OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 18 January 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 18 January 2022

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
2nd Meeting 2022, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

*Paul O'Kane (West Scotland) (Lab)

COMMITTEE MEMBERS

*Stephanie Callaghan (Uddingston and Bellshill) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Evelyn Tweed (Stirling) (SNP)
*Sue Webber (Lothian) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jackie Brock (The Promise Scotland)
Shelley Buckley (Mental Health Foundation)
Alex Cumming (Scottish Association for Mental Health)
Susie Fitton (Inclusion Scotland)
Helen Happer (Care Inspectorate)
Lucy Hughes (Who Cares? Scotland)
Kate MacKinnon (CELCIS)
Sam March (Association of Scottish Principal Educational Psychologists)
Joanne Smith (National Society for the Prevention of Cruelty to Children Scotland)
Dr Mairi Stark (Royal College of Paediatrics and Child Health)
Humza Yousaf (Cabinet Secretary for Health and Social Care)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Robert Burns Room (CR1)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 18 January 2022

[The Convener opened the meeting at 08:30]

Decision on Taking Business in Private

The Convener (Gillian Martin): I welcome everyone to the second meeting in 2022 of the Health, Social Care and Sport Committee. I have received no apologies from any member for this morning's meeting. The first item on our agenda is to decide whether to take items 6 and 7 in private. Do members agree to take those items in private?

Members *indicated agreement.*

Health and Wellbeing of Children and Young People

08:30

The Convener: Our second item is two evidence sessions as part of our short inquiry into the health and wellbeing of children and young people. The first session will focus on mental health and child and adolescent mental health services.

I welcome Shelley Buckley, who is the programme manager for families, children and young people at the Mental Health Foundation; Alex Cumming, who is assistant director of delivery and development at the Scottish Association for Mental Health; Susie Fitton, who is policy manager at Inclusion Scotland; Sam March, who is principal educational psychologist at South Lanarkshire Council and is also representing the Association of Scottish Principal Educational Psychologists; Joanne Smith, who is policy and public affairs manager at the National Society for the Prevention of Cruelty to Children Scotland; and Dr Mairi Stark, who is Scottish officer at the Royal College of Paediatrics and Child Health.

I will make a few housekeeping points before we start. The clerks have allocated one committee member to lead the questioning on each of the eight main themes that we have divided our questions into. If any other member wishes to ask a supplementary question on a theme, they should put the letter R in the chat box and I will bring them in if time allows.

We have six panel members. We will try to bring you all in when we can, but as we have eight themes and there may be supplementary questions, we might not be able to get round all six of you on every question. Committee members will always direct their questions to a specific panel member initially. If other panel members want to contribute, they should put the letter R in the chat box and I will come to them. We will prioritise your contributions over supplementary questions. You are our experts and we want to hear from you.

I will kick things off and, contradicting myself straight away, I will go round every panel member so that we get everyone's initial thoughts. The programme for government contains a lot of commitments around child and adolescent mental health, particularly on getting more support in community settings. One pledge involves a commitment that

> "every GP Practice will have access to a mental health and wellbeing service"

and there will be funding for 1,000 additional dedicated staff.

We have been hearing for years now that mental health services need to be in communities, and there was a previous pledge about having school counsellors in place. The pandemic seems to have had an impact on deployment of that pledge at local authority level. Lots of interventions are coming down the line and lots of pledges have been made. Can I get an assessment from each of you of what needs to happen with community services? What variations are you seeing around Scotland in relation to the deployment of previous interventions?

Alex Cumming (Scottish Association for Mental Health): Good morning to everyone. Convener, you are right—there are some really exciting building blocks for and previous pledges on child and adolescent mental health services. We at SAMH have certainly been advocating and looking for further commitments on community-based services. Children and young people and those that they work with—those who we are speaking to—are crystal clear that there is a lack of services for that community base, and particularly those who are under the CAMHS threshold.

The £30 million that the Government pledged for community mental health services is really positive and it should be commended but, from what we can see, a large number of those services are still in the implementation phase, so we do not yet know what the impact will be, although I think that it will be positive. The big thing for me is how we are marketing and communicating on those services, particularly to the new colleagues in primary care that you mentioned, because, if all those things are not connected, we will not make the best use of the resources.

Shelley Buckley (Mental Health Foundation): The focus of much of our work at the Mental Health Foundation is on promotion and prevention. Ultimately, under the current model, we constantly treat the problem as opposed to looking at ways of reinforcing the factors that we know protect communities and families. We need to rebalance the resources and shift some of them into that sphere.

We need to think about how we can enhance and promote the whole-school approach. You mentioned counsellors, but it is about more than that; it is about how we can, early on, promote in families, young people and communities healthy behaviours that will promote good mental health and support positive strategies for stress management. That will include connecting services such as school nurses and community-based organisations, considering how they can link more meaningfully to schools and communities, and understanding better what the needs of those communities are.

It is important to build skills. We need to support universal services in all community-based services and build skills around health-promoting strategies and techniques that can be utilised. We need to enable those services to work together and connect more closely into statutory services, and we need to think more holistically about how we can bolster the skills of those staff.

The big thing is to take the pressure off statutory services. At the moment, we have a real bottleneck in crisis services, whereby we are almost having to up-threshold or up-tariff families in order to get a service. That is a really big problem. An example is young people who are waiting for assessment because of neurodiversity.

I am doing some research on CAMHS in Dundee and we have identified eight key areas that involve straightforward approaches that we could take with community-based services. It is about shifting the skills of the experts in CAMHS and asking them to support the community-based organisations on some simple tasks such as managing sleep, positive parenting practices and helping families to communicate better with schools about their child’s learning and development needs. The feedback from parents has overwhelmingly been that they do not necessarily want their child to have a label or to have medication. They want to get holistic support and advice that they can engage with and feel in control of, rather than having to wait for very long periods of time for that support.

There are some really simple strategies that we can use in targeted ways to support families and communities. We can strengthen the protective factors by using the skills of the specialist services to build capacity in community-based organisations. The empowerment of that relationship is going to be really important.

We need to change our narrative on the topic, because there is still such a lot of stigma and shame. In order to address some of the problems earlier, we need to support families and communities to be able to articulate the challenges. We know that poverty and inequality and their cumulative impacts are some of the biggest factors that contribute to poor mental health in our communities, but that in itself is a big thing for families to be able to articulate and address.

We welcome the Scottish Government’s policy of free bus passes for the under-22s, which enables them to move around and access opportunities in their communities more freely, because social interaction is important. However, access to such things needs to be made easier and we need to ensure there are no practical barriers that will cause difficulties. I am just after getting the bus pass for my family and I noticed that there are quite a lot of layers of bureaucracy. There are quite a few challenges for families that do not have the resources or the technology to access that universal benefit and opportunity. The policy is good, but there is something to be said for looking at how it works on the ground and whether we are further excluding people.

The Convener: I asked a topical question on that subject last week and I made those points.

Susie Fitton (Inclusion Scotland): Disabled children and young people are more likely to experience social deprivation, social isolation and digital exclusion and to have poor mental health as a result. Children and adolescents with learning disabilities are over six times more likely to have a diagnosable mental illness or psychiatric disorder than children who do not have a learning disability, so timely access to child and adolescent mental health services is extremely important for disabled children and young people.

Our research during the two lockdown periods, as well as research from other disabled people's organisations, has shown that disabled children, young people and their families have experienced what we can really only describe as a mental health crisis during the pandemic, and that they have been harder hit by Covid-19. That is not only because they may be at greater risk of contracting the virus and severe illness, but equally or more so because the pandemic has supercharged the existing inequality that they already face and it has made new inequality likely.

Child and adolescent mental health for disabled children is being compromised by factors such as strained family relationships, digital exclusion, academic stress at school, loneliness and reduced social contact with friends. That has been magnified by the reduced access to routine mental health support, including CAMHS provision, care and rehabilitation services that would take the pressure off families of disabled children. The disruption to routine that everyone has experienced during the pandemic has been particularly pronounced for disabled children and those children who do not understand why their lives have changed so much or why there has been so much disruption to routine. Social isolation has been much more pronounced, in some cases public health messaging has been poorly tailored, and there has been a lack of emergency preparedness.

I will be talking about the removal and reduction of social care during the lockdown periods for families of disabled children and those families with disabled parents, which has created an inordinate amount of stress and anxiety and has only exacerbated disabled children's mental health issues.

There have been positive pledges on CAMHS, including further commitments on community services, as has already been discussed, such as the £30 million for community mental health services, and those things will have positive impact. The Scottish Government has made strong commitments to supporting CAMHS. However, as Shelley Buckley said, the mental health issues that disabled children and young people face often relate directly to social deprivation, and there is a link between disability and poverty. Disabled parents and disabled children and young people are much more likely to be living in poverty, and we need to address the poverty that is experienced by children in families with disability. I will make further reference to some of the ways in which we can do that later in this evidence session.

08:45

The Convener: One of my colleagues will ask about the additional Covid-19 pressures.

Sam March (Association of Scottish Principal Educational Psychologists): Alex Cumming's point about connection is a really good one. We need to work on our connections and our single point of access and avoid what I call pinball-type referrals whereby young people are bounced through the system.

I also highlight Shelley Buckley's fundamental point about whole-school approaches. A whole-school approach is a preventative approach, and it is a key thing. The Scottish Government's "Whole School Approach Framework" document was launched last summer, and that framework should be a good building block for prevention in schools over the next few years. It is a challenging time to do that and to connect all the dots in the system, but we need to get that right.

ASPEP educational psychologists are involved in the implementation of counselling and community mental health interventions. Counselling comes a bit further on, although it is seen as an early intervention resource. It is having to pick up a bit more across the country—in particular, it is having to pick up more acute needs following Covid—but it is getting fairly well embedded in schools. Some young people want to work with people whom they already know and have relationships with, and counselling is part of the solution. Good things are coming from community mental health and there has been good use of the third sector, but this is an early stage of implementation. Local authority partners are excited about working with the third sector and about some of the things that are already happening and that they are involved in.

When we get it right, we provide a good single point of access to ensure that families get early intervention. We need to think creatively about routes—for instance, the GP route to CAMHS—and alternative loops that can provide earlier support. An intervention that has been trialled in South Lanarkshire is distress brief intervention—DBI. I believe that that comes from separate funding, but it is a really promising intervention. It has a loop back into CAMHS, it is a responsive early intervention, and it is easy to access.

A lot is going on and it is a matter of connecting some of those things. This is a hard time to do whole-system implementation, and my concern about the early intervention, counselling and community side is whether the funding for that is dwarfed by the funding that specialist services get. It is right to be cautious about community mental health in some ways as it is a new service and it is hard to get it right. However, as the convener said, that is where we want to provide support that is accessible for families, children and young people.

Joanne Smith (National Society for the Prevention of Cruelty to Children Scotland): Thank you for the opportunity to present further evidence today. I agree with Shelley Buckley's point about the need to balance the urgent crisis with longer-term strategic service planning. The Government's commitments on community mental health services were introduced in January 2021, and it would be really helpful for the committee to ask the Government what we are learning from the robust multi-agency monitoring processes that accompanied the establishment of those services. One year on, what do we know about the readiness of local areas to implement a community mental health approach? Can we be confident that our children and young people are now receiving timely assessment and appropriate referral?

Our learning from ChildLine data suggests that we have not been getting it right during the pandemic, which is unsurprising given the pressure on the system. Children are contacting our counsellors saying that they are in distress about the inability to access support and the long gaps between any support that is available, and they talk about the disillusionment that comes with a decision that their criteria are insufficient to warrant support. That sends a strong message to children about how we value their wellbeing, so there is much to be done.

On the question of what we know about what is happening around the country, Sam March mentioned that CAMHS is one element of a system of support around children and families, and we know that the wider support system has been undermined by cuts to local authority budgets. On behalf of the NSPCC, Susan Galloway carried out research that looked at the availability of family support provision in Scotland. The research was initially carried out in 2013 and revisited in 2020, and we saw a decline in availability in both the third sector and statutory services.

The pressures on our wider systems will undermine any attempt to create a community mental health offer for children and families, but a critical first step is to understand what capacity exists locally in our systems. We need to map our capacity—not in single disciplines, as is happening in some areas, but across disciplines—and determine the strengths and weaknesses in our local systems so that we can ensure that the investment that is made is targeted accordingly to deliver the best outcomes for babies, children and families.

Dr Mairi Stark (Royal College of Paediatrics and Child Health): Thank you for giving me the opportunity to discuss some of the issues that we are seeing increasingly in paediatrics.

