OFFICIAL REPORT
AITHISG OIFIGEIL

Public Petitions Committee

Thursday 7 December 2017

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 7 December 2017

CONTENTS

PUBLIC PETITIONS COMMITTEE
22nd Meeting 2017, Session 5

CONVENER

*Johann Lamont (Glasgow) (Lab)

DEPUTY CONVENER

*Angus MacDonald (Falkirk East) (SNP)

COMMITTEE MEMBERS

*Michelle Ballantyne (South Scotland) (Con)
*Rona Mackay (Strathkelvin and Bearsden) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Graeme Henderson (Penumbra)
Carolyn Lochhead (Scottish Association for Mental Health)
Ellie Stirling
Amy Woodhouse (Children in Scotland)

CLERK TO THE COMMITTEE

Catherine Fergusson

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Public Petitions Committee

Thursday 7 December 2017

[The Convener opened the meeting at 09:00]

Continued Petition

Mental Health Treatment (Consent) (PE1627)

The Convener (Johann Lamont): Welcome to the 22nd meeting in 2017 of the Public Petitions Committee. I remind members and others in the room to switch phones and other devices to silent.

Agenda item 1 is evidence on a continued petition. PE1627, on consent for mental health treatment for people under 18 years of age, was lodged by Annette McKenzie.

Members will recall that we previously reflected on the evidence that the committee received in relation to the petition. That evidence highlighted the importance of young people's right to confidentiality and, therefore, did not support any change in terms of young people being able to consent to their own treatment. However, recognising the issues of confidentiality and consent, the committee agreed to invite oral evidence from charities with expertise in youth mental health services, to explore the wider support that is available to people under 18 years of age who experience and seek treatment for mental ill health.

I am grateful that we are able to explore some of those issues with Graeme Henderson, director of services and development at Penumbra; Carolyn Lochhead, public affairs manager at the Scottish Association for Mental Health; and Amy Woodhouse, head of policy, projects and participation at Children in Scotland. I am grateful that you are all here.

In order to make the most of our time, we will move straight to questions. Following the petitioner's evidence, the committee felt strongly that there is an issue here. If the issue is not on the question of confidentiality and sharing information, it may be on what we can do to keep our young people safe. We hope that you can help us consider some of that.

What are your views on current support services for young people with mental ill health?

Amy Woodhouse (Children in Scotland): Thank you for the opportunity to talk to you this morning.

I recognise the sad reason why we are here. It is right that we explore the issue and what can be done to prevent unnecessary deaths.

There are about 1 million children in Scotland. It is estimated that about 10 per cent of them will have a diagnosable mental health problem—if you can do the maths, that equates to about 100,000 children. That is not an insignificant number; we are talking about a large number of children and young people. Those children have a diagnosable problem—they do not just have low moods or stress with school or life.

We have statistics on child and adolescent mental health services and staffing numbers and waiting times. They show a bit of a gap. There are about 1,000 members of staff in the CAMHS workforce—one to every 100 young people with a diagnosable mental health problem. About 4,000 referrals go to CAMHS every quarter—4,000 referrals but 100,000 children. The CAMHS workforce has a very small role within the overall support provision for children and young people with mental health problems. We need to talk about the response to that and whether that is the whole picture.

Given that three representatives from the voluntary sector are here, we would say that that is not the whole picture and that statutory CAMHS are only part of the story and the overall service provision for children and young people with mental health problems. The voluntary sector has a huge role to play. I particularly acknowledge the role of youth work. As you may be aware, Children in Scotland is a membership organisation from the children's sector. We have about 500 members across Scotland, many of whom provide support to those 100,000 children, and many more.

The voluntary sector is strapped for cash and its services are short term, but it is providing a vital role—as part of that picture of support—not just in helping those with mental health problems, but in prevention. That work is vital if we are going to address the significant problem of young people's mental health in Scotland.

Carolyn Lochhead (Scottish Association for Mental Health): I absolutely agree with Amy Woodhouse. There are another couple of points to be made on CAMHS.

Amy Woodhouse is absolutely right in the statistics that she cites. It is important to remember that we have targets and statistics only for the upper levels of CAMHS. CAMHS are intended to be a four-tier system, starting with universal services—schools, general practitioners and health visitors—and moving up to more specialist services. We have data only on referrals to tiers 3 and 4—the more intensive sectors. People are waiting longer than they should be in

those sectors. Only about 80 per cent of children and young people are seen within the 18-week target—a target that we feel is too long.

One in five young people is rejected from CAMHS for one reason or another. We are grateful that the Scottish Government has recently asked us to look into that. There is a lot to look into and we hope to discover what is going on and make some recommendations to improve the situation.

Amy Woodhouse is right that it cannot all be about clinical and national health services. We are particularly keen to see the provision of support in schools. Most children—not all, but most—are in school, so it makes sense to provide support there. We would like to see the provision of counselling for all children of secondary school age. That would go a long way towards providing support to children where they are and when they need it, rather than their having to go through what can be a tricky and complicated referral process. About a quarter of a million children in Scotland have no access to school-based counselling. Fourteen local authorities have no on-site provision of school-based counselling—only 40 per cent of secondary schools have that provision. The Scottish Government is looking at that issue and we think that it is urgent.

Elsewhere is the United Kingdom, there is a guarantee of school-based counselling—particularly in Wales, which has quite an advanced system. Good evidence is coming out that school-based counselling makes a difference. Scotland should be no different; Scotland's children deserve no less than those in the rest of the UK. We would like to see action on that.

The Convener: Do you have a view on the case that prompted the petition? The young woman was out of school, but in work, and was under 18. I presume that some support can be provided by pastoral care staff. How does the model work for young people who are not in school, but are under 18?

Carolyn Lochhead: You raise a really important point. CAMHS are defined differently across different NHS boards. In some areas, services are provided up to the age of 18. In other areas, that is only the case if children are in full-time education—otherwise services are provided only up to the age of 16. There is a problem with children falling through those gaps.

We want CAMHS to be extended up to the age of 25 for those who are already in the system, because the transition can be very difficult and, to be honest, is not always well managed. We have also heard from young people—via the Scottish Youth Parliament, which has done some excellent work on the issue—who feel that people of that age do not really fit into either child or adult services. In the longer term, we need a specialist service for the 16 to 25 age group, so that people do not keep falling through the gaps.

Graeme Henderson (Penumbra): I will move away from CAMHS and turn to the services that the third sector can provide. Since 1994, Penumbra has provided open-access youth services, including work in schools, for those with mental health issues. For example, we worked in all 19 secondary schools in Fife, for a cost of about £200,000 per year—about £10,000 per school. To give you an example of the issues that were raised by young people—we were working with those from secondary 4, 5 and 6, typically—in one term, 120 young people expressed suicidal thoughts. That service was closed by the council because of cuts. It is now provided by another organisation, but on a much smaller scale.

