them had been referred to the Rivers centre. One had gained access within two weeks of bringing her case to someone’s attention. For the other two, the periods were three months and eight months, although the latter case involved the person seeing a specialist. I believe that they declined participation because group work was offered.

What do group sessions mean? Are they part of the assessment or treatment, or are they holding operations? I was not clear from what was explained to me this morning exactly what they mean. I asked questions, but I could not come to a conclusion on that from the answers that I got.

Dr Fyvie: I will quickly tell you about the path that people take when they arrive at the Rivers centre. Within six to eight weeks of every referral, we do an assessment that looks to find out whether the person is in the right place or have come to the right service. There is no point in someone sitting on a waiting list to see us if it turns out that they will be better served somewhere else. We also consider the degree of risk, such as how high their suicidality is or their risk of self-harming behaviour?

If they are in the right place, we decide with the client whether it will be suitable for them to go into a group. I think that the people to whom you spoke were talking about our psychoeducation group, which is a small group of about six to eight people that is facilitated by two clinicians. The aim is to provide an understanding of traumatic stress reactions so that people have a better understanding of what has happened to them, what is going on and the problems that they are having. We start to get information across about managing those problems.

People generally start off in that psychoeducation group. It is a seven-week group, and at the end of that time we do a review. The patient will meet two clinicians, who will consider where the patient has got to. If the patient needs individual treatment after that, they are put on a further waiting list for that treatment. Most people require individual treatment, and they get one-to-one evidence-based treatments at that point.

It is a process, and not everybody needs the same input. We try to tease out what works best for whom.

Gil Paterson: So some people go into the group sessions, and that is the end of their journey, because things develop in that context and their needs can then be taken care of outwith the centre. However, that seems to be a low number of people. Is that what you are saying?

Dr Fyvie: It is a low number. Sometimes people say to us at the end of the group, “I now know I’m not going crazy and I’m not going to end up in the Royal Ed. I understand what’s happening to me. I can make sense of it now, and I know what I need to do. Thank you—that’s all I need.” We part company with some people at that point, but they are a minority.

Gil Paterson: Is the group part of the treatment or is it a parking exercise while the person waits? From what we were told, it seems that the whole process until the person sees a specialist lasts about eight to nine months.

Dr Fyvie: The psychoeducation groups are run by specialists—senior clinicians. Part of the group process is about the clinicians getting to know the patients. It is a two-way thing. If there is any reason to take a person out of the group process and prioritise them, I would hope that our staff pick that up, and they will do that. People are seen by specialists from day 1.

Dr Douglas: That work is part of the treatment. The treatment of choice, particularly for complex trauma, is called phase-based treatment, and phase 1 is about establishing safety. It is about psychoeducation and learning how to cope with anxiety, so it is clearly part of the treatment.

Gil Paterson: I have another question given one of the explanations that we heard of what happened to an individual and my experience with some friends who are involved in the police service. There seems to be a high incidence of care required for individual officers.

As with the armed services, should we look to other services for expertise? I am thinking about prevention. Before something gets really serious, perhaps we should invest in flagging things up and looking for signs that something is happening. Having said that, I know a person for whom everything was hunky-dory, then the next day their whole world collapsed. I know that the situation is complex, but should we look more meaningfully to the services, or can work be done only by referring to experts?

12:30

Dr Fyvie: Are you asking whether we should learn from the occupational health services of the emergency services?

Gil Paterson: Yes, I think so.

Dr Fyvie: The answer is yes. We certainly try to do that in Lothian and Borders. As I said, we have worked for about 15 years with Lothian and Borders Police, which we provide with a fast-track service. If its occupational health services pick up early problems, they will refer people to the Rivers centre, and we see them within 10 days. The police pay for that contract.

Gil Paterson: I missed that earlier—thank you.

Elayne McBride: The only way to provide a full trauma service, whether for adults or for children and adolescents, with whom I deal, is to have more people. It is not the case that we have enough resources and, just need a better pathway. My colleagues in child and adolescent mental health services are on their knees in dealing with the amount of other cases that come in.

We are trying to expand into a full trauma team rather than a team that deals specifically with sexual trauma, but we have 4.3 whole-time equivalents across Edinburgh, Midlothian and East Lothian to provide the service, which is not a lot of people for Lothian, given the longevity of some of the cases that we work with.