I am the Scottish officer for the Royal College of Paediatrics and Child Health, and I am also a general paediatrician at the new children's hospital in Edinburgh. Yesterday, I was reflecting on the fact that I am a paediatrician, but I also seem to be becoming a child psychiatrist. A huge amount of my work is now child psychiatry, and it is very difficult to get expert help for the children. There are definitely children out there in crisis.

Mental ill health includes a lot of different issues such as anxiety, chronic fatigue, anorexia and neurodevelopmental conditions such as autism spectrum disorder. Increasing numbers of children are coming to clinic with physical issues due to their underlying mental health issues that have not been met, and which might not have been met for years.

A lot of those children are not in school. If I refer a child for an ASD or mental health assessment, they will have to wait 10 months to two years for that. That might be two further years out of school, and if they are 12 or 13, that has a lifelong effect. It affects their education and career opportunities and their health as adults. We know that 50 per cent of adults with mental health problems had their difficulties before the age of 14. Therefore, we are looking at not only children's difficulties, but adult difficulties further down the line. It is really important that we take that on board and start prioritising children.

The Covid pandemic has severely affected children. They have not been dying in intensive therapy units, but their life chances are being significantly reduced because we are taking services away from them, when we need to be building up services for young people.

Waiting times are getting longer and longer—they are months and months—for CAMHS referrals and for general paediatrics, which is full of children with mental health problems. It is easier to get into general paediatrics, so we are seeing them in that area and doing our best to improve their lives. There are people who should be on our acute wards, but we cannot get them in. For example, at the moment, people who have anorexia are coming to the general paediatric ward. Over the weekend, no mental health beds for young people were available in Scotland.

That is the situation across Scotland, and it is difficult. We do not want to send children to England for community services that should be provided here, so we need to increase capacity for all services.

We need data on the prevalence of mental health conditions in Scotland. How many children have anxiety? How many children are waiting? How many people see their GPs with their parents but are sent away and told that there is no point in doing a CAMHS referral, because they will just get bounced back? Many children are not even getting referred, because it takes a lot of time to do those referrals and GPs know that they will not be seen.

How will we sort that? We will have to do a lot of different things, including basic community interventions. Poverty is an issue. People who are in poverty cannot afford to buy good food, to go to groups or to take part in exercise opportunities. Young children tell us that poverty stops them feeling healthy, happy and well. That is the underpinning of all those things.

Children need help when they are toddlers. In my clinic, I can identify two-year-olds who I know will have mental health difficulties when they are 12, 13 or 14. We need to intervene early and look at ways to improve children's health right at the beginning. We need to give all children opportunities to do exercise and have healthy diets, because those are the building blocks for good mental health.

We need neurodevelopmental services. Increasing numbers of children who are maybe 12 or 13 are coming to my paediatric clinic with underlying ASD that has never been diagnosed. It takes two to three years to get ASD assessments and, by the time they get interventions, they will be moved into adult services.

We need to get school counsellors and supports in place for those children. There is a whole group of children who are in second year at school and who have missed their primary 7 and secondary 1 residential trips. That might have been the only time that those children would have had the opportunity to go away from the family home and do activities and team building with their friends. That opportunity is gone and there are no plans to catch up on opportunities. They are just told, "Oh, well, you missed that—tough luck." Those children feel that they are not being prioritised by the Government.

With regard to businesses, it is great that adults will get to go to restaurants and nightclubs, but what about all the community groups that need funding? Some of them are quite cheap to run, but they are not getting funding. Third sector organisations, including youth work organisations, have to go for funding every few months and spend half their time trying to get funding rather than looking after the children. We need more youth workers.

We now have youth navigators on our paediatric wards, to try and support families who are in crisis, because we know that we need to do something. However, the funding for that will not necessarily continue. We need to keep funding going and get the building blocks. We cannot magic up lots of paediatric psychiatrists or paediatricians, but we can get more community services across the board. We need to help those young people.

The Convener: Thank you. We have heard a lot of issues, and my colleagues will dig into those. We will not have the opportunity for every member to put questions to all six witnesses, because we do not have time. I wish that we had the time, because there is a lot in there.

My colleague Sue Webber has questions on accessing specialist support.

Sue Webber (Lothian) (Con): We have heard, at length, that there is a challenge in accessing services because of the scale of the issue, as well as the challenges that our young people are facing. We have received evidence that

"The number of referrals continues to rise year on year",

which resonates with what the witnesses have said this morning. Why do you think that more children and young people require specialist services for their mental health? Dr Stark has just intimated that poverty might be one of the key factors, but is there anything else that might be driving that?

The Convener: Could you direct your question, please?

Sue Webber: I put it to Dr Stark first, as I referenced her previous statement.

09:00

Dr Stark: There have always been mental health issues, but Covid has been very difficult. Some children were having difficulties and anxiety issues, and we took them out of school, put them on to virtual learning and told them to stay in their bedrooms and be on a computer all day. The children who were very anxious have now lost the ability to go out and meet people and do things. Some children are desperate to get out and meet people and go on the bus and socialise, but some have lost those skills and are becoming increasingly anxious. It is very difficult for children to gain that confidence. A lot of the opportunities that they might have had previously are simply not there. If they are not doing things, they lose that ability and lose confidence—we all lose confidence. That will not be helping.

There are a lot of children with chronic fatigue, but we have no chronic fatigue services in Scotland. I had hoped that some of the long Covid money would be directed to that, but so much of the money and things that are available are for adults. Children are missing out, and it is very difficult for families to support young people, because they do not have the tools.

Susie Fitton: To back up what Dr Stark said, I note that we did some research during lockdown to find out what impact the pandemic was having on disabled people—adults and children—across Scotland. It was clear from our analysis of the responses that the risk from Covid-19 for disabled children and young people was about much more than simply risk to health. We found that stress, fear, anxiety and sleep disturbance were pervasive for disabled children and young people who were shielding, self-isolating or trying to follow social distancing measures.

The impact was very significant for disabled children and young people with pre-existing mental health conditions, which were made worse by social isolation and anxiety about the future. Disabled children and young people who were shielding and who lived with key workers and were therefore at high risk of catching the virus were under particular strain.

There were also disabled children and young people who had limited social networks or who found digital or remote communication difficult or impossible. Digital exclusion has been pervasive for many disabled children and young people, and has only exacerbated poor mental health. Disabled children and adults who struggle to understand and follow social distancing rules were also in very anxious and stressful situations.

We had some really difficult situations for the families of disabled children and young people who were shielding but who relied on external carers or family members for personal care. Some disabled children went from having two-to-one support in residential accommodation to being sent home to parents who were trying to juggle the childcare of other children and home working while getting no statutory support to care for disabled children. Some parents told us that their children were exhibiting behaviours such as self-harm, vocal tics, very low mood and challenging behaviours because of the removal of structure, daily activity, routine, face-to-face contact with friends and access to the outdoors.

I will reiterate some of what Dr Stark talked about and note that disabled children were, in fact, losing their social skills and independent living skills. Many parents talked about how they saw their children regressing—particularly during lockdown—after all the efforts that had been made by residential schools or schools in general to support their social skills.

Obviously, our evidence is from during the two lockdown periods, and some of the stresses on disabled children will have lessened as the restrictions have eased. However, that evidence is still important, because evidence from previous pandemics—such as severe acute respiratory syndrome in 2003—has demonstrated the potential for long-lasting effects on children's mental health. The length of time that children felt lonely predicted mental health problems up to nine years later, particularly depression.

In many ways, the evidence from disabled children during lockdown is as important now as it was at the time, because children who experience extreme social isolation are much more likely to require support from mental health services and to experience high levels of post-traumatic stress.

Sam March: It is a big question. There is no one reason. We consulted young people during lockdown, and 72 per cent of more than 3,000 young people said that the biggest thing that affected their mental health was family life, followed by peer relationships. There is a mixed relationship with social media and the school experience. If you track back over the past 15 or 20 years, children are slightly more likely to say that concern about school work is a factor in their mental health. There are a range of factors.

Loads of work has been done on school culture and ethos and promoting positive relationships. School is a buffer in relation to mental health outcomes for many young people. The number of young people who say that they do not enjoy school has not fundamentally changed, unfortunately. During Covid, we did research that found that, in the early lockdown, some young people were seeking the comfort of slowing down and avoiding life stressors. We need to take a really holistic perspective to understand why modern life is placing greater stresses on children, young people and families. Family stress is part of that, too.

Shelley Buckley: I will not repeat what other people have said, because I agree with everything that they have said on the issue. Covid has escalated or exacerbated the existing vulnerabilities in our communities. Our report "State of a generation: Preventing mental health problems in children and young people", which was published just before Covid, highlighted the issues that reinforce that. It covers young people who experience trauma, abuse and neglect, refugees and asylum-seeking families, parents who have comorbidity problems and looked-after children. Those are all factors that influence children's home life. Sam March made the point that family conditions and relationships have a significant impact on young people's wellbeing and how they develop into adults.

Another massive issue that came out of our report is about identity. Our society is changing; there is a technological and digital revolution and a generation of young people are growing up with a perception of the world and the expectations and roles that they perform within it that is vastly different from our, and certainly my, childhood experience. We are going through a change in society. In some respects, we are using an adult lens to analyse and assess the needs of our children and young people, but their perspective is skewed because how society functions, how they engage in relationships and how they communicate with one another is extremely different from our experiences.

Another significant issue that came out of our report was that racial and ethnic identity is massively important. Are we speaking the same language? Are the words that we use when we talk to families about mental health and wellbeing understood in the same way? Are we taking account of the diversity of beliefs and values? Sexual and gender identity is massively important and is one of the biggest issues that schools deal with in relation to young people trying to figure out who they are, how to form relationships and what healthy sexual relationships look like.

There are intersectional issues that flow from that. Susie Fitton talked about learning disability and identity; the issue has been massive for a long time and continues to be so; those young people's vulnerabilities have been exacerbated for all the reasons that Susie talked about. Issues around identity and school transitions, leaving school and academic pressure and uncertainty have all been escalated because of Covid.

There is an issue around body image and the idea of what a successful person looks like—what you have to be and what achievement looks like. The narrative and the images from social media are incredibly influential, and young people are being exposed to social media 24 hours a day. There is no respite from that. If we think about how that then links in with bullying, we found from a survey of young people that they did not find it all that useful to separate out bullying and cyberbullying. To them, it was simply bullying, because in their world there is no separation, necessarily, between the virtual world and the real world.

The Convener: Thank you. There is time for Sue Webber to ask a follow-up question.

Sue Webber: Shelley Buckley stated that we look at everything through an adult lens; specifically, she was talking about looked-after children. Bearing that in mind, I declare an interest as a corporate parent and councillor in the City of Edinburgh Council.

Last night, we met a lot of young people who were in care or were looked-after children. We were talking earlier about a single point of access to services, but many of them struggle because they do not have a parent behind them, pushing. What could and should be done to inform children, young people and their parents and carers of the services that are available to them and to make those services easier to navigate? I can see Shelley Buckley nodding, but I will ask Sam March that question first, given his position with South Lanarkshire Council.

Sam March: That is a really good question. I am trying to make it clear that children who are care experienced and in our children's houses have access to and know about our counselling service. We also have a trauma counselling service. Work is being done with children's house managers on advocacy, awareness and communication.

I have a responsibility to make sure, when I look at service use, that the service is reaching the right children and young people proportionately and that alternatives are provided. We need to speak to young people and work out the individual barriers to accessing services. I mentioned earlier that not every young person wants to access counselling in school. We need to ask whether there are alternatives and try to be creative around that.

On the creation of services, we have also used a really good sector intervention called the blues programme, which works for a lot of children and young people. It involves earlier intervention as well as group work, and young people rated it really positively, so we are continuing the use of that programme.

We have a real responsibility to co-produce services. Co-production features strongly in all the mental health project board specifications, and we are doing it like never before. There is a great resource—from NHS Education for Scotland, I think—about evidence-based interventions. There is no point in configuring and planning such services without speaking to the young people who are the service users. There is absolutely no point in just plucking a service off the shelf and saying, “That looks great, because it worked in Connecticut”, for example. We have to speak to young people and work out what the barriers are. We are doing work on that in local authorities.

Alex Cumming: Sam March has just made the point that I was going to make about co-production being key; I am sure that all the witnesses would agree with that. I will build on Sue Webber’s question about what else we can do to create a single point of contact for young people and parents. The need for co-production also relates to parents. We want to bring in their thoughts, themes and ideas as to what would work. It comes back to the point that Shelley Buckley and Dr Stark made about the services being adult services. Right at the start of the meeting, the convener mentioned the additional resources that are going into primary care and mental health support in GP practices, but are they still focused on adults?