We are currently working with primary 3 and 4 pupils on body confidence, because that is an issue that affects people at that age and later and has a massive impact on mental health and wellbeing.

We have a number of open-access youth projects, which were originally funded by the choose life programme, which started around 2005. However, as Amy Woodhouse said, the cuts to, and pressures on, council budgets are having an impact on those services.

Rona Mackay (Strathkelvin and Bearsden) (SNP): Do GPs have all the necessary training to support people with mental health issues generally? More specifically, do GPs have the necessary training to make appropriate decisions when prescribing mental health drugs to under-18s, to ensure that those around the young people are informed of the possible side effects of medication? How confident are you that GPs are well enough equipped to deal with prescribing drugs to young people?

Carolyn Lochhead: There are two points to be made. First, you are right to highlight the role of GPs. Most people say that they would go to their GP for help with their mental health, so GPs have an absolutely central role.

A few years ago, we did some research with GPs. GPs told us that they wanted to know more about mental health. They did not always feel that they had enough information; I think that just over half of GPs were aware of the Scottish intercollegiate guidelines network guidance that exists on non-pharmaceutical approaches to depression. We would like to see an increase in that awareness. There is an issue with GPs receiving more training and support on mental health issues and, indeed, guidance on confidentiality and when they can break it. In our

response to the petition, we said that there is currently the ability to break confidentiality when a young person is potentially in danger. We are not sure that that is widely understood.

Secondly, we want to see evidence-based treatment and support for children and young people. In many cases, that can be a referral to a psychological service, or another service. However, medication has a role to play. I worry sometimes about the impression that we give if we talk about mental health medication in a different way from how we talk about medication in other areas. Many people find medication helpful in their support, and we should be careful not to stigmatise people who are prescribed medication. That said, GPs need more support and training in mental health treatment and understanding the range of what is available.

Rona Mackay: I go back to what you said about confidentiality. As I understand it, individual GPs have discretion as to whether they inform parents or a close family member. To your knowledge, does that happen a lot? Do GPs often go down that road?

Carolyn Lochhead: I have heard of that happening. I have never seen any figures that would indicate what scale that is on.

Rona Mackay: There are no statistics.

Carolyn Lochhead: Not that I have seen.

Amy Woodhouse: There are a couple of issues. One is on confidence in talking about mental health. From my previous experience of working at the Mental Health Foundation Scotland—prior to my current post—with the Royal College of General Practitioners, GPs themselves identified that area as one in which they lacked training. Across the board, there is definitely a need for more training. GPs recognise that and would support opportunities for such training.

Then, there is the issue of confidence in talking to children and young people. Again, more could be done in that area. Some practices have specific GPs who focus on that issue. Young people are encouraged to make appointments with that GP. Things can be done about private spaces and signposting information; that is really important.

The links worker role that exists in some GP practices is primarily for adults, but there is probably a lot of scope to extend that model to include children and young people. GPs would then know what options are available in their local areas so that more social prescribing can be done.

The royal college also talks a lot about the amount of time that GPs have with patients. Can you really have a complex detailed conversation about mental health in 10 minutes? No. Young people are probably not aware of their right to ask for a double appointment, but even in 20 minutes you will not be able to cover everything. However, it could help if young people were aware of that and knew what they were entitled to.

It is also about how we talk to young people about GP services, how their rights can be met and how to get the most out of those services. In addition to what Carolyn Lochhead said, there is quite a lot there.

09:15

Graeme Henderson: Given that we all have mental health, it should be mandatory for GPs to have training on mental health treatment. Yesterday, at the biannual forum on the mental health strategy, several GPs from the Royal College of General Practitioners and accident and emergency consultants mentioned that they had not had mental health training since they did their university training. They were in their 50s, so it was a long time since they had had that training.

GPs are not aware of other options so, in struggling to come up with a solution, they might revert to medication as the only answer, which it clearly is not—there are other options for people.

Brian Whittle (South Scotland) (Con): Following on from Rona Mackay's questioning, will you clarify whether the current guidelines that are in place for GPs to support young people presenting with mental ill health are fit for purpose and being adhered to in practice?

Carolyn Lochhead: A mix of SIGN and National Institute for Health and Care Excellence guidelines exist for medical staff in general. There is a SIGN guideline on non-pharmaceutical approaches to depression, but it is not specific to children and young people, and there is NICE guidance for children and young people that relates to depression and social anxiety. There are no further NICE or SIGN guidelines that relate specifically to mental ill health in children and young people, which is possibly an area that we should look at. You have had evidence from the General Medical Council about its guidelines, which I am less familiar with.

We hear from GPs that they would like to know more about mental health and how to support children and young people, in particular, but there is not a lot of evidence about how strictly the guidelines are adhered to.

Amy Woodhouse: As a children's rights organisation, we always advocate asking children and young people what would help them and what would make services more accessible for them.

In the spirit of things from the past that are still relevant, I point you to the work of the Paul Hamlyn Foundation, which a few years ago had a

five-year £5 million programme that looked at how GPs should support young people aged 16 to 25. It produced a series of guides on how practice could be improved that were written from the perspective of the young people and included what they felt would be helpful. The guides cover having conversations about, for example, knowing what the side effects of, the alternatives to and the benefits of medication are. They back up what the GMC says in its guidance and provide a bit of assurance that we are covering the information that children and young people need to make informed decisions.

If this is all based on young people having the capacity to make decisions about their care and treatment, we all have a duty to ensure that they are given the information that they need in a form that is clear and understandable to them. It must go beyond the technical side of medications to how we have conversations with children and young people about what the medications mean for them and their lives.

Graeme Henderson: I mentioned earlier some of the services that we provide, and one of the services that we worked with in Glasgow was a peer-mentoring service for S3 to S6 pupils. It was a project that trained S5 and S6 pupils to be peer mentors to S3 and S4 pupils, because young people tell us that they get a lot of information from their peers. Whatever the issue might be, they talk to their peers before they talk to anyone else, which is why peer mentoring and supporting young people to become peers would be a helpful way forward. As we all know, GPs have little time to talk to people and, as Amy Woodhouse said, even a 20-minute session would not provide adequate time to talk through some mental health issues.

Brian Whittle: What is your view of the links worker programme? To what extent are general practices in Scotland currently participating in that programme?

Graeme Henderson: Penumbra has just started a links worker project up in Moray, where there are six workers across 13 GP practices. The project has been going for about a year and the evidence that is coming back from it is that the bulk of the issues that are being referred to links workers from GPs are social issues, mainly around housing, poverty and family relationships. Mental health probably makes up about 20 per cent of the referrals that are coming through.