There is a lot of willingness to offer a trauma service and a lot of evidence that it would work, but the only way that we can do that is if we are given the funding for more staff to provide the service and do all the stuff that we are talking about in an organised way with pathways, psychoeducational stuff and groups. Groups with children take up a huge amount of time, because they must be well contained—kids can go all over the place. We know that all that stuff works, but it is staff intensive and we do not have enough staff to do it.

The Convener: That is interesting. What should the workforce look like? Should it involve educationists or artists?

Elayne McBride: It should be a combination.

The Convener: What skills are needed? We know that GPs are not trained to the level that is needed. Should we look to GPs? Why does every practice not have a mental health or trauma nurse to deal with such issues? For example, we have specialist nurses who deal with diabetes and other conditions. We know about the scale of the problem, but the question is how seriously we take it.

Paul McLaughlin: Our problem is with getting support to access the resources that are apparently out there but which we certainly are not seeing signs of. Nobody is coming to us and nobody is opening doors for us. We need that to happen.

You ask for specifics about the workers who are needed. We could provide the services if the resources were put into our organisation to allow us to beef up what we do. We know what we want to do, where we want to go and what support we need to offer our people, but we do not have the opportunity. We would rather employ people and take the work in-house. We would employ a specialist in each area, whether that was medical treatment, support with legal cases or education.

We would rather have a bespoke service in our organisation, which could offer all the things that our client base needs. Our organisation was created by people who have suffered trauma. They are putting on the table their requirements. We just need to find ways of accessing resources.

The Convener: Are there any other questions? I see Richard Simpson twitching—do you have a quick question?

Dr Simpson: CAMHS in particular are under massive pressure, but so are adult psychiatry services. All the services that we have heard from today are under pressure. Is there stuff downstream that we should be doing? For example, Gardening Leave was set up to try to help people who did not necessarily need Hollybush house and the veterans organisations. Groups such as Artlink Edinburgh provide wraparound services, and those tend to be offered by small charities. Are those things helpful to people who are not at the stage of being diagnosed as having PTSD? Is it helpful to give people the space to manage issues at an earlier stage? Do we need to beef up those services and train their staff so that they know what is appropriate and how to get people to understand what they are going through?

Dr Fyvie: I would say definitely yes. When we were asked to give our views on the mental health strategy for Scotland, that was one of our main comments. People who have been traumatised do not generally come to professionals like me—a psychologist is probably the last person they want to see. People go to their families and communities first. Our comment on the mental health strategy was that it did not take enough account of that. If we are going to beef up resources, we need to put the money into community-based—and probably voluntary sector—resources.

Kate Higgins: We are piloting some projects this year called communities putting children first. They are like back to the future for Children 1st, because they involve us going back to our roots. The projects are about training volunteers to engage with communities, individuals and groups and to help them to build resilience and the capacity to think about what they can do to protect children more. People are taking responsibility, thinking about their attitudes and changing their behaviours, rather than sitting back and waiting for the professionals or statutory agencies to come in.

That is a whole-population approach that is similar to the work of the Glasgow Centre for Population Health and Harry Burns on an assets-based approach to health, and investing in families and individuals' resilience and capacity. We do some of that work with families. When the parents of children who are referred to us are non-abusive, we will support them. Even in our family support work and the parenting support that we provide, we acknowledge that children will eventually leave the programme, after however many weeks, to live with parents who have issues. We have to build resilience in those children to cope with what life will continue to throw at them.

It is about practical skills such as healthy eating and understanding the importance of getting themselves to bed if, as they get older, somebody is not there to do that. It is also about soft skills such as coping, dealing with their anger, knowing where to get help and looking after their wellbeing. If more of that work happens through universal services for the whole population, people will be more resilient, no matter what life throws at them. That will free up specialist services such as the Rivers centre to cope with the severe impact of trauma on some individuals.

The Convener: I thank all those who have taken part in the session, and give a special thank you to those who took part in our earlier informal session. Thank you for your attendance. The session has been very good and challenging. From the committee's point of view, I see many ways in which the evidence fits with the evidence that we have received on teenage pregnancies and the integration of health and social care, and of course the Victims and Witnesses (Scotland) Bill. Although this has been a one-off session, it has been important to the committee. I thank you all on the committee's behalf.

12:39

Meeting continued in private until 12:44.

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