09:15

In south Edinburgh, we are about to pilot an initiative involving a children and young people link worker. Similar initiatives are going on in Glasgow and a number of other local authority or health and social care partnership areas. Is that where children and young people can go to? Will young people feel that those services are for them and access them? That is the big question. It is important for all of us in the third sector and primary care to promote those services as accessible to young people so that they recognise that they can go to those places and be linked in as a result.

The Convener: That is a good point. I know what Sue Webber was referring to, as I was in the same meeting with young people last night. I was quite distressed to hear a young person say that they could not get past a GP receptionist when they were in crisis. Your point is well made and certainly resonates with some of the experiences that we heard about last night.

I will bring in Stephanie Callaghan, who has a question on the same theme, and I will then move on to questions on CAMHS waiting times from Evelyn Tweed.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): Good morning. It is good to see the witnesses here this morning. It was good to hear Shelley Buckley and Joanne Smith talking about neurodiversity and the long wait for help with quite basic things such as issues around sleep, positive parenting and communications with schools. Joanne Smith talked about long gaps and the disillusionment when young people are told that they do not meet the criteria for support. That certainly chimes with me. I should say that I am a parent to neurodiverse children and that I am a councillor in South Lanarkshire Council.

In South Lanarkshire, we have the autism resources co-ordination hub, or ARCH, which does amazing and quite groundbreaking work on holistic support and integrating the council, the third sector, the health service and parents and carers. One of the top things that parents ask for is advocacy support. Should that be a top priority for the Scottish Government? I direct that question to Mairi Stark first.

Dr Stark: Neurodiversity is a big issue. We need to have much more rapid assessments for young people and children, and then we need to provide school supports. On advocacy, people need advocates because they have to fight through the system, but should we not have a system that people do not have to fight through? It should be easier. Somebody mentioned the free bus pass. Figuring out how to apply for that has not even got on to my to-do list. All that I have heard is that it takes a lot of time and is difficult. Why do we need to make things so difficult?

Some families will not be able to advocate for their children. We need to look out for those children. Schools and anybody who looks after children need to be their advocates. We should just make the system easier for people. It should not have to be a fight. It should not be the case that only if you have what is referred to as a stroppy or difficult parent will you get the help that you need. All families and children should be able to get the help that they need without fighting. It should just be available.

All families that have a child with neurodiversity find that difficult. They do not need the system to be difficult. We need to make things as easy as possible for families so that we can provide good care at the right time, and not with long waits.

Shelley Buckley: An interesting project that I have been working with involves working closely with community-based organisations and statutory services in the Dundee area. That is part of wider community mapping and looking at what is available. Actually, there is loads out there but, because the system is so complicated, people do not know how to access it or are diverted the wrong way or round so many houses to get there in the first place. It also takes a lot of knowledge on the part of the particular worker who has been approached for support to be able to signpost someone in the right way or provide them with the right support.

A simple thing that is being piloted at the moment is a fast online referral tracking—FORT—system. Community-based organisations are the first point of contact, and they look at how families can be supported. In essence, they triage the needs of families and look at and advocate for the type of support that they need.

In Dundee, it was thought that that approach would be more beneficial, because many community-based organisations had a better understanding of the cultural dynamic of some of the communities and the key issues affecting some sections of those communities. They had a better relationship with families and were more accessible. The default position is that, if it is a mental health issue, it goes to CAMHS, but those organisations understood that it is important to look at what is causing a family's distress and to ask whether it is because mum and dad have complex needs themselves, such as being under a lot of financial pressure, which leads to the children experiencing distress. What would be the best support in that context? Would it be to refer the child to CAMHS or to support the parents so that they can support their child better? A more holistic approach is taken to understanding the social, environmental and cultural factors impacting on the child's wellbeing.

That pilot project is on-going. It is trying to make the system more accessible, with families having one point of access so that they do not have to go around the houses.

There are different things that we can do. Co-production and having conversations with the families and communities will be really important so that the localities understand what will work best.

The Convener: I am sorry, but we need to move on to questions from Evelyn Tweed. I ask committee members to keep their questions short and to the point. In that way, we will get round everyone.

Evelyn Tweed (Stirling) (SNP): Good morning. I thank the witnesses for all the information and answers that they have given us so far. They have been really helpful.

My question is on waiting times. It is great that the Scottish Government has made significant announcements about CAMHS and funding. However, in my area and in other areas across Scotland, there are still significant waiting lists. I know that some of you have touched on this in previous answers, but what is your view on that? Why are there still significant waiting lists, and what can we do to help with that? That question is for Joanne Smith.

Joanne Smith: We are very concerned about the demand for crisis services. The NSPCC argues strongly for investment in the early years. We recognise that there is a balance to be struck between meeting that and addressing immediate crises, but we need a long-term strategic approach that is informed by the evidence that many mental health difficulties have their roots in infancy. If we can get it right in the early years, we can lay the foundations for all future wellbeing and health, thus stripping out the demand for crisis intervention later on.

Other people have spoken about how we find ourselves in this crisis. There is universal consensus about the role of poverty and the impact on family functioning and child wellbeing. We endorse the findings of Katherine Trebeck's report, which called for fiscal decisions that prioritise wellbeing over growth—that is what is required to improve the mental health and wellbeing of children.

We also need heavy investment in preventative services. The committee is well placed to do some of that thinking, because it is carrying out an inquiry into perinatal mental health. That is a really exciting opportunity to accelerate long-standing ambitions on prevention. We have an opportunity to build mental health infrastructure into an integrated early years offer that will support families at a point when it is likely to have the biggest impact, so that we can drive down the demand for our crisis services and, therefore, the waiting lists.

As a note of caution, it is worth pointing out that, as we emerge from lockdown, health visitor data shows an increase in developmental delay for children who are starting nursery. If that is not treated and responded to quickly, it will grow and continue through those children's lives. That will stack up a continuous demand for crisis intervention later on. We need a robust, universal early years offer for families now.

In Scotland, we have really strong foundations to build on because of the priority that has been given to early years by the Scottish Government over the past 10 years. That is where we can make the biggest difference now. The children that we are failing now will go on to have children of their own, and that cycle will continue. We make a plea for the early years to be a priority in the committee's inquiry.

Evelyn Tweed: What support should be available to children and young people when there is a big gap before they get a CAMHS appointment? That question is also for Joanne Smith.

Joanne Smith: Do you mean what can be provided for children when there is a gap in the availability of support?

Evelyn Tweed: Yes. If a child or a young person has a long wait, what can we do during that time to help them?

Joanne Smith: It is critical that we have local community family support available. Through our family support work in Scotland, we have highly skilled professionals who are grounded in communities and have the local relationships that allow them to get alongside families and provide that more holistic, integrated support. Much of the work that needs to be done for a multi-agency integrated approach is happening locally. We need to promote that and invest in it. There are good plans to do that, and there are good examples of holistic family services in GP practices.

However, for that to work, there needs to be significant investment. It is unlikely that the £500 million wellbeing fund will be sufficient to plug existing gaps and to build capacity. We have got right the vision of what good community mental health services look like, but the question is whether we are investing to deliver those services in practice.

Alex Cumming: I want to follow up on the previous couple of points. Three years ago, in partnership with Young Scot, the youth commission on mental health services recommended a multi-agency approach to triage, and the Government accepted those recommendations. Although there are some good isolated examples of that approach—which Shelley Buckley and Joanne Smith have commented on—that is not happening everywhere. That key aspect will reduce waiting times and the number of people on waiting lists.

Once someone is waiting for an assessment, no matter what that might be, it is important that they have a consistent point of contact. Sam March mentioned the pinball scenario in which people are sent from pillar to post. Once someone is in the system, it is important that they have regular communication, to give them updates and a consistent point of contact for support and help.

The Convener: I am afraid that we will have to move on to the next theme—we are rapidly eating up our time. I will try to pick up people as we go along. We will move on to the theme of rejected referrals.

Gillian Mackay (Central Scotland) (Green): In its submission, the Royal College of Psychiatrists said that there is

> “a wide variation by health board in how even CAMHS set its expectation for who would likely need care in its services”

and that that is dependent on particular geographies and availability of resource. To what extent does regional variation impact rejected referrals? That question is for Joanne Smith.

09:30

Joanne Smith: What is available locally is a postcode lottery. We need to urgently understand what the local capacity is across health boards. There are examples of good practice, with people working well to build multi-agency hubs, but the levels of provision are variable across the country. We must have a clear national picture of what that looks like, because we do not want to have a scattergun approach to using any new investment.

It is really important that the Scottish Government recognises that the issue is a huge challenge and that we need to take a tiered approach to implementing the changes. That will require us to take stock of the position in local areas, including of the infrastructure, and to consider how we best enhance that.

As I mentioned previously, a similar expansion of perinatal and infant mental health services is taking place. All the issues that exist in CAMHS around recruitment and retention and capacity exist in the perinatal expansion as well.

Two parallel processes are happening, and organisations are trying to recruit large numbers of staff for both. The likelihood is that people will move between health boards and between disciplines, rather than capacity being built, because the specialism does not currently exist.

To make that work in practice, we must of course consider clinical need, but we must also think seriously about education, recruitment and training, so that we can be confident that any new posts can be filled with new capacity, rather than it being a case of moving deck chairs—[*Inaudible*.]

The Convener: Thank you. Paul O’Kane will pick up some of the themes around workforce.

I will bring in Alex Cumming, because it is important that we hear from CAHMS on the issue.

Alex Cumming: I will follow on from Joanne Smith’s points about why referrals are rejected in the first place. Last year, through the programme boards, and now through the joint delivery boards, new CAMHS criteria were launched. However, there is still a lack of understanding in some areas, and among the wider public, about what CAMHS are for.

Understandably, families want what is best for children and young people, and young people want to get the best support, but are CAMHS the right support for them? A couple of the other witnesses mentioned a whole-system approach. We need to look at everything in that way and to direct people to the most appropriate support through the triage system, for example.

That would stop disappointment, which we want to avoid. No young person or family should be rejected from CAMHS. We need to upskill and to increase information and knowledge across the widest community in Scotland, so that people know what CAMHS can do, what the school counsellor is there to do and what the school nurse is there to do.

Prior to Christmas, lots of people had through their letterbox a really helpful leaflet from the national health service about where they should go during the Covid period if they have a health issue, such as a dental issue. Perhaps we need the same thing for child and adolescent mental health services. We know that that breadth of services and tiered approach will work, as there is good evidence for that. Whether it be through primary care or other referral routes, we are still sending young people and families to CAMHS when they should be going elsewhere. A bit of upskilling is still needed.

The situation is no one’s fault. People are making referrals to CAMHS because they think that that is the best place for those in need of support, or because they do not understand what is available locally. Increasing information and knowledge across the sector is really important.

The Convener: Thank you. I will correct myself: I said CAMHS when I should have said SAMH, for which I apologise.

Gillian Mackay: The other issue that I want to touch on is data. The lack of data on rejected referrals has been highlighted to the committee. Do we have a sense of whether children and young people from certain backgrounds with certain conditions, or from marginalised groups, are more likely to be rejected for support? I will go to Dr Stark on that.

Dr Stark: Data is useful, because it enables us to see what is going on. The prevalence of mental health difficulties is probably much higher than we realise. We often see only the tip of the iceberg, but a lot of children could do with a lot more support. We need to look at not only mental illness but mental wellbeing, and at how we make all children feel a bit more secure and happier, and make them more resilient to developing mental illness, because we are not currently doing that.

With regard to the difficulties around waiting times and everything else, we need to stop the flow of patients coming in. I am not sure how we would get the data on how many people are affected—schools are probably the best place to do that, because they can offer a much broader view and we can see which socioeconomic groups are more affected. There definitely needs to be more input for care-experienced children and families who currently have less support. If parents have mental health difficulties, they may not be equipped to give their child as much support because they are dealing with their own issues.

It is not just about one group, however—there are difficulties across society. We might think that some children are fine because they have professional parents, when they might in fact be having difficulties, too. No child should be excluded, and we should be looking at the universal picture. Nonetheless, some groups—children who are care experienced and children who are living in poverty, in particular, are good examples—definitely require more intervention.

The Convener: We move to questions on integrated services and partnerships from Emma Harper. As several witnesses have already mentioned that issue, it would be great if you could direct your questions and pick up on some of the things that have been said.

Emma Harper (South Scotland) (SNP): Good morning, everybody. You have touched a lot on integrated services and partnerships, which I was going to ask about. Dr Stark has just mentioned poverty, which we know is a huge contributory factor in mental poor health.