We also have a wellbeing centre in Moray, which takes referrals from the links workers as well as having a walk-in facility. I know that there are other links worker programmes around the country, but that is what we have in Moray.

Carolyn Lochhead: We also provide links work services, particularly in North Lanarkshire. We were very involved with the initial pilot that was led by the Health and Social Care Alliance Scotland and the deep-end GPs, which you are probably aware of.

There is a lot of benefit in the model, not least because it begins to address some of the issues that Amy Woodhouse raised about the time that is available with GPs. The job of the links worker is to be embedded in the local community and to have that sense of what is available locally—the strengths and assets that people can benefit from.

Mental health, in the broadest sense, tends to be one of the big issues that are raised. It can be a specific mental health problem, but it can also be an issue such as bereavement or it can be related to debt or unemployment. The model offers the opportunity to explore issues and look for what will help the person at the time. It allows them to lead the conversation, so it is very much about identifying their goals and helping them to link in to what is available.

We see more and more GPs starting to engage with that model and, indeed, more integration joint boards beginning to commission such models. It has a lot of potential to ensure that people can access the services that exist.

Amy Woodhouse: I do not have much to add to that apart from the point that you need the services to exist in order for the links model approach to work. That requires a strong community sector that provides support to young people and adults where they live.

There are slightly different models that involve a self-help support approach—with life coaching and a little bit of talking therapy as well—and there might be a bit more scope for young people to explore those models.

It adds considerably to what the practice can offer when the GPs know what is available within their communities. The time that it takes to find that out is not readily available at the moment, so the links model is invaluable where it exists.

Michelle Ballantyne (South Scotland) (Con): I declare an interest in that I managed services that provided mental health support up to tiers 3 and 4.

As you are aware, it has been widely reported that there has been a significant increase in the rate of antidepressant prescribing to under-18s in recent years. The Scottish Government's explanation for that is that the number of young people seeking help has gone up. Do you agree with that explanation, or do you think that other factors, such as access to other therapies, should be considered?

Carolyn Lochhead: We have definitely seen an increase, over the years, in the number of young people seeking help for mental health issues. We have figures that demonstrate that the rate is going up.

There is some evidence that the prevalence of emotional issues in young people is going up, particularly among young girls, who are experiencing increasing emotional issues. Trying to unpick how much of that is due to the fact that society is more open about mental health and how much of it is due to a genuine increase in the number of incidents is difficult, and I will not pretend that I have the answers.

We want to make sure that, when young people take what is often a very difficult and brave step of seeking help, they get a correct, evidence-based response. That comes back to the issues that we have discussed already. It is about making sure that GPs and others whom they speak to have the confidence, the awareness and the tools at their disposal to make a good decision about where to refer someone or what to prescribe them, if that is appropriate.

An issue that we have not touched on so far is people's confidence in having conversations about mental health with children and young people. We recently surveyed staff working in schools and got more than 3,000 responses, with about two-thirds of teachers saying that they did not feel that they had had enough training in mental health to do their job properly. We worry about the level of confidence and the knowledge of mental health in children and young people generally, as well as about ensuring that the services are in place.

The CAMHS statistics show that, at the end of each quarter, more people are waiting to start treatment in CAMHS than started treatment during that quarter. That suggests that demand is outstripping the services that are currently available.

Amy Woodhouse: I agree with Carolyn Lochhead about the concern for teenage girls. We know from longitudinal evidence from the health behaviour in school-age children study that something happens when girls in Scotland hit their teenage years. Their mental health deteriorates quite significantly, and we do not fully understand whether that is to do with increased pressures in society. Social media has been cited as bearing a lot of responsibility for that, and I am sure that it is a factor, but schools clearly have a role to play. We know that relationships across the board and teenage girls having a trusted relationship in their life can be important protective factors.

The statistics do not surprise me, but that does not mean that they are accurate. It is not easy to know what the correct rate of antidepressant prescribing should be. I remember when there was a health improvement, efficiency, access and treatment target for reducing antidepressant prescribing, which was felt to be a good thing, but we did not really know what the right rate should be. I guess that it is the same for children and young people. We should recognise that a prescription for antidepressants probably is the right thing for some children and young people, but are we doing enough to prevent that stage from being reached? If it gets to the stage at which a young person needs a prescription for antidpressants, we have left it too late. We need to focus on what we can do to prevent their mental health from getting to that point.

That is not easy, but we have a role to play. The early years are important in building resilience and good attachments—we know that and have evidence for it. If we are going to follow up on what should be done, we should put more into the early years and into parental support, as that would make a difference. As children get older, they need to be made aware of mental health issues so that they can understand their own mental health. That is absolutely key as well. They need to know the things that are likely to make their mood deteriorate or that will help to boost them and keep them well. Having a trusted adult is vital, and we know that it can be the protective factor that makes all the difference, so how can we ensure that they have that relationship?

Graeme Henderson: On the rise in the disclosure of mental health problems by young people, it is worth thinking a bit differently about what people disclose. Often, they disclose not mental health problems but distress of some kind.

One of the things that we discussed yesterday at the mental health biannual forum is that people who present to GPs or to accident and emergency units and disclose distress, unhappiness or whatever it might be often do not get to the point of having a diagnosed mental health problem, so they do not enter the mental health system. That means that they are unable to access other services, so they go away without a solution to whatever their distress is. It is therefore important that the distress brief intervention pilots that are running gather that information in relation to mental health, not just in relation to general distress.

09:30

Michelle Ballantyne: I looked very hard at what the GMC and other contributors to our inquiry said, and two things stood out for me. One was the statement by the GMC that doctors

"should only prescribe medicines if they have adequate knowledge of the patient's health and are satisfied that they serve the patient's needs".

What amount of time would you say that doctors need to spend with a young person before they can "adequately" make that decision?

The second thing was the GMC's very clear statement in its letter that

"doctors should disclose information if this is necessary to protect the young person from risk of death or serious harm".

We all recognise that from the safeguarding procedures that are part of the mandatory training for most third sector organisations, which has to be regularly updated. What I did not get from the statement was whether GPs are required to undertake that mandatory training on a regular basis and, if so, whether training on the information-sharing regulations that most of us are bound by, recognise and would explain to a young person is undertaken regularly.

What is your understanding of those two things and your response to the GMC's comments?

Amy Woodhouse: It is difficult to say what amount of time is needed. I suppose that it depends on how well the GP already knows the young person. We could look back to the golden era when everybody knew their family practitioner and had built up a relationship with them, although there were issues with that as well. If a GP knows the young person too well and knows their family, would they feel able to talk about mental health or something that would be potentially stigmatising? The point, though, is that 10 minutes would probably not be enough for an issue as sensitive as that.