I note from our papers that the Promise Scotland’s “Family Support” document outlines 10 principles of intensive family support that will be embedded in practice. I will not read out all 10 principles, but they include

> “Community Based ... Responsive and Timely ... Work with Family Assets”

and

> “Empowerment and Agency”.

A submission to the committee from Darren Little, of Dumfries and Galloway children’s services strategic and planning partnership, referred to the need for

> “Multiagency strategic planning and implementation at a local level”.

We know that, if people work better together, that will support better outcomes. What impact would greater integration of services have on the demand for CAMHS and on service delivery? I will go with that question first, and then I will wind my other two questions into one.

The Convener: Would you like to direct your question to a specific witness?

Emma Harper: Yes—to Shelley Buckley, and then to Sam March.

Shelley Buckley: I completely agree that integration of services is incredibly important. Having a range of perspectives is important in enabling our specialist services to understand the needs of their communities. It is important that we have social work, occupational therapy, community psychiatric nurses, psychiatry and psychology all working together to enable us to come at a problem from a variety of perspectives and identify families' needs accurately.

Another important aspect is the need for integration at all levels. For example, during the summer, we had a focus on mental health promotion. Using some of the Scottish Government money around the get into summer programme, we worked alongside the Thrive Edinburgh collaboration and CAMHS services, and 22 community-based organisations. We used the stress less tool, which is a mental health promotion tool. It is about skilling up staff in promoting mental health as opposed to identifying mental health problems and symptoms. The 2,500 young people with whom we worked all experienced mental health problems—they all came from family backgrounds where there was a lot of adversity, distress and poverty, so we knew that there were multiple challenges.

The outcomes from taking a mental health promotion approach were incredible, given that it was a very short project. The approach addressed the risks that we often mitigate, such as inequality and poverty. We found that staff started to work together really quickly in identifying the range of needs and sharing resources, ideas and skills, because we got staff working together across the various teams. That happened over two months, which is a very short period. That work was important, because staff in some areas identified that they did not have certain resources or access to certain skills and knowledge, but partnerships were formed very quickly.

We identified that staff knew certain groups really well. For example, they knew that, in certain families, young people had huge confidence issues, perhaps because they were young carers and were dealing with multiple difficulties. Staff were able to facilitate support from the young person's front door and to support the parents to enable the child to engage in community activities that built their confidence over the summer.

The young people were able to engage in activities and programmes that they would not otherwise have been able to afford, because the activities were part of a wide universally accessible programme. They were able to take part in leisure activities, and their travel and food were all included, so there was no shame or stigma in participating and engaging.

Young people were supported to engage in new things that they might have been afraid or frightened to do. They were able to revisit things that they had done before Covid but which they were really nervous about doing again. That included things such as getting into the swimming pool and going to the sea; we are not talking about complicated issues. However, the feedback from the young people on how the project enhanced their wellbeing was overwhelming.

Many witnesses have highlighted the need to talk about wellbeing and to promote the protective factors that we know will enhance young people's wellbeing. That will reduce the risk and support parents. We enabled parents to engage with their children in those social activities and to give them positive experiences. The youth workers were able to support them with that, because they had specialist long-arm support from specialist mental health professionals. They had been given tools, through the stress less programme, to engage in proactive ways.

The young people came back and said that it had been nice to talk about mental health in a different way. We always focus on the things that are wrong and negative, but mental health is also about doing things that help people to feel good about themselves and about understanding who the right people to talk to, and who are good for them, are. Who is the best person to be their friend? People should have the confidence to share their thoughts with their friends.

The project was about taking a different approach, changing the narrative and having a different conversation. The consequences of that, in a very short space of time, were really empowering. There was empowerment between organisations, and there were empowering conversations between communities and the organisations involved. That had a long-term effect, in that a lot of the work has gone beyond the project and has seeped into schools and other parts of the community. Children have been brought on as sessional staff and have had employment opportunities as a result of that activity.

That shows that small initiatives at ground level that use co-production and an interdisciplinary approach can have a massive impact in strengthening the protective factors.

Sam March: There is a lot of integration among children's services and different agencies, including with the third sector, whether it be via the Promise board or child protection planning committee. We continue to meet, plan, share data and jointly commission where possible. The conversation around issues such as community mental health is multi-agency. On the conversation about sharing data with CAMHS, we have local data and are using it to examine gaps.

09:45

There is a high level of integration, including with the third sector. There are also some really good examples that others have talked about of multi-agency hubs. We have a newly set up early support hub to provide early intervention. There are other really good examples throughout the country.

Alex Cumming mentioned triaging. My view is that, when you reach CAMHS, signposting will not cut it. Multi-agency triaging is essential. That is an area for development.

In local authorities, we get money that is sliced up as being for this and that—for example, attainment challenge funding—and is short term only. That can be a challenge for prevention, early intervention and joint commissioning.

The Convener: I apologise to Emma Harper for not coming back to her, but we have three more committee members who have not yet asked questions. If I have time at the end, I will bring her back in.

We move on to questions from Carol Mochan on inequalities in accessing mental health care.

Carol Mochan (South Scotland) (Lab): It is a huge area, but we do not have a lot of time, so I will be direct in my questioning.

We know that groups such as people from poorer backgrounds and children with learning disability have more difficulty in accessing mental health services. What can we do to improve access for children, young people and their families?

We have talked a lot about the cuts to local authorities. I am keen to know whether the witnesses think that those have affected people. I am concerned about that issue.

I cannot see all the witnesses at the moment.

The Convener: It might be an idea to bring in Susie Fitton. If anyone else wants to come in, they should use the chat box.

Susie Fitton: Our research during lockdown highlighted a particular issue for families of disabled children and young people with cuts to social care provision, some of which were austerity driven and some of which were a response to the pandemic. We found evidence of very concerning situations, in which children's and young people's mental health had been directly impacted because their own social care support had been stopped or reduced, or the social care support on which their parent or parents relied had been suddenly reduced.

In some cases, the support was reduced overnight. People had no prior warning that the support that they received through social care—local authority provision, largely—would be removed. Because of that, families were left in quite desperate situations, with parents suddenly being thrust into caring responsibilities for young disabled people and trying to juggle those responsibilities with home working and, potentially, home schooling other children.

The strain on local authorities, particularly in relation to the provision of social care support, has exacerbated mental strain for families and, in some situations, has made pre-existing or pandemic-related mental health issues worse for disabled children and young people.

The other pandemic-related issues that created mental strain included families struggling to get food and medicine. Many families that experience disability because of a disabled child or a disabled parent reported to us that they struggled to get the food and medicine required by a disabled person in the family. That created an additional layer of anxiety and stress for families, particularly in the early part of the pandemic, when it was very difficult to get delivery slots and it was very difficult for some disabled people to access supermarkets. People who were shielding, in particular, found it difficult to get the support that they needed. That only exacerbated the mental strain. Disabled parents were concerned that they might lose their job, and financial pressures, especially during the beginning of the pandemic, only served to exacerbate family strain.

In that context, families who were previously reliant on statutory services, which they accessed via the school or via respite provision, reported to us that they felt abandoned by those services, particularly when it came to local authority provision, at a time when they most needed support. That feeling of abandonment has not abated for some families, even though services have, in some cases, been reinstated. That feeling that emergency planning did not cater for the needs of the families of disabled children and young people has left people fearful for the future, particularly if we have to go into lockdown in another period.

Sam March: You asked whether anything can be done. I have a slight concern about the suitability of school counselling and wonder whether we need to be more flexible in the services that are provided. The initial spec is very much fixed on talk therapy. There has been a lot of discussion in the networks about alternative types of therapies being more accessible for some children and young people. That is an on-going consideration.

You also asked about local authority budgets and whether the cuts in those had had an effect. I would say yes, in a range of ways: the most obvious statistic that I have to hand is that educational psychology numbers have dropped by 20 across the country since 2017-18. We have a significant role in mental health and wellbeing work at a variety of levels, including in supporting the most vulnerable children and families as part of our casework, along with a wide number of other involvements, some of which I hope I have articulated.

The Convener: I apologise to Carol Mochan: I am not able to come back to you, as we still have two committee members wanting to ask questions.

We were going to move on to the specifics of Covid-19 with Sandesh Gulhane, but we are difficulties with broadcasting and getting him back on screen. We will therefore go to the deputy convener, Paul O'Kane, to save the day.

Sandesh Gulhane (Glasgow) (Con): I am here, convener.

The Convener: You are here, Sandesh. That is great—I thought that we could not see you. We will come to you now.

Sandesh Gulhane: Thank you, convener. Covid-19 could obviously take up the entire evidence session, so I will focus my question. We have heard about the impact of Covid-19 on people with disabilities, and that has been well articulated. I would like to know what impact Covid-19 has had on young children based on their ethnicity. How do we get data and information around the prevalence of mental health issues not just in the ethnic community, but throughout children in Scotland?

I suppose that I can put that question to everyone, although if there is anyone in particular who has—

The Convener: Sadly, we cannot go round everyone. Let us go to Joanne Smith first; if anyone else wants to chip in, please put an R in the chat box.

Joanne Smith: That is a really important question. We recognise that there are real limitations to how we disaggregate data related to who is accessing mental health—[*Inaudible*.]—much better at that. However, we know that there are cultural issues that make it less likely that people will access a referral pathway that starts with a GP, for example. Some people would not be reaching out for help, and it would be much more suitable to provide a community-based resource for them that is embedded within local cultures and practices.

Data is a massive issue. We have had a range of reviews and committee inquiries over the past 15 years that have flagged up the lack of comprehensive data on spend, planning and outcomes. That area warrants urgent attention. By getting a robust evidence base, we can design a system that would reach those groups who do not typically access specialist services.

I will make a point about looked-after children. In the year of the Promise, we know that children whose mental health difficulties co-exist alongside other adversity tend not to access specialist care. They are often excluded from specialist care when their psychological distress is manifesting as risk taking and hypervigilance, for example.

There is a whole tier of vulnerable children and young people unable to access mental health specialist care, whose difficulties are not even understood in those terms, so they are often excluded from therapeutic support. Those children are much more likely to find themselves interfacing with police or social work services. Therefore, any expansion of CAMHS needs to be coupled with protection in our statutory services. If we do not have that expansion in communities, we will further exacerbate what is already considered to be a two-tier system of support for children. If we want to realise the Promise, we need to reprioritise investment in communities.

I will make one final point about looked-after children. Given that we must focus on the Promise, the NSPCC is trialing an innovative multi-agency intervention for very young children in care. It is multi-agency in that it is co-located. NHS staff, social work staff and family support workers are working together as a team to ensure that there is timely assessment of needs and appropriate care, and to increase the quality of decision making around care needs. The model is being tested in a randomised control trial, which is due to report next year. The findings tell us that the integration of services to ensure that we are meeting marginalised groups requires dedicated time, resource and strategic leadership.

Integration will not happen on its own. We need to make genuine efforts to build multi-agency teams and strip away the barriers to multi-agency working. We have aspired to do that for a long time, but we are not delivering that in many areas.

I highlight innovative work that is under way to make an integrated model work in practice. The Glasgow infant and family team is working with the most vulnerable families to ensure that both baby and parents get therapeutic input. The evidence suggests that we are improving outcomes for that child and for subsequent siblings.

It is such innovation that we need to point to. There are really good examples that could drive the shift towards prevention that we have all aspired to in Scotland.

The Convener: We are reaching the end of our session. I will extend it by about 10 minutes, but I cannot do more than that because we have another panel and so much else to get through on our agenda. I ask Shelley Buckley to respond quickly to Sandesh Gulhane's question before I move on to questions from Paul O'Kane.

Shelley Buckley: I will be really brief. The data is important, but the difficulty is our need to address the issue of cultural humility in services. That means speaking the same language as different communities.

The language that we currently use around mental health and wellbeing is westernised and culturally fixed in our United Kingdom communities and culture. We are doing some research and project work with young refugees. We are having to strip the language right back, because even the term "mental health" does not translate. From my perspective and that of, say, a young Vietnamese person, the way in which we articulate how we treat, assess and understand mental health is completely different.

A huge amount of work needs to be done in mental health services and across the board to truly understand what wellbeing, emotional wellbeing and spiritual wellbeing—all those things—look like for different communities. Instead of talking about cultural competence, which assumes that we get to a point at which we know what we are talking about, we should be talking about cultural humility and supporting that criticality in services. I will leave it at that.

10:00

The Convener: We go to Paul O'Kane for a question on workforce. Please direct your question, Paul.

Paul O'Kane (West Scotland) (Lab): I will bring together a few questions for the sake of time.

The programme for government committed to 320 additional staff in CAMHS over five years. Is there a sense that that is enough to grow services and meet demand over the next five-year period? What level of recruitment is required? That is a more open question. What sort of roles are needed? Are there additional roles that are not already in the system that would help to reduce pressure on waiting lists? I would like to go to Mairi Stark first.

Dr Stark: One of the things that we must do, which we have talked about already, is to stop the flow, and community services are important in preventing children needing CAMHS in the first place. We see increasing numbers of patients being referred so waiting lists increase, and it is difficult to magic up more psychiatrists and psychologists.

We need to look at how we support our mental health colleagues. At the moment, CAMHS are separate from paediatrics, but perhaps they need to be joined up so that we can work closely together. We should look at what different bits can do so that we have a more unified service and better links with community services. Most paediatricians do not know what is available in the community for families. We need to join things up and we need single-point contacts in the community for people so that we can support families in a better and more robust way.

The Convener: I will bring in Alex Cumming.

Alex Cumming: I want to talk about types of roles, which Sam March mentioned earlier. In a number of areas in Scotland, we are piloting a distress brief intervention service for under-16s. Although there is a need for clinical roles and to bolster support in those settings, as Dr Stark said, non-clinical roles in the community and in different services are also important.

We and a number of other third sector providers are involved in the delivery of distress brief intervention services and programmes across Scotland. The under-16 pilots will be really interesting over the next 12 months. DBIs are a slightly higher and escalated level of support for when a young person is in distress but not quite at crisis level—it is definitely not tier 1 or tier 2 level. Those types of roles will be really important in supporting all the statutory services.

Sam March: Alex Cumming mentioned DBI and I agree that that is one of the services that needs to be closely looked at. Conversations that we have had suggest that DBIs can provide support, which is key, and prevent escalation to CAMHS. That service needs to be independently evaluated.

On the question whether that is enough, I am not sure of the answer. We are dealing with the need for support as a result of and pressures from Covid, so we must have a balanced approach that includes a focus on early intervention. The communities mental health and wellbeing fund must not become the poor relation, because our aspiration over the next 10 or 15 years is to provide community-based support, as that is where children, young people and families will feel most comfortable getting support.

Shelley Buckley: I echo what other witnesses have said. Task-sharing with community-based organisations is really important, but that must be done in the context of robust community mapping so that we identify the needs of communities and ensure that people are being skilled up in the interventions that will have the biggest impact for the greatest number of people in those communities. We are not dealing with infinite resources, so community mapping and assessment are crucial in underpinning that.

Sam March talked about quality assurance. With any specialist intervention, we must ensure that there is strengthened collaboration between specialist mental health providers, who are skilled in those areas, and community-based organisations, so that they are supported by a warm arm and coached. That improves the prioritisation flow and ensures that the right people get the right support from CAMHS at the right time.

There is the universal piece around mental health promotion and wellbeing. We need to change the narrative and strengthen the things that we know protect people and communities, such as free access to travel—we must make that easy to get. We must ensure that young people have access to leisure activities and that parents who are under financial pressure are not worrying about that. We must ensure that their children are not hanging about the streets and are engaged in meaningful and purposeful activities that are fun. All those things are simple but make a massive difference.

In addition, we must ensure that the environments in which people live are safe and that they provide safe access to green spaces and community spaces; there must be meaningful activities in places where families can be together.

We must also ensure that we have a two-pronged approach. In the interim period, we must plug the gap in the middle so that the people who are in between services are not languishing—we must meet their needs. At the same time, we must reduce the bottleneck into services.

We are playing the long game. If we focus on early intervention in perinatal and health services, and on getting it right in communities, we hope that, in 10 or 15 years, through the actions that we take and the activities that we put in place now, we will see the benefit of what we do. We have to hold tight and be strong on that; we have to be committed.

The Convener: We have run well over time so I will have to bring the session to a close. I thank every one of you for the compelling evidence that you have given us and for your time.

We will suspend briefly.

10:07

Meeting suspended.

10:15

On resuming—

The Convener: In this session, we are focusing on the health and wellbeing of care-experienced children and young people. I welcome to the committee Jackie Brock, who is chief operations officer of the Promise Scotland; Helen Happer, who is chief inspector at the Care Inspectorate; Lucy Hughes, who is policy development co-ordinator at Who Cares? Scotland; and Kate MacKinnon, who is policy associate at CELCIS. Good morning to you all and thank you for coming.

Last night, we had a private informal session with a lot of care-experienced young people. One thing that really struck me was a comment from a young woman, who said that local authorities know when care-experienced young people are leaving the care system. They know how many are leaving, they know when it is going to happen and they know that it is a very difficult time for those young people’s mental health. Why is nothing in place for those young people at that time, so that they can get in touch with somebody if their mental health is suffering?

Do looked-after children and young people and care leavers have access to intensive support that ensures that their health needs are fully met? That is something that the Promise seeks to deliver. I put that question to all the witnesses and ask you to reflect on what that young woman said, because it struck me as a very sensible approach. That question goes first to Helen Happer.

Helen Happer (Care Inspectorate): That is a salutary statement from that young woman, because it sounds so simple. We know that it is a very challenging period for any young person and, if they are leaving a situation without the on-going family support that their peers have, that makes it triply difficult for them. One of the challenges is that we know that young people need to make mistakes; they need to try things out and see what works for them and what does not, and that sometimes means leaving care and coming back—it is not just a case of them making decisions that work out for them. That is extraordinarily difficult for local authorities to manage. For example, maintaining foster placements—where children leave but have the option to come back—is very difficult. Therefore, there are structural challenges in providing that support, as well as housing and financial support, for children and young people.

The evidence from a lot of our inspection activity has made it very clear to us that the outcomes for older young people—care leavers and young people in continuing care—are much poorer than the outcomes for other children. We have seen lots of improvements in the outcomes for younger children as they move up through the care system, but the outcomes for older young people have been stubbornly stuck. We believe that there is a lot of goodwill around, but the structure around the pathway planning process for care leavers is out of date. It has been in place since 2003 and has not been reviewed. We believe that it is not as well linked to the getting it right for every child approach that has been quite successful in helping staff work together more effectively across different services to plan for younger children.

That is certainly an area that the committee might want to have a think about, and one that it is time to address. That might help with the forward planning that the young woman who spoke to the committee was probably thinking about, which involves recognising that not everything will go smoothly—that does not happen for anybody—and allowing for contingencies when young people need extra support.

The Convener: Thank you. We move on to Jackie Brock.

Jackie Brock (The Promise Scotland): Thank you for telling us what you heard last night from the group of young people you spoke to, which reminds us that this should be reasonably straightforward. Helen Happer set out some of the complexities, but it is important to remember that the legislation is in place to fulfil what that young person asked you for. There are rights in place for young people who leave the care system or who transition from children's services to adult services.

What is preventing that from happening? There will be issues around resources and so on. There are also the challenges that Helen Happer set out. It is very clear that young people need a relationship-based approach that involves them being asked, "What's your situation? How do we need to support you? Do we need to support you into independent living, to remain with your foster carers for longer or to navigate through school and into college?" There is an intensity around the support that is needed, but that intensity will be worth it in relation to improving outcomes for young people in the care system, which, as we all know, are completely unacceptable.

As, I hope, the committee can see within the Promise as a whole and in the "Plan 21-24" and the change programme that we produced last year, there is a real sense that the framework is in place. We have laws, duties, commitments and principles set out for what we should be achieving. What is necessary to make those a reality? There needs to be a clear focus on this group of young people, which is not a large group at national level.

We need to home in on how we can get it right for the 16 to 17-year-old age group, to which I suspect that the young people the committee talked to last night belong, because we know that services do not build themselves around young people and the transition that they face at that stage, together with the complexities of adolescence. There is the children and families service, in relation to which there are legal requirements, and there is a set of adult services, but when the scaffolding of school is lost, how do we help a young person to transition into that more complex system?

A lot of progress has been made. Some amazing work has been done on throughcare and aftercare. As Helen Happer pointed out, there is also the inspection and regulatory framework, which should support that. However, we need to focus on keeping the Promise and the clear suggestions, proposals and plans that are in place through the Promise. Let us use the inspection and regulation system to figure out what matters for children and young people. Let us ask them what matters, as the committee did last night, and then look at how we can deliver that.

That will mean that changes will have to be made in relation to how the workforce is organised, but we are convinced from all the discussions that we have had that members of the workforce know that they must, and are desperate to, deliver their services differently, in line with the needs of the young people concerned.

We at the Promise Scotland are hopeful but, frankly, we cannot keep hearing the same questions, which should be easy to answer—they would have been easy for the committee to have answered last night—because what the young person told the committee about their life experience and the support that they need is perfectly reasonable.

The Convener: Before we hear from your colleagues, do you think that Covid-19 has impacted on the implementation of the Promise?

Jackie Brock: Thank you for the opportunity to answer that. The Promise was accepted in full in February 2020, and the commitment from the First Minister and across the Government and all parties in the Scottish Parliament was to keep the Promise by 2030 at the very latest. Then, of course, the pandemic hit. During the past two years, the workforce in its broadest sense has had to shift into supporting an emergency, and that is fine. Despite that, some incredible work has been done to maintain progress. The national care service consultation has also possibly raised additional questions about how the Promise is going to be achieved, and that has not always been helpful. The picture is therefore mixed.

As we reported in the change programme, we have also found that the pandemic has stretched to the limit the real challenges in the system that the Promise is designed to deal with. We have seen those challenges being exacerbated by the pandemic. For example, the experience of children and young people in children's houses has been stretched to the limit because the workforce has been forced to wear personal protective equipment and so on, so those houses are not like a home. The committee will have seen recent reporting about the use of restraint, which is clearly a symptom of the internal stresses and strains that have been exacerbated by the pandemic.

It is fantastic that keeping the Promise is one of the key points in the Government's Covid-19 recovery programme, but the pandemic has not been at all helpful, and we still have a commitment to deliver by 2030. The committee's inquiry and evidence of building on the Promise and accelerating progress is desperately needed.

The Convener: We will hear from Lucy Hughes next.

Lucy Hughes (Who Cares? Scotland): Thank you for inviting us to give evidence. For those who are not aware of our work, Who Cares? Scotland is an independent advocacy and national membership organisation for care-experienced people, and our members were among those whom committee members spoke to last night.

First, I want to address the language that we are using—when we talk about "care leavers", we are continuing to use the same system language. We assume that transitions will happen at 16 and 17 for young people in care, but the message that we hear from our members time and again is that care experience is a lifelong experience. It does not just cut off when you turn a certain age. We really want to work with the Promise and with partners to understand how we can encourage the sector and the system of support to think about people beyond those age brackets, or beyond the age at which a young person becomes an adult. The support that they need might not change as they age out of services.

On your initial question, convener, about what the young person said last night, that support is not in place for a lot of older care-experienced people. We set up a Covid helpline and the majority of calls came from care-experienced people over the age of 20 who had absolutely no statutory support in place and were not known to adult social work, but had left care at some point in their teens or earlier in their childhood. The committee needs to acknowledge that those older care-experienced people, whether they are 16 or in their 20s or older, can also have significant mental health needs that are not being addressed. As a population, they are sometimes invisible to statutory services.

I encourage the committee to think about care experience beyond childhood and as a lifelong need, and about what we need to do to address that.

We see the proposed national care service as an opportunity. If policy cohesion is addressed and matches what is happening under the Promise, we can join up the approach that we take across people's lifetimes, from cradle to grave, in the same way as we have with the NHS. Someone should not leave care and have their support stopped; it should be a lifelong offer. Adults can be affected by their childhood experiences and we need to acknowledge that and get beyond that language of the "care leaver", which we are still stuck with, as a nation.

The Convener: That came across clearly last night when I was speaking to young people.

10:30

Kate MacKinnon (CELCIS): Thank you for inviting me to give evidence today.

I agree with some of the points that my colleague from Who Cares? Scotland made. It is important to think about what all children and young people experience in their lives. For non-care-experienced children and young people in Scotland, the average age for leaving home is around 26 and rising. For care-experienced children and young people, it is nearly 10 years younger—the average age is 15.

When we are thinking about the health and wellbeing of care-experienced young people, and what they need as they grow up, it is important to think about the wider stresses that they experience in their lives. They have to move out at a much younger age, and their support sometimes disappears overnight, in contrast to their peers, who might have support from parents that goes on for years, decades or a lifetime. The gap between policy and the legislative landscape, which are progressive and aspirational in many senses, and how that policy and landscape are felt in the lives of children, is important. I thank Jackie Brock from the Promise Scotland for also mentioning that point.