In my previous role, I did a lot of work around long-term conditions and mental health. When I talked to people who went to their GP practice with multiple conditions, they told me that the mental health condition was always left until last. It was almost as though, as they were leaving through the door, they would say, "Oh, and another thing, doctor—". That is because it is not easy for people to talk about how they are struggling and having difficulties with a stranger who is acting in a professional role and has more power than them.

I do not know what the answer is other than more time, doctors making efforts within their practices to become inclusive and welcoming to children and young people, so that the practices feel like safe spaces, or having other professionals such as nurses, links workers or even youth workers based within practices who can have those conversations. Some practices have clinics for young adolescents and hold drop-ins at which they can talk about sexual health and other issues. It would be helpful to extend those and ensure that they also cover mental health.

On the duty to share information, I do not know about the technicalities of practice in Scotland, so I would probably be overstepping the mark by going into that. We have good suicide intervention training in Scotland, through ASIST—applied suicide intervention skills training—and STORM, which is skills-based training on risk management. There were great pressures to ensure that a high proportion of the workforce was trained through those packages. It would be interesting to see what proportion of primary care staff—GPs, in particular—have had specific training through those standardised packages. I am sure that there are ways of finding that out, but I do not know the answer.

Graeme Henderson: We mentioned the training packages at the forum yesterday, including the mental health first aid training through ASIST and STORM. There was originally a Scottish Government target that 50 per cent of front-line staff should receive that training, and it appears that that target was reached—I think that the figure of 52 per cent was reached. Now that that target has been reached, we need it to be 100 per cent.

The Convener: Are you saying that the Government stopped having a target?

Graeme Henderson: There is no target now—it was achieved. It appears that that box has been ticked. However, it is my view that 100 per cent of front-line practitioners should have training in mental health first aid through ASIST and STORM.

The Convener: We may be able to pursue that.

Angus MacDonald (Falkirk East) (SNP): Carolyn Lochhead mentioned the Scottish Youth Parliament. Its members favour an increased focus on social prescribing opportunities such as peer-to-peer support—which was mentioned by Graeme Henderson—talking to youth workers, information centres and counselling as alternatives to or to complement medical interventions. Can you expand on the views that you have articulated about those alternatives? Are you aware of any good practice that has not been mentioned this morning?

Carolyn Lochhead: The Scottish Youth Parliament has done some excellent work on mental health in recent years. Its report "Our generation's epidemic" was one of the factors that pushed SAMH towards campaigning specifically on children's and young people's mental health. The Scottish Youth Parliament has done a great job of highlighting the problems and potential solutions.

We absolutely agree that social prescribing, links work and all the approaches that you have mentioned should be developed and made more available so that they are available to people when they are the best option. I am a little wary of presenting them as alternatives to medication

because I do not want to suggest that medication is always a bad thing. There is an evidence base for medication, as we have said. People should be given the right treatment and should not be made to feel stigmatised for it, but a wide range of approaches should be made more available. In particular, I would highlight the need for counselling to be available in schools.

There are some good examples of peer work, with young people supporting each other. As long as the young people who are doing the supporting are themselves properly supported and trained, that can be helpful. I absolutely support the suggestions that the Scottish Youth Parliament has made.

Amy Woodhouse: Again, it is probably worth asking young people themselves about what helps them, and digital spaces are important in that regard. We must recognise that young people get a lot of peer support online. We talk a lot about the risks that are associated with social media, but it also offers great opportunities. For example, someone who lives on a croft in a remote part of Scotland and does not have the opportunity to go to a youth centre in their local community will find online space invaluable for connecting with others who have had similar experiences to theirs and for getting vital peer support.

We have a responsibility to tool ourselves up with knowledge about the places where young people are going to find support so that we can encourage them to go to the places that are good and supportive and can steer them away from the ones that are risky and damaging—which certainly exist in relation to self-harm and suicide, for example. Most young people live their lives equally online and offline in a seamless manner, and mental health professionals and people in the public sector—like probably everybody else—are not necessarily fully equipped to understand how young people use online spaces. The option of seeking support online should be one that people who are involved in social prescribing have in mind. It can certainly be a great resource, and I know that it has saved people's lives.

Graeme Henderson: I can give an example of that. Our Fife service set up a closed, managed Facebook group that the young people requested, and those young people used it to support each other. It was managed by Penumbra workers to ensure that there was no inappropriate behaviour.

Earlier, I mentioned work that we are doing with primary 3 and primary 4 schoolchildren on body confidence, which is a huge issue for young people. A lot of the pressure around it comes from social media, so there is a need to educate people and to focus on body confidence and not negative body images, which is the prevailing approach in the general media.

Angus MacDonald: I am pleased to hear the Scottish Youth Parliament being praised for its work so far on this issue. A couple of weeks ago, I was involved in a question time at a high school in my constituency, and the issue that we are discussing was the one that was of most concern to the high school pupils.

I want to skip on to the Scottish Government's 10-year mental health strategy, which was introduced earlier this year, and the issue of CAMHS, which has already been mentioned. I believe that, as part of the mental health strategy, the CAHMS budget was to increase by £15 million—I do not have the figure in front of me, but I think that it was £15 million. I probably know the answer to this, but is that enough to support school-based counselling services? Are you surprised that the provision of such services was not already included in the mental health strategy?

Graeme Henderson: As well as a general lack of resources, there is a lack of outcomes and targets in the strategy, and there is a specific issue with the lack of resources directed at children and young people. In both the previous and present strategies, the focus has been on NHS and medical interventions, not on non-medical, upstream interventions with younger people. We wait until people are diagnosed with an illness before we put in support. Whether the figure is £15 million or £100 million, it is still not adequate, because much more of the resource should be directed at children and young people. I think that we spend about £1 billion on mental health; at yesterday's forum, there was a call for 50 per cent of that money to be spent on children and young people. That would be a good place to start.

Angus MacDonald: So early intervention is the key.

Amy Woodhouse: We know that most mental health problems start in adolescence and that, if they are not treated early, they will continue on into adult life and will have hugely debilitating effects on the rest of many people's lives. They will be responsible for the health inequalities that people with mental health problems experience and which result in their dying younger.

There is an imperative to address the issue, not just because children and young people have a right to good mental health here and now but to prevent them from incurring extra costs—emotionally, socially and financially—in their adult lives. Therefore, a very strong case could be made for putting a much higher proportion of the overall budget towards children and young people. You will not get any complaints from us about that.