There is a real need for a sustaining agenda to implement the policies and legislation that we know are important. That will involve systematic change. Care-experienced people are more likely to have experienced trauma, adversity and disrupted relationships, and too often, there is a drop-off when they move between services for children and services for adults. That is the case across the board in care and protection needs and health. It is therefore crucial to ensure that we have systems in place that meet the needs of a child or young person, and that we do not expect the needs of children and young people to be dependent on the services that are available.

The other important aspect of implementing the legislation is to listen to children and young people—[*Inaudible*.]—who were able to meet care-experienced people last night and describe the experiences that we all agree should not be happening. That is the absolute core of implementing any change. Secondary to that, it is important to listen to and support practitioners with regard to the barriers that they experience in their day-to-day practice that prevent implementation of the legislation.

At the beginning, we spoke about the data that we have on care-experienced people, when they leave care, and their needs in their life journeys. CELCIS is publishing research, which I think is going to the Scottish Government this week, on that gap, what we understand about how many young people are being assessed to become eligible for continuing care, and how well we are implementing their rights and eligibility for continuing care. I would be glad to send that to the committee when it is published.

The Convener: Thank you. I wanted to ask you all about the national care service, but I really want to give more time to my colleagues in this session, because we nearly ran out of time in the previous one.

I will move on to questions from Sue Webber on the health and mortality of care-experienced children and young people, and the statistic and reasons behind that.

Sue Webber: The convener and I were on the same breakout group last night. It was very insightful with regard to today's session.

My question is predominantly for Lucy Hughes. What actions could help the higher-than-average rate of prescriptions and hospitalisations for care-experienced children and young people? What actions could help to reduce the number of care-experienced children who are hospitalised because of injuries, drug poisoning and other external causes? There is a lot to cover in that, but it is all part of a similar theme.

Lucy Hughes: You have asked a really important question. In relation to health and mortality, I want to acknowledge that, as a membership organisation that holds relationships with many care-experienced people of all ages, we have, personally, felt the impact of the loss of people who died far too young, who we worked with and supported. I want to take a moment to acknowledge that.

In 2014, we began to create a record of those people because we felt that their lives and loss were not being recorded in the stats on deaths of care-experienced people. I will get to your question about actions, but I wanted to raise the issue of the invisibility of some of the early deaths that we see. Sometimes, young people leave care before they are 16 and they are not picked up by after-care services. Sometimes they are off the radar of social work and others, but we know who they are because we hold relationships with them. That is more of a data issue and we can talk to the committee about in it more detail, if you would like us to do that.

On actions to secure better health and reduce health risks for care-experienced children and young people, we need to acknowledge the inequality that exists in the context of looked-after children's experiences of health.

It is really important that there should be a right to healthcare, especially care for mental health, from the point at which someone is looked after or comes into care. We need there to be a proactive approach to offering different kinds of support to people from an early age, so that we are not waiting until there is a crisis.

I tuned in to the earlier part of the meeting, and the discussion echoed so much of what the general mental health community is saying: people are having to wait until they are suicidal and at risk of taking their own life before there can be an intervention.

We should be offering young people all different types of support, as early as possible. We know that care-experienced people potentially have greater needs when it comes to their mental health and wellbeing—Kate MacKinnon talked about early experience of complex trauma and difficult relationships—so we need a proactive approach.

That is not just about referral to CAMHS and clinical models; it is about all different types of support for wellbeing and health. The substance misuse and other issues that Sue Webber raised and which lead to hospitalisation are to do with unaddressed need from earlier in life, and young people being left without proactive support for their problems, with no curiosity, questioning and understanding about what they need to thrive and how those needs can be met.

Our big ask is that the committee should think about how we can support the workforce, work alongside the Promise and ensure that, from the earliest stage possible, children in care have a proactive offer of support for their wellbeing, across physical and mental health and any other health needs that they have, so that we are not waiting for a crisis point at which hospitalisation might occur, whether that happens later in life, when the person is an adult, or while they are still being looked after.

I hope that that answered your question.

Sue Webber: Yes, thank you.

The Convener: I will bring in Jackie Brock on this. I should say to our witnesses that, although members might direct questions to certain individuals, if others want to add something, they should put an R in the chat box and I will bring them in.

Jackie Brock: I just want to build on the points that Lucy Hughes made. I am interested in what she said about how the current legislation might be improved. We would be happy to consider how we could support that work as we look at the plans for the next steps for the Promise Scotland. We can give the committee a bit more detail on that. We will also build on the committee's recommendations.

The key contribution of the Promise Scotland, I hope, is that we have brought together a range of bodies—including Who Cares? Scotland—to look at the data, hand in hand with CELSIS and others, and to focus on what matters to children and young people with care experience. That will be a useful resource. That is how we will work with the Scottish Government and others to measure progress.

So much of what the committee is battling with is to do with waiting lists, referrals and so on, but when it comes to what actually matters to children and what is effective, there is huge gap in the available data, evidence and intelligence.

We simply cannot achieve sustainable progress until we get a grip on what data it is important for us collectively in Scotland to use, based on what children and young people tell us about their experience. In July, the Promise Scotland will publish, on behalf of and with our partners, a proposal for a central database and how we can use the data, based on what matters. That data is out there, but we need to pull it together, map it and collect it. That will start to make progress in linking what we want to achieve and our policy goals with the knowledge that it is having the right impact on individual children and young people.

I should say that that approach has had significant support from local authorities and other partners such as the Care Inspectorate and the workforce. For example, we work closely with Unison. I hope that that is helpful.

Helen Happer: I will make the perhaps obvious point that our care population is not representative of the population in general. We have a population of young people who find themselves in the care system and who come from backgrounds of poverty and disadvantage. We know that health inequalities in Scotland are huge and that, when children experience poverty and disadvantage from an early age, their health—not just their mental health but their physical health—is blighted. Some structural things really need to happen to address poverty and disadvantage for children and young people.

We should not forget that we have large numbers of children who are looked after at home and who are still in the care system, although they happen to be living with their families. Those children's families often struggle to meet their basic needs for food, warmth and care.

We need to address those issues as well as looking at what is happening in the system. We need to address the health inequalities, which we know have an impact all the way through life. The impact is not just in childhood; it follows people into their adult life.

The Convener: Thank you for that. Every single person who has been in front of the committee in this inquiry has made that point.

I will bring in Kate MacKinnon before we move on to the next theme, with Stephanie Callaghan.

Kate MacKinnon: I will be brief. I completely agree with the points that my colleagues have made. There is absolutely a need to improve how we collect data to improve how we support people early and how we address the wider health inequalities that affect care-experienced children.

I will add a few more points to those considerations. Some of the recommendations in the Care Inspectorate's periodic reports in the area chime with what we already know we need to do to support children and young people. The continuity of relationships in their lives is crucial. We need to look at what structures and supports should be in place across Scotland to ensure that we build and enable stronger relationships that matter to them.

Another smaller example is that the recommendations also mention earlier identification of risk. We know that the assessments that are involved are done by really skilled practitioners. We need to continue to support those practitioners and ensure that, in addition to their skills, they have day-to-day support to make those highly complicated risk assessments, as well as work coaching to ensure that their wellbeing is looked after while they make those assessments. Again, that chimes with the point about the importance of relationships. In making those complicated and complex assessments to support and protect children and young people, it is important to have a strong relationship with them.

I just wanted to add those two points to show that much of what we know that we need to do in terms of the particularities chimes with other aspects of what we need to do.

The Convener: Stephanie Callaghan has questions on sexual and reproductive health. Please direct your questions to a specific witness, Stephanie.

Stephanie Callaghan: Given that almost a quarter of girls in care get pregnant and that care leavers are at much higher risk of having their babies removed, what steps can we take to tackle stigma and to help care-experience young people to plan for the future and make confident decisions?

The Convener: Who would you like to answer that? Shall we bring in Lucy Hughes?

Stephanie Callaghan: I was thinking of either Lucy or Jackie Brock.

The Convener: I will bring in Lucy.

10:45

Lucy Hughes: Our written submission contains evidence on that from our members. We have done quite a bit of work to explore the area of sexual and reproductive health. Recently, we have done some more focused work on care-experienced parenthood and some of the challenges that you referred to in pregnancy and decision making.

Our members have given us clear messages about what would help. We can take quite a few actions to improve how young people in care are supported to understand sexual health, and to feel that they have autonomy and control of their bodies and that they are making decisions in a way that feels informed and safe.

One of the key messages for the committee is about how we can support carers, families and those working with young people to feel more confident in that space. It is difficult to get the approach right in conversations about the issue. As I said on the other health inequalities that we discussed, it is about taking a proactive and positive approach that is not disciplinary, punitive or risk averse. Carers need to feel able to start conversations and normalise talking about sexual health and the changes that young people experience and think about as they go through their young lives. We can work on that and hear from care-experienced people about how they would want those conversations to be led in their homes, wherever they are living and whichever care placement they are in.

We also need to understand the right to inclusive education for all young people whose relationships are often disrupted, especially when they are moving placements. A lot of those conversations are based on trust and honesty. Young people need to know that they can share something that might be scary and that they are not sure about, or an experience that they might have had, without feeling that they are going to get in trouble or that there is a risk associated with it. There is a need for guidance and information and for people to be listened to in a judgment-free space.

We have made a lot of progress with relationships, sexual health and parenthood education. We have taken a new approach in schools, from the early years all the way up to secondary school, and we now need to bring that conversation into homes and into the way that carers give their care to young people in the care system. Our members have told us that they want carers and others to be confident about leading those conversations proactively, and to create a safe space for people to bring up any concerns that they have.

If we do not do that, we know that young people will turn to the internet and to friends and peers. People access information on sexual health in many other ways, but that information is not always accurate. Also, when a young person accesses information in that way, they do not have someone to discuss decisions with and really work through the worries, fears or concerns that they might have in trying to navigate the issues.

We often talk about young pregnancy and the risk-averse approach to teen pregnancy. We need to shift the approach and consider how we can support proactive conversations on sexual and reproductive health that feel supportive and are rights based. It is about supporting young people to feel ownership of their bodies and the choices that they make on sexual and reproductive health.

Our written submission to the committee contains our members' views on the issue, and has far more detail on those topics.

Stephanie Callaghan: I realise that you are probably talking about carers and families getting the support that they need from health and social care workers to do that well. On a wider and more general level, what training needs exist in the health and social care workforce in relation to sexual and reproductive health?

The Convener: Is that directed to Lucy Hughes again?

Stephanie Callaghan: Yes.

Lucy Hughes: Thank you for that follow-up question, which raises a really important point. Although we are talking a lot about the home environment, we know that sexual and reproductive health services will be needed for many young people in care.

A key message that we are hearing is that we need trauma-informed practice across the whole NHS and universal sexual health services. We have some amazing practice out there—for example, we know that there is the NHS Education for Scotland programme—but we need that to be across the board.

Part of what we are hearing is that young people who are interacting with those services need to have choice about, for example, the gender of the professional.

There also needs to be more understanding. Being “trauma informed” can be a bit of a buzzword, but it is about how that can really play into the practice of the NHS and the services that we provide. It is not only about people being able to choose the gender of their doctor, but also an awareness of how a history of sexual abuse might impact on someone who is interacting with those services for the first time, and not making assumptions about things such as a person’s family background.

One of the key things that we have heard is that, when care-experienced people interact with universal services, there can be a lack of understanding of what care is and of the fact that people will not always have a solid family network to fall back on and to which they can go to get support after an appointment or procedure. There needs to be a much broader awareness of that.

As corporate parents, the NHS and health boards have a responsibility to think about tailoring those services and how they identify the needs of care-experienced people and meet those needs in a trauma-informed way.

The key messages are that there needs to be more awareness of what care experience might mean for someone, and that being trauma informed needs to play out in practice across that first point of call with GPs but also in specialist, sexual and reproductive health services.

I hope that that is helpful.

Stephanie Callaghan: That is really helpful; thank you very much, Lucy.

The Convener: Kate MacKinnon wants to come in on that point.

Kate MacKinnon: I will be brief and simply add to the points of my colleagues.

When we are thinking about the importance of training and skilling the workforce, it is also important to ensure that the capacity is built into the workforce. My colleagues rightfully pointed out the importance of young people being able to—[*Inaudible.*]—the adult or practitioner that they feel that they are closest to and that they trust or have a good relationship with.

We need to ensure that there are the skills, support and time in the day to have what will rarely be one-off but rather on-going conversations, and that the workforce is equipped and has all those resources across the board, even in small ways. For example, the receptionist at a GP office should have the same trauma awareness as teachers in schools or youth workers. It is important to think about people’s capacity when we are thinking about the importance of a trauma-informed workforce.

The Convener: That is a very good point. An individual last night pointed to the fact that receptionists should also be trauma informed, as they are often the gatekeepers for getting to speak to somebody.

I will go to Jackie Brock.

Jackie Brock: I will briefly add to that, linking Lucy’s and Helen’s work with evidence that the committee was given in the earlier session around the 10 principles of intensive family support in relation to Ms Callaghan’s question about dealing with stigma.

We have a great opportunity to look at the Government’s commitment in relation to whole-family support, which a significant amount of money has been put into over the years. If we were to apply the principles of family support, and the resources in the way that Lucy set out for us, it would give people the best start in the ways that Lucy described and achieve the most effective outcomes for that family. It is about how we work to support families that will be made up of children and young people with care experience who are now having their own children, and ensuring that we do not continue to treat children and young people with care experience as isolated figures as they are forming and heading up families. They also deserve the support that is available from health and social care services. Local authorities need to consider that and ensure that the workforce is sufficiently trained to avoid stigma, as it does. As we have heard, there are many good practices. A key principle of intense family support is that it is non-stigmatising and underpinned by rights.

We have a great framework in place to tackle structural and systemic issues. Seeing those with care experience as beneficiaries of the forthcoming resources that will be available for whole-family support is critical. Those people should absolutely be prioritised, and services should be planned, delivered and reshaped accordingly.

The Convener: We must move on, although each theme that we are covering could have two hours to itself. Evelyn Tweed will ask about Covid-19 and the health harms that are associated with it.

Evelyn Tweed: We could have a whole hour on just Covid-19. What impact has Covid-19 had on the mental health of children and young people? My question is to Lucy Hughes.

Lucy Hughes: That is a really important question. My first point is that, although the pandemic has put a huge strain on the mental health and wellbeing of care-experienced people of all ages, including children and young people, many of the issues that our organisation has seen through our independent advocacy and the helpline that we set up during the pandemic were there before. As Susie Fitton on the previous panel said, the pandemic has supercharged inequality. I draw attention to the fact that a lot of the things that we are hearing about are not new issues, although Covid has exacerbated the situation.

I will raise key points from our evidence. During Covid, what have we all done? We have all turned to our support networks—our families and loved ones—for support through the past couple of years, which have been incredibly challenging for the mental health of all of us. The assumption is that people have such support and that it is up to individuals to support themselves through a lot of what has been happening.

From the people who called our helpline and asked for support for a variety of practical matters—a lot of calls were about the financial impact—we know about a sense of social isolation and a lack of connectedness, which have been a theme in many of the committee's evidence sessions. That has a significant impact on care-experienced people, who might not have trusted relationships or a support network. That is particularly the case for older care-experienced people, who I referred to—they have left care and might no longer have support networks of carers or family. Many of them also live by themselves.

The pandemic has isolated many individuals in the past couple of years. A huge part of our work is creating connection and belonging through our programmes, such as communities that care, and through our participation work. All that face-to-face youth work and community development work has been paused for a long time. We have done some of it online but, as many people at today's meeting can attest to, that has been challenging. Digital exclusion and many other barriers have been in the way of continuing that work.

The key message is that a lot of the health and wellbeing impact—in relation to loneliness, isolation and struggling to access services—existed for the care-experienced community before the pandemic, but the pandemic has brought that to light and made a lot of the rest of the population understand such issues for the first time. We can see now that we need to have a lot more conversation about that.

Why do we accept that older care-experienced people do not have access to the same mental health support and support from statutory services in a specialist way? Like the rest of us, those people have to try to access universal services, which is not good enough. If anything, Covid has added fuel to our fire to change that. We are working alongside the Promise Scotland to address the needs of the community that exist now, while doing prevention work to stop care-experienced people feeling unsupported with their health and wellbeing as they grow up.

The question is huge; I hope that I have answered some of the points. If you want to ask us about anything in particular, please let me know.

The Convener: Thank you. Evelyn, I would like to move on to questions about resources and workforce from Gillian Mackay. I am sorry to curtail your questioning, but I am very conscious of the fact that we have other items on the agenda to get to.

11:00

Gillian Mackay: I have heard from the social care sector that increasing workloads and reduced—[*Inaudible.*]—have undermined its ability to build relationships with the young people, families and carers who it works with and to make early interventions. How has that affected the wellbeing of care-experienced young people? I put that to Lucy Hughes.

Lucy Hughes: Thank you for the question. It varies around the impact that Covid has on the ability of services to respond to health and wellbeing needs.

Gillian Mackay: In general, the pandemic has obviously had an effect on increasing workloads and things like that, but the growing number of young people who need support has probably impacted it, too.

Lucy Hughes: Yes, and that is definitely an important question. With Covid, so many people had to be redeployed to deal with crisis—we have heard that from many in the sector and in local authorities. We saw a withdrawing of services for various reasons, as many people were having to deal with crisis situations. That meant that some of the support that existed for care-experienced people was more difficult to access, and it meant that need was hugely exacerbated by the needs that were already there.

For many care-experienced people, it became much more difficult because of feelings of loss, grief and bereavement. That has affected so many people throughout the pandemic, but care-experienced people were already having to address those issues before the pandemic. It has created even more challenges by raising a lot of feelings that might have been below the surface.

Through our helpline, we heard about their difficulties and not having someone to connect with and talk to about the issues that they were experiencing. The average call time was more than an hour. Even if a call was initially about financial support, a lot of the time people just wanted someone to speak to and connect with. I think that we can all relate to that in terms of how the pandemic has made us feel less connected with each other.

To point to something that we did as an organisation to address what we saw as a huge unmet need in mental health, we set up a counselling referral service during the pandemic. We realised that, because of Covid, the waiting times were just going to get worse for a lot of those services, for which there was such a huge need. We helped hundreds of people to access a counsellor of their choice. Sometimes, the waiting time was as little as 24 hours from when they called the service and explained what their needs were to when they accessed a counsellor. Many of the people who we spoke to through the counselling referral service had been on waiting lists for 18 months or two years by that time.

There are different, innovative approaches that we can take if we understand that there is a specific need out there for care-experienced people, of all ages. We need to have something that is much quicker. It is not about, as we have heard in earlier evidence sessions, just saying, “We are going to add you to the waiting list for CAMHS”. There are other approaches that we can take.

We would be really keen to do that. We have a report coming out on the impact of the counselling service, which we would love to share with the committee and with you, Gillian Mackay, if you are interested and would like to learn more about that work.

Gillian Mackay: That would be great.

The Convener: I think that it would be a good idea to bring in Helen Happer to talk about her perspective on workforce challenges.

Helen Happer: Lucy Hughes made the point in her answer to the previous question that a lot of the issues have been exacerbated by Covid but are not new. It is very important to say that the situation for the social care workforce in general—let alone for children’s social work and social care and other services for children—was pretty critical before the pandemic. It has been impacted by the exit from the European Union and by Covid.

We are in quite a difficult situation in general with regard to the workforce. The number of people who are needed is pretty mind-blowing, when we think about the expansion of the early years workforce and the need for better resourcing for care for older people—all of that will be coming from the same pot of people, so to speak. It is quite a dire situation.

When talking about the workforce, it is important for us to remember that foster carers, kinship carers and adoptive families also make up part of that workforce, but they do not always feel that way. The number of foster carers has decreased year-on-year since 2016. We need to be thinking more broadly.

It is important to have a workforce that is harnessed to a common understanding of trauma-informed practice and of what young people who find themselves in the care system are experiencing and have experienced. There are lots of good ideas about revisiting the common core of training and support to support our existing workforce, but we cannot get away from the fact that the numbers situation is very challenging. We need to think about how we support people in our workforce and how we attract more people into that line of work. We need to make our workforce feel valued, cared for and well supported, because well-supported staff are likely to deliver much better work and support young people and their families much better than if they feel that they are at the bottom of the pile, their conditions are poor and they are not valued as contributors.

The Convener: Thank you. As usual, time has whizzed past. We have to move on to our final theme.

Paul O’Kane: Good morning, members of the panel. I will cover the transitions theme, looking at what a good transition looks like and how we can do more to achieve good transitions.

Has the local implementation of policy on transitions resulted in improved transitions for care-experienced young people, or has the situation not moved forward as much as we might have hopes? I direct that question to Lucy Hughes first.

Lucy Hughes: That is an important question. In a legislative sense, we have made a lot of progress: aftercare rights have been extended to the age of 26 and continuing care has been introduced, but we need to acknowledge that we are not seeing the full practice and implementation of those ambitious—[*Inaudible*.]—commitments. I am not sure of the most recent data on how many people are accessing those services, but I know that it exists. There is still a lot of unmet need.

To go back to my earlier point, it is important that we think about how we talk about transition, which is about lifelong support for care-experienced people. An important quote from one of our reports was that being care experienced does not leave you and does not just go away after a few months of support in a transition. Let us say that someone was having aftercare support for a few months and then it stopped. What would happen next? That is where the national care service could have an opportunity to link up how we view a social care service over a lifetime or how we view different support over the lifetime of a care-experienced person.

We are still stuck in the sense that a care-experienced person is considered to be a child or a young person. We are a community organisation and we have many older members who have no ability to access support that is based on the fact that they were looked after as a child at some point. There have been huge developments in that area: for example, the care- experienced bursary has no cap on age. We could bring so much to the health and mental health arena with that same lens and focus.

It is not about transitioning from one service to another; it is about continuity of support for a lifetime. Our older members, in particular, have really pushed us on talking about that much more loudly. The current thinking about transitions is based on how the system works—how young people age out of services and where they go next. Many of those young people will not have anywhere to go if we do not have a joined-up approach with housing and different support services.

In a lot of adult services, care experience is invisible. People present to lots of different services with no acknowledgement of the fact that they are care experienced or that they had experienced care in childhood. There are no robust ways to understand that across homelessness, unemployment and so many other life outcomes.

Returning to the point about poverty, I know that the committee has talked about poverty with many different witnesses. From the relationships with care-experienced people that we have held for a long period, we know that lack of support in transitions leads to many of them living in situations of poverty and continued inequality. Even if there have been interventions throughout childhood because they come from a family where there is disadvantage, they could end up in the same situation in their own adulthood. As we were saying earlier, these are people who will go on to have their own families and children. They should have access to all the things that we want, as adults, to thrive and feel supported to live healthy lives throughout our lifetimes.

I have covered so many things there. When we talk about transitions, it is very much thinking about the system as it already exists in relation to care and protection, but we need a rethink about how we can support people with care experience across their lifetime.

The Convener: Thank you, Lucy, for covering all those things. We have gone over time and we have two more agenda items to cover. Thank you all for the comprehensive evidence that you have given us. If there is anything that you wish you had mentioned or flagged up, please email the committee and we will take it into account.

There will be a five-minute break to change witnesses.

11:12

Meeting suspended.

11:18

On resuming—

Public Health Protection and Health Security (Common Framework)

The Convener: Our third agenda item is evidence on a provisional common framework on public health protection and health security. I welcome to the committee Humza Yousaf, the Cabinet Secretary for Health and Social Care, who is joined by Erin McCreadie, the Scottish Government team leader on sexual health and blood-borne virus and infectious disease.

Cabinet secretary, the backdrop to my question is the response to the pandemic, when the common framework was not in place. Many of us want to know whether the framework would have made any difference to the Scottish Government's ability to respond in the way that it did. Does this common framework still leave room for a differentiated response by the Scottish Government to public health threats in the future?

The Cabinet Secretary for Health and Social Care (Humza Yousaf): Good morning to you, convener, and to all committee members. I hope that you are all keeping safe and well.

You have come straight in with tough questions. I am not surprised that you are asking such key questions. I will take them in the order in which you asked them.

It is difficult to answer whether, if the framework had been in place at the outset of Covid, it would have significantly changed the response of the four nations. I suspect that it would not have done because the data sharing with the United Kingdom Government has been good. It has evolved as we have gone through the pandemic, but it has certainly been good in my time as Cabinet Secretary for Health and Social Care. Of course, I was in the Cabinet in a different role at the beginning of the pandemic, so I know that it was good previously.