It is worth bearing in mind that other parts of the Government are partly funding mental health responses. I mentioned youth work, and it is also

worth being aware of the pupil equity fund, which provides funding to address the poverty-related attainment gap. It can fund literacy, numeracy and health and wellbeing activities, and many schools are choosing to use their money to invest in school-based counselling and mental health support for pupils. In that way, they are contributing to the response to the issue.

Whether that is right or wrong, though, is open to debate. Whose responsibility should it be to fund such work? Should it all lie with the Government's mental health unit or should it be spread across Government? There is an argument that says that mental health is everybody's business, so it is education's business and communities' business—it is probably also fisheries' business in one way or another. If all parts of Government made a contribution, we might have a better chance of reaching the total that we need to enable us to respond effectively.

Graeme Henderson: I have a caveat to Amy Woodhouse's point about mental health being everyone's business: if it becomes everyone's business, it becomes nobody's business. At yesterday's forum, we spoke about doing a mental health impact assessment across all policy areas of the Scottish Government. Equality impact assessments and environmental impact assessments are routinely done, but mental health impact assessments are not. If they were, every Government department would have an idea of what the impact of policy on people's mental health and wellbeing would be.

09:45

Carolyn Lochhead: There are some other points to be made about the issue of school-based counselling that you raised. We know that the strategy contains a very welcome commitment to reviewing school-based counselling, and we know that children in Northern Ireland and Wales already have a guaranteed right to that, as they do in England, to a lesser extent. It seems fairly clear to us that there is no reason why Scotland's children should not have that right, and we would like that to be acted on quickly.

We have also previously called for the CAMHS budget to be doubled. Someone asked whether that would be enough; the answer is no, but it would be a good start.

Although the mental health strategy contains good actions relating to children and young people's mental health, there are some things worth looking at. This week, a green paper on children and young people's mental health was published at Westminster; it builds on the existing £1.4 billion of additional money that has been made available for children and young people's mental health, and it commits to recruiting 1,700 more therapists and supervisors and ensuring that an additional 70,000 children and young people obtain support from mental health services.

I do not want to overemphasise what is happening, because some of that is being rolled out quite slowly and only in certain areas of the country, but it is still worth looking at what is happening in other areas of the country and asking whether we are doing enough and whether we can learn from other areas. Is there more that we can do?

Brian Whittle: Going back to the petition, I have to say that a question has been in my mind since hearing the evidence. When a person's mental health deteriorates to a point at which medication is required, should we not ask about that person's competence to manage their own medication?

Amy Woodhouse: Is that a question about capacity?

Brian Whittle: The petition obviously concerns a tragic and extreme case. In cases where medication is required, we are passing to the patient the competence and ability to manage their own medication, but should the GP be doing that if the patient's mental health has deteriorated to a point at which they need medication?

Amy Woodhouse: As a representative of a children's organisation, I probably have to think about that from the perspective of the rights of the child. In that respect, several rights are relevant. As we talked about earlier, there is the right to have a say about matters that affect you in your life. Children and young people are individual citizens in and of their own right and if they have the ability to make decisions, particularly at the age of 16, they should be able to do so, especially as they have many other rights to exercise and decisions to make, such as how to vote, whether to get married and so on. Decisions about their care, in principle, are also fundamentally important.

One of the articles that are relevant here is article 3, which says that adults should do what is best for you. Are we doing enough to ensure that? I recognise that young people are vulnerable, because of their mental health, and they need all the support that they can get to make those decisions. There might be a role for advocacy to ensure that those young people have an adult, perhaps at one remove from the mental health practitioner or the GP, who can talk through the options with them and come up with a plan so that they are not just making the decision by themselves. I recognise that it could be a difficult decision, particularly if you are being offered medication or nothing. That is Hobson's choice for many young people, especially when they

consider the side-effects that might be associated with the medication.

I am reluctant to talk about all this. The implications of your question are that someone with a mental health problem does not have the capacity to make decisions about their care. I fundamentally disagree with that: everybody who has mental health problems deserves support from professionals to help them to make such decisions and work through the process in a rights-based way. They are entitled to have choices that will help them with their care and treatment.

The Convener: I suppose that the petitioner's point is that, had she known that the tablets had been prescribed to her daughter—even if she did not agree with the treatment, or she was concerned about her daughter taking the tablets—she would have known to look out for and to understand the side effects and support her in managing her medication. This was not a case of a hostile person denying a young person their rights; rather, it was a case of a person who, had they been provided with more information, could have provided the support that clearly was not available in the system, because what was available in the system was medicine. Linked to that, I wonder whether, if a person does not have that guarantee—in other words, if there is no supportive person who can help manage their medication—there should be a limit on how many tablets they are prescribed at a time.

Carolyn Lochhead: I would be extremely concerned if we were to go down the road of assuming that a young person with a mental health problem lacks capacity—

The Convener: With respect, I did not say that—

Carolyn Lochhead: I understand that—I am responding to Mr Whittle's question.

The Convener: It is not that they lack capacity, but distress and anxiety has brought them to that position. We have all known people who have been in such circumstances. If I have broken my leg, and it causes me distress, I do not expect someone to tell me to just get on with it. Non-medical supports will be put in place, and there will be an understanding that I will need support, because I might be in shock or whatever.

The question of how someone feels when they finally get to a doctor should be recognised. I am assuming that that is the case, because I have spoken to GPs and they tell me that it is not simply a question of handing over tablets and telling the patient that they are confident that they can deal with the matter themselves. Is there an issue of GP practices being under phenomenal pressure? They can prescribe, because they are allowed to do so, but they do not have the time to do the other things. Should there be in place a hierarchy of interventions by the GP before they get to the point of prescribing tablets?

Carolyn Lochhead: Absolutely, and the point that I was about to go on to make relates to points that we have made before on the importance of reviewing prescriptions when they are written to make sure that people are not simply given a prescription and left for a long time. They should be reviewed quickly; indeed, prescriptions should not be made unless they are in line with evidence-based guidelines.

In the earlier question—the one to which I was responding—it was suggested that there might be a question mark over the ability of a young person who has got to the point of being prescribed medication for the treatment of mental health to manage that medication. I would have great concerns about making a blanket assumption that those young people would not have the capacity to manage their own medication. It is really important for GPs to be aware of the guidance on whether they should prescribe—and, if so, how much they should prescribe—and at what point they ought to breach confidentiality. When I read the petitioner's evidence, those were the questions that were going through my mind.

We have mentioned the Scottish Youth Parliament's excellent work. In its evidence, it expressed concern about whether young people, if they did not consider that their confidentiality would be respected, would come forward for help at all. That is a genuine point. We must also recognise that not everybody has supportive parents who want to, or who will, understand the issues, and not everybody has supportive parents who will help them manage their medication, if they are put in that position. We need to look at every case individually, but we must also ensure that the guidance for GPs—and other professionals—on managing such cases is well known and followed.