The collaboration between the four nations in response to the pandemic has been good, although there have been times when it has been of concern. We have raised those concerns, sometimes in private and sometimes publicly. That is well understood, but, on the whole, the four nations' collaboration and sharing of information on the pandemic has been good. That does not mean that it will always be thus. Therefore, whether for the pandemic, which still has to run its course, or for any future public health threat—goodness forbid—it is important that we have the framework underpinning the principles of that collaboration.

The second part of your question is equally important. Again, I stress that, although the framework has overarching principles, it does not prevent any of the four nations from acting in a different way if it wishes to do so. In essence, the framework is policy neutral. It does not prevent the Scottish Government, the Welsh Government, the Northern Ireland Executive or, indeed, the UK Government from taking decisions that diverge from those of the other home nations.

The Convener: That is helpful. Thank you for outlining that.

We will move on to questions from Gillian Mackay on the role of Parliament and, indeed, the committee.

Gillian Mackay: Cabinet secretary, will implementation of the framework impact on parliamentary scrutiny and decision making in the policy area? If so, what impact will it have?

Humza Yousaf: I expect that the Parliament will have no less of a role than it had under the previous system. The Scottish Government is absolutely open to that role being enhanced where possible, but I suspect that that will become clear only as the framework is embedded in our public health infrastructure. A review period is built into the framework and might provide a good hook for Parliament to consider its operation and whether it delivers as well as we hope that it will.

Ultimately, those are questions for the Parliament, as opposed to the Government, to answer. However, if the Parliament wanted further scrutiny and thought that the review was the correct point at which to invite me, as the Cabinet Secretary for Health and Social Care, and my officials to comment, or if the committee wanted to undertake a detailed review or scrutinise work plans, I would be open to any role that the Parliament wished to have in the agenda, because it is so important.

Gillian Mackay: Thank you, cabinet secretary. That is all from me, convener.

The Convener: We will now have questions on international relations from Paul O'Kane.

Paul O'Kane: Good morning, cabinet secretary. Is the Scottish Government comfortable that the common framework will provide sufficient opportunity for the Government to input to any future negotiations or for fulfilment of international obligations in the policy area?

Humza Yousaf: The framework does not alter the devolved settlement in relation to international obligations or any future negotiations. That is important. Paul O'Kane and I probably have slightly different views on whether Scotland should have more of a role—or, indeed, its own role—in relation to international treaties and obligations. Notwithstanding those differences—we can park them for a minute—the framework does not alter the devolved settlement.

The UK's fulfilment of international obligations relates largely, though not exclusively, to reserved matters. Where we have a distinct legitimate devolved interest in reserved matters, I believe that the framework provides us with a useful set of tools that gives us the greatest chance of influencing negotiations. The framework process thus far has been really engaging, and, in terms of engagement with the EU and the memorandum of understanding that the UK has signed with the EU, Scotland has been able to represent itself in relation to the ECDC, for example, which is positive.

Ultimately, I cannot promise you that there will always be alignment between what the Scottish Government or, indeed, the Scottish Parliament wants in relation to international obligations and what the UK Government ends up doing. The framework does not alter that significantly.

Paul O'Kane: I know that I have asked the cabinet secretary about this before in relation to other areas of this work, but what about dispute resolution when there is a difference of opinion? I know that he will use his good nature and strong relationships to try to find a way through in relation to the Scottish Parliament's position or, indeed, Scotland's position on an issue, but is there is a robust resolution procedure that we could use? Would that be invoked more readily, or does he have concerns—I am sure that he does—about unilateral decision making? Does he have confidence that such a procedure is in place?

Humza Yousaf: Paul O'Kane will know that, if there is a chance for me to put on record my concern about the approach that the UK Government is taking, I will not be shy in doing so. I will do that regularly—quite rightly, as my job is to stand up for the interests of the people of Scotland. Equally, when things are working well, I am not shy or reticent about saying that they are working well.

The common framework process has involved really good collaboration. Therefore, I do not envisage that we would get to the stage of dispute resolution in relation to this particular area of the common framework and what it seeks to address—certainly not from the evidence that I have seen thus far. Of course, this is about the future, too. Ultimately, if we could not get agreement—if every lever that we had tried through informal discussion with the UK Government, official level discussion, ministerial level discussion, correspondence and so on, had not worked—that dispute resolution mechanism would be there, and it exists for good reason. However, on the evidence thus far, I do not see that needing to be invoked—certainly not in the short or medium terms.

The Convener: Thank you. We will move on. We have questions on information sharing from Sue Webber.

Sue Webber: Thank you, cabinet secretary, for coming along today, albeit virtually. We hear at length from everyone about how much pressure everyone is under with their workloads, so I am hoping that you might be able to help. Do you get a sense that the framework will reduce duplication in the likes of the scientific advisory and expert groups that we have across the four nations? Also, are there any plans to develop greater consistency in how data is collected, analysed and presented across the UK?

Humza Yousaf: That is a really good question. In time, it might well do that in terms of reduction of duplication. However, it is also important—I think that Sue Webber would ultimately agree with this—that each of the Governments across the UK nations has bespoke advice, because, although there will absolutely be some common themes that affect Scotland, England, Northern Ireland and Wales, there are also distinct issues that affect us uniquely. Therefore, having that scientific advisory group for the Scottish Government is really important for us, given the unique pressures that we might face, which might be different from those faced in parts of England and Wales—or, indeed, in Northern Ireland where it shares a land border with a member of the EU, which is perhaps the most obvious example.

On the question about reducing duplication, I would say that—yes, absolutely—that will probably happen more as the framework is embedded. However, I would always reserve our right to make sure that we have that bespoke advice where appropriate.

Sue Webber: Thank you.

11:30

Emma Harper: Good morning, cabinet secretary. Do you have any concerns about cross-border co-operation with the EU? It says in our papers that access to the EU's early warning and response system will be on an ad hoc basis, which pretty much means that, if there is a potential health issue, it will be up to the United Kingdom to write to the EU and ask whether the UK can be part of the process.

Humza Yousaf: I will not labour the point. I think that everybody here understands that the Scottish Government would have preferred by far that we had retained our EU membership. That would have given us greater access and we would have been part of the European Centre for Disease Control, for example. We would not have had to have memorandums of understanding, which, although they can be positive, are suboptimal compared with EU membership. There is no point in labouring that point, but it is important to put on record that any arrangements that we put in place for cross-border co-operation with the EU are suboptimal in comparison with EU membership.

On co-operation, we expect there to be a strong system of intelligence and data sharing. As we know, the UK Health Security Agency has entered into an MOU with the ECDC. We are pleased that the MOU has been signed, but we will not have the parity of access that we had previously.

Emma Harper asked an important question about the Scottish Government’s involvement. Again, if I was to go by the process of the framework, I would definitely be encouraged. There was certainly a role for Scottish representatives in influencing those discussions with the European Union. Ultimately, though, if we were ignored, there would not necessarily be adequate recourse for us to ensure that our desires in relation to cross-border co-operation were being satisfactorily met.

Emma Harper: We are talking about cross-border co-operation with the EU, but there is also cross-border co-operation with our neighbours south of the border. I am thinking about zoonotic diseases such as severe acute respiratory syndrome, middle east respiratory syndrome, swine flu and avian influenza—even Creutzfeldt–Jakob disease, in the past. We need to make sure that all the scientists are working together. Will the framework improve co-operation within the UK, so that everybody shares their scientific knowledge and we are better prepared for any future pandemics that we need to worry about?

Humza Yousaf: The danger with our exit from the EU was that we would lose the co-operation that we were duty bound to have. The framework ensures that we do not have any less co-operation, which is important. Looking forward, the framework and the MOU that sits alongside it ensure that there will be good collaboration not only within the UK but with our European Union partners. That, too, is important.

On the framework, members will be aware—I am sure that it will be in their briefing—that there is the oversight group, which will be really important. Scotland will have representation on that group to ensure that co-operation is being maximised wherever possible. I think that the framework will evolve as it embeds, but the early signs are encouraging.

David Torrance (Kirkcaldy) (SNP): Good morning, cabinet secretary. Do you have any plans to increase the health protection resource in Scotland in areas where Scotland has been identified as the lead—for example, in review of disease notifications, analysis of four nations working groups and the evolving science of genomics?

Humza Yousaf: The framework does not necessarily impose costs on any of the Governments that are taking the lead in certain areas. That is not to say that we would not bolster resources, because we would, particularly in the area of genomics. The pandemic has taught us a lot of things—among them, the importance of genomic sequencing. The Government has put on record our desire to further increase our resources around genomics—the First Minister has spoken about that on a number of occasions—so, although the framework does not necessarily do that, we want to ensure that the areas where we lead are well resourced.

Sandesh Gulhane: It is good to hear you talk about the positive aspects of the common framework. Does what you are saying also mean that there will be increased sharing in other areas of health research?

Humza Yousaf: The framework might not go into detail on that point, but that is a vital issue. Where we can share further research and intelligence, that helps us to build up our knowledge, particularly in relation to the pandemic, which is the current issue that we are facing. Research studies from across the UK have helped to inform our thinking and decision making.

You and I have different opinions on the constitutional future of Scotland—that is fine. However, ultimately, whether we are independent or part of the union, the sharing of information across borders—on these islands and with the European Union—is hugely beneficial, and I would not want to lose that, regardless of what our constitutional set-up might be.

The answer to your question about whether we will continue to share information is yes. The framework might not determine all of that, but I know from my discussions with the UK Government that it is in the same place as I am in that regard, and I know that my Welsh and Northern Irish counterparts feel the same way. The more that we can share research on health, the better for all of our citizens.

The Convener: I thank the cabinet secretary and his officials for their answers to our questions today and for joining us this morning. We will now move to the next item on our agenda.

European Union (Withdrawal) Act 2018

European Qualifications (Health and Social Care Professions) (Amendment etc) (EU Exit) Regulations 2022 [Draft]

11:37

The Convener: Item 4 on our agenda is consideration of a notification from the Scottish ministers for consent to a piece of subordinate legislation. The purpose of the instrument is to correct errors in the European Qualifications (Health and Social Care Professions) (Amendment etc) (EU Exit) Regulations 2019 and to correct an error that was created by those regulations in the National Health Service (Performers List) (England) Regulations 2013.

Under the protocol between the Scottish Parliament and the Scottish Government, the consent notification has been categorised as type 1, meaning that the Scottish Parliament's agreement is sought before the Scottish Government gives consent to the UK Government making secondary legislation in areas of devolved competence.

Does any member have any comments on the consent notification?

Sandesh Gulhane: I accept that the instrument merely makes corrections. However, I want to place on record the fact that I am against the idea of having a performers list. I think that it is outdated and something that we should be able to get rid of across the UK and in Scotland.

The Convener: You have put that on the record. As the matter sits at the UK level, it is something that you might want to flag up to our colleagues in the UK Parliament.

Emma Harper: Having read our papers, I think that, when there are changes to legislation in England that could impact our healthcare system in Scotland, we need to ensure that the cabinet secretary keeps us informed and that we have an opportunity to pay attention to what is being taken forward. Especially when we are in a remote-working environment, it can be difficult to pick up non-verbal information, look at what we need to do and ask the right questions, so we need to ensure that the committee is kept fully informed about this kind of issue.

The Convener: I take on board the comments that have been made by Sandesh Gulhane and Emma Harper. As there are no further comments from members, are we content that the provisions that are set out in the notification should be included in the proposed UK instrument?

Members *indicated agreement.*

The Convener: I am looking carefully at certain members to ensure that I have their consent. I see that we are all nodding.

Finally, is the committee content to delegate authority to me to sign off a letter to the Scottish Government, informing it of our decision today?

Members *indicated agreement.*

The Convener: I would not ordinarily ask for a robust shake of the head, but, as Emma Harper just mentioned, there can be issues with non-verbal cues on this kind of platform.

Subordinate Legislation

Food (Withdrawal of Recognition) (Miscellaneous Amendments) (Scotland) Regulations 2021 (SSI 2021/477)

11:41

The Convener: Item 5 on our agenda is consideration of a negative instrument. This instrument removes exemptions for certain products in a number of regulations to help ensure that imported products meet compositional rules for food in Scotland and that Scottish business can maintain access to unfortified flour.

The Delegated Powers and Law Reform Committee considered the instrument and made no recommendations. No motions to annul have been lodged in relation to the instrument.

Do members have any comments ?

As there are no comments, do members agree not to make any recommendations in relation to this negative instrument?

Members *indicated agreement.*

The Convener: At our next meeting, on 25 January, the committee will take more evidence from stakeholders as part of our inquiry into the health and wellbeing of children and young people. We will also take evidence on the national planning framework 4.

That concludes the public part of our meeting.

11:42

Meeting continued in private until 12:15.

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