Brian Whittle: I want to clarify my position. I was not suggesting for one second that there be a blanket policy saying that young people do not have capacity in such situations, but surely a question about their ability to manage the medication must be in a GP's head when handing it over.

Rona Mackay: I have a question on the same topic, which takes us back to a much earlier question about GPs' training and competence. There seems to be no standard framework for GPs. The situation is not like prescribing someone a course of antibiotics and telling them to come back if they do not feel better. Surely a GP must know that if a young person is at the point where they must go to a doctor and receive medication,

their treatment must be followed through; they cannot just be given a load of tablets to deal with. Surely in the GP's mind, that must not be the correct way of treating the situation. What are your views in a professional capacity of a doctor handing out tablets to someone who clearly has mental health issues?

Carolyn Lochhead: In our original submission, we reviewed some of the guidance for GPs. I am very wary of talking about an individual case when I do not have all the facts, but it is important to ask whether the guidelines were followed. For example, was consideration given to whether to involve the parents or breach the child's confidentiality? Doctors can do that—they have the right and, I would say, a duty to do so. Were the guidelines followed on what and how much to prescribe? These really important guidelines should be well understood and followed, and I am not sure that they always are.

Amy Woodhouse: An additional question that it would be useful for doctors to ask young people is whether there is an adult in their life whom they trust enough to talk to about this. What do we do with looked-after children? What do we do with young people who are taking on a caring role? What do we do with children who do not have a positive relationship with their parents? We can ask them whether there is somebody else in their life. Do they have, say, an auntie or a granny? Is there an adult who can support them through this, and can we tell them about it? We can share information if we have young people's consent; the first thing to do is find out whether doctors are asking that question. I do not know whether they are.

Michelle Ballantyne: What we are dealing with here is the difference between a mental health consultation—which, for a young person, would probably last an hour—and a 10-minute GP appointment. I am sure that I read in the previous papers for this petition that the petitioner's daughter declined psychological support. Am I correct in saying that, convener?

The Convener: I think that there was some suggestion of that, but I do not think that we will want to second-guess what was decided in an individual consultation. The question that we are asking is how we build on that. In some circumstances, people repel all boarders at first but can be persuaded or encouraged later.

Michelle Ballantyne: The NICE guidelines are very clear about the process that GPs and others should follow when prescribing medicines. In the case of antidepressants, the guidelines indicate that a person should be seen within a week of the prescription being issued and encouraged to do other things. It goes back to the whole business of training and updating, because we seem to have a gap there in the treatment of young people.

I wholly support young people having the right to confidentiality and the right to make decisions. They should be able to see a GP without feeling that whatever they say will be passed on to all and sundry. However, the safeguarding requirements with regard to information sharing should be paramount. Things such as the NICE guidelines are there for a specific reason and are the result of consideration of the evidence base.

When we discuss guidelines for treating young people and make decisions and come up with strategies, is adequate attention paid to the evidence base? When young people ask for help—particularly in the context of mental health—do we need a much more robust response? I am talking about a bit more than just having a guideline that may or may not have been read or thought about recently. There has been a huge increase in the number of young people who are seeking such help. As Amy Woodhouse indicated earlier, we do not entirely understand why, but perhaps we are not responding adequately. What do you think should be done?

10:00

Amy Woodhouse: I guess that the GMC would be the best place to find out whether there is adequate adherence to the evidence base and the guidelines, and whether complaints have been made in general practice. I cannot illuminate the issue, because I do not have that information.

On the question of a more robust response, I whole-heartedly agree that we need to do more to ensure that support is available across the whole of the tiered-model approach, which has been around for quite a long time. There is low-level prevention and awareness-raising work in schools and community settings, which—as you will know from your service—can be ramped up or down as required, depending on the needs of the children and young people. At the moment, we have specialist services, which are small and overstretched, and with CAMHS, we have some awareness raising happening at the lower level but very little in the middle. There is a real gap there and that should be our focus. It is a gap that primary care often fills, but primary care does not seem to offer much for children and young people at the moment, other than medication.

I should mention that Audit Scotland is currently doing an audit of child and adolescent mental health services, which is due to report in September, and that will be invaluable evidence. It is a challenge, but Audit Scotland is looking across the whole tiered approach. I do not know to what extent it will get into the community-based stuff,

but that will give us a picture of what mental health services for children and young people look like in Scotland. At the moment, we do not really have that picture. The audit will show us where the gaps are, and we will be able to use it to advocate for change. I urge members to look out for that report when it comes, if you are not already aware of it.

Carolyn Lochhead: It is frustrating that we already have good, well-written, evidence-based guidelines but that they are not always adhered to and people are not always aware of them. As Amy Woodhouse says, the GMC is the place to look for factual information on awareness and adherence. There is a question for the GMC and the royal colleges about how we increase that awareness and ensure that people are working to the guidelines. There is an issue about not just the guidelines but the support that is available. When you recognise that a young person is in need of some kind of help, do you know what is available? Is there enough available?

In the coming months, as part of the audit that I mentioned, I hope to look at the threshold and the criteria for CAMHS. What a particular service provides can vary across the country, as can the threshold that someone has to meet to qualify for it. It sounds to me as though, in some areas, a young person would have to be really quite unwell to get access to CAMHS. Is that the right approach? If it is, what else are we making available for those people who clearly need some help but might not meet that rather high threshold?

Graeme Henderson: Specifically in relation to GPs who prescribe psychotropic medication, it might be possible to have a guideline that tells them not just to prescribe medication but to do something else—whether that is providing access to a supportive adult, arranging a nurse follow-up in less than a month or referral to another service, such as a talking therapy.

Michelle Ballantyne mentioned the safeguarding requirements. As a service provider, all our staff are contractually required to adhere to safeguarding rules, but I am not sure whether the same applies in other areas.

Carolyn Lochhead: It might be worth clarifying that the NICE guidance on depression in children and young people says that they should be offered a psychological therapy as well as an antidepressant. That is another point to note in relation to the awareness of guidance.

The Convener: My mother's generation were routinely offered antidepressants, but the world has moved on and said that there should be a presumption against that. Perhaps what we should be exploring further is the possibility of taking further steps to dispel stigma. If people need medication they should get it, but the inappropriate use of medication is a historic fact. People did not really address the questions around mental health; they simply said, "We'll give you a tablet and you can deal with it." As a result, a whole load of people got tablets when it was perhaps not appropriate.

I was concerned by a response from the Scottish Government on the increased prescribing of drugs—I am not sure whether it was in relation to this petition or a later one—that said that it was good, because it meant that more people were coming forward. It might mean that because they are under pressure, GPs are prescribing to people who are coming forward with mental health issues. We might want to explore that.

I will let other folk in to suggest how we should take forward the petition. It has been a very useful session. We have explored a range of challenges for anybody who works with young people who have mental health issues.

I have been told anecdotally that young people have to refer themselves to CAMHS, whereas if they go to a GP and something is physically wrong with them, they are referred to a consultant. We might want to explore that. The issue of there no longer being a target for training is also something that we might want to highlight.

We have already discussed the possibility of inviting the Minister for Mental Health to the committee, and I think that we should agree to do that.

Michelle Ballantyne: Absolutely.

The Convener: Is there anything else? We can check back in the *Official Report* of our meetings for other things that have come up that it might be worth pursuing. We got a response from the GMC, but there might be things that we want to remind ourselves of ahead of any meeting with the minister.

Michelle Ballantyne: I would like us to go back to the GMC to ask about safeguarding training and adherence to guidelines. Its response was very full, and it is quite clear that all those things are there in line with its expectations, but there is a difference between them being there and them being done.

There is an enormous amount of pressure on GPs at the moment, and most of them are not paediatric specialists. Dealing with the mental health of young people is a big piece of specialised work that they have probably had minimal experience of, and I would like to know what requirements there are and what percentage of GPs—if the GMC has that information—are doing their safeguarding training and their updating on mental health.

The Convener: I do not know whether that is something that the royal colleges would be more aware of—there is a distinction between them and the GMC. Of course, you might know more about it than I do, but we might want to check where we would get that information.

Brian Whittle: Following on from that point, I would be interested to find out about access to continuous professional development generally across the health service. It might be available, but do staff have the time capacity to access it? As has been said, some people might be 30 or 40 years into being a GP, and mental health services have moved on dramatically in that time.

Michelle Ballantyne: CPD is compulsory for registration, but obviously people are not necessarily going to cover every subject. The question is what, if any, mandatory CPD there is.

The Convener: There is also the balance between GPs who are unaware of what the training is and those who are under such phenomenal pressure that they are simply managing the process. I had the privilege of meeting the GPs at a practice in my area, who made the point that they are so under the cosh in terms of appointments that they do not necessarily have the time for CPD.

There is also the issue of the provision of link workers in deep-end GP practices. That is only a small part of the provision, but it might be something that we can look at further.

Do we agree to invite the Minister for Mental Health to explore the issues that are highlighted in the petition? We recognise that the petition has arisen from very difficult, tragic circumstances and that although the solution that it offers on confidentiality might not be the answer, it highlights a number of other issues that we would want to look at so that we can protect our young people and keep them safe.

Rona Mackay: Is it an issue for health and social care partnerships as well? Should they issue guidelines, or do more than that, in their local areas? If a young person is prescribed treatment, should it be a requirement that they are signposted to local counselling? I do not know whether that is within our remit.

The Convener: When we invite the minister to come to the committee, perhaps we should ask what role she sees local health and social care partnerships having.

Michelle Ballantyne: I think that it all comes back to safeguarding. Information sharing has been a huge element of discussion over the past few years. The safeguarding guidelines that are produced by every local government and NHS area are underpinned by the question about when to share information. Information should be shared when there is reason to believe that the young person's life might be in danger or that they might be endangering somebody else.

That decision making is crucial, because the right to independent and confidential access is paramount, but the safeguarding procedure overlays that. That is the point at which the decision is made about whether it is necessary to tell somebody about what is going on with that person. For me, that is the crux of the problem in the petitioner's case and in many of the cases that relate to it.

Rona Mackay: It is important to remember that we could be talking about 16-year-olds, and 16 is very young.

Michelle Ballantyne: Safeguarding applies to vulnerable adults as well, so it would count either way.

The Convener: The issue is how visible the situation is to somebody. If a person is in total crisis, you could spot that, but if somebody is quite calm when they present and says that they are suffering a bit from stress or that they feel anxious—

Michelle Ballantyne: But that is also about training, because the ASIST training teaches you that truly suicidal people are extremely calm; they are not het up. It is a question of being able to spot and understand what is going on.

The Convener: There is loads for us to explore with the Minister for Mental Health on the whole question of how we address support for young people and ensure that they get the appropriate support and treatment if it is deemed necessary.

I thank the panel for being here—we found the session very useful. We look forward to further consideration of the petition. I suspend the meeting briefly to allow the witnesses to leave the table.

10:11

Meeting suspended.

10:14

On resuming—

New Petitions

Cat Population (Management) (PE1674)

The Convener: Agenda item 2 is on new petition PE1674, on managing the cat population in Scotland, which was lodged by Ellie Stirling. The petition calls for a review of the code of practice under the Wildlife and Natural Environment (Scotland) Act 2011 to control the domestic cat population and protect the Scottish wildcat.

We will take evidence on the petition from Ellie Stirling, whom I welcome to the committee. Committee members have a copy of the petition and of the written submission that you provided to support the petition. You have the opportunity to make a brief opening statement of up to five minutes. After that, committee members will ask a few questions to inform our consideration of the petition.

Ellie Stirling: It is a privilege to have this opportunity and I really appreciate it. The committee's consideration of my petition represents a change of tack from the previous discussion except that, as I worked all my paid working life as a clinical psychologist in the mental health service in England and Scotland, it was interesting to hear it. Having said that, I think that that experience is relevant to my petition. I am not paid to do the work that I do now, but I work virtually full time—as some people do when they retire—in environmental work. For some reason, I seem to be attached to cats and, just as I worked with vulnerable people in vulnerable circumstances, I have tended to try to help cats that live in vulnerable circumstances.

In the 20 years since I moved back to Scotland, I have been doing trap, neuter, return. As some members might know, that is an approach that is used universally and which has been used by the Scottish wildcat action project to limit the number of cats of the domestic species that crossbreed with the wildcat. I suppose that I should not have been surprised, but I have found that it is a war zone out there: there are animals living in circumstances that you would not dream of for your own pet. Some members might not have pets, but those who do know that people who keep pets—dogs, cats, rabbits or whatever—tend to see them as vulnerable and important members of the family. They are vulnerable in the sense that we have the responsibility to keep them safe and meet their needs, as we do for our children. However, that is not happening for the cats out there. A lot of people think that feral cats are a different species from our domestic cats at home, but they are not. They are exactly the same cats, but they are uncared for.

I had been doing that work for perhaps 10 years before I noticed that the areas where I had neutered all the cats started to fill up with cats again, which turned out to be cats that came from the pet cat population. A bit late in the day, I did some research and found some studies, which you have references to in your papers. The studies told me that a minority of pet cat owners still do not neuter their cats, although pet organisations have made great headway, to the extent that 90 per cent of owners now do so. However, 10 per cent of owners—13 per cent in Scotland—do not. You would think that that is fine and that we can just keep nudging the owners and we will get there, but it is not happening.

I looked at more figures, which showed that the number of homes available for cats stalled in 2013. That number is not getting any higher; if anything, it is going down. Enough new animals are being produced—because of the 10 per cent of cat owners who do not have their cats neutered—to increase the pet cat population by a factor of more than two every four years. It is simple arithmetic. Where are the cats going? They are overspilling, as there are not enough homes for them. We can talk about the figures later, if members want, but the cats are overspilling into back streets and the countryside.

By that time, I had shovelled alongside the Scottish wildcat action project and was helping it with TNR techniques. I discovered the crucial importance of controlling our domestic, stray and feral cat populations to saving the wildcat in Scotland. The research that I did—only this year, to my shame—has brought me to this point today. It seems that we are at a tipping point and a decision point. If we go on in the way that we are, producing cats that join the enormous and growing feral and stray population, neither the existing wildcats nor future reintroduced wildcats will have a chance. There is also the issue of the horrendous welfare implications for the cats.

Alternatively, we could look at the new measures of neutering and identification chipping—I understand that they would have to be looked at carefully—which would seem to be a basic necessity for good cat care and health. Veterinary professionals support neutering and ID chipping as basic essentials of good cat healthcare, as do all the cat and pet welfare organisations, which neuter and ID chip their own cats.

To sum up, what has brought me here is the fact that we are in a unique position. We have the wildcat to think about and it is a big responsibility. There are fewer of them than there are tigers, and

poorer countries than ours are doing a lot more on conservation to help tigers. We need to help the Scottish wildcat action project with its legacy. It can start by back-breeding the wildcats that are left, but we have to do the rest by creating a habitat that is safe for them to thrive in in the future.

In my view, and in the view of most other people who have signed the petition, we also have a responsibility to keep our domestic cats safe and not let this carnage and waste of lives happen. I would not like to see Scotland on the wrong side of history, so I have brought the petition to you so that I can share my thinking and have you ask me questions.

The Convener: Thank you. I invite ask Angus MacDonald to open the questioning.

Angus MacDonald: In your submission, you say that you have written to the Scottish Government, the cabinet secretary, the cross-party group on animal welfare and your regional MSPs, as well as discussing the issue with your constituency MSP, Graeme Dey. What feedback have you received as a result of all those approaches?

Ellie Stirling: I have written three times to the Cabinet Secretary for the Environment, Climate Change and Land Reform and received responses from the animal welfare section, but not from the conservation section. I wondered about that.

I have had support from my MSPs in that my constituency and regional MSPs have written to the cabinet secretary for me. They got a very standard response: the Government's position is that cats are not really an issue—they go about their business, look after themselves and do not cause humans any difficulties. I beg to differ. The evidence suggests that they cause some nuisance to some people and distress to others who care about animals. They also have an impact on internationally important conservation.

Given the letters that I have had back, I would like to see an update of the Government's information and awareness of the issues that I am raising. That might lead to some different thinking.

I met the convener of the cross-party group on animal welfare some months ago and I was positively listened to. I have written to all MSPs now and those who have taken the trouble to write back to me have recognised the importance of the twin issues of animal welfare and conservation that I have raised. Their main concerns have been about the apparently compulsory nature of the steps that would need to be taken.

Angus MacDonald: The figures in your submission are quite staggering. With 400,000 feral cats, and with 286,000 kittens being born every year, we can see the reason for the overspill that you talked about in your opening remarks.

Michelle Ballantyne: I have to say that I am a bit shocked. I did not know all this information about cats so the petition made for interesting reading.

You said that ownership and degree of control are ill defined and open to interpretation in the code of practice and the Scottish Natural Heritage guidance notes on native range. I also noted your comment that owned domestic cats that roam freely are considered to be "under human control"—something that my husband might disagree with—if they are "expected to return" to their owners. Can you expand on that point? Do you have an example of a better definition to provide in the notes?

Ellie Stirling: When I did the research earlier this year, I was also quite stunned to find that definition. Because cats, dogs and farmed animals are all classified as non-native species, that general term "under human control" is applied to them all. Farm stock, horses and other sorts of kept animals can be fenced in as a simple way of keeping them under human control.

If you kept a horse and a tree fell down and broke the fencing and the horse escaped, under the legislation and the code of practice, you might be open to criminal prosecution for not maintaining your fencing or not checking it. Because it is a strict liability offence, the responsibility would be on you to demonstrate that you had checked the fence the day before and it was perfectly all right, but there was a storm overnight.

With dogs, there is human control involving leads, training and what have you; with cats, as Michelle Ballantyne alluded to, it is different. Everyone who has read my petition has said to me—front-line, war-weary cat rescue volunteers all say this, too—that cats are not under human control in the way that dogs are. You cannot just call them and expect that they will come back. Only a few cats are under human control in that way. Cat behaviour varies along a continuum.

There are welfare issues, whereby cats cannot legally be contained in the way that a horse can be contained. Cats cannot be fenced or shut in—if they were, that would rightly be a welfare issue. For me, for veterinary professionals and for conservationists, as well as for cat owners—or 90 per cent of them, at least—the middle-of-the-road solution is neutering, because if a cat is neutered, it will be free of hormonally driven behaviour, such as wandering, roaming and territorial fighting, which leads to the transmission of disease. For female cats, neutering will free them from producing two to three litters a year of five kittens each, which is a ticket to early death as well as to

not coming back, because cats move out and colonise new areas when they produce young.

I have suggested a simple change to the definition of "under human control" in the code of practice. Instead of saying that animals that are under human control are "expected to return", which is a subjective judgment, the definition should be objective and pragmatic and should relate to something that can be observed, touched, felt or measured. It would be sensible for the definition of a cat that is "under human control" to be a cat that is neutered. If a cat is neutered, that will satisfy the vast majority of cat lovers, every vet professional and every member of the public who does not like cats—people who do not like cats do not want to have 60 living next door to them. It seems to be a middle-of-the-road requirement to have a cat neutered. That way, it would be regarded as being under human control.

Michelle Ballantyne: How would breeders and showers be dealt with under that arrangement? Would they have to be specially licensed?

Ellie Stirling: I have not worked in those areas of licensing, but there would be nothing to stop a person being a breeder of cats. There is no compulsion to not breed. Someone who wanted to be a breeder of cats would apply for a licence that would exempt them from the non-native species legislation. People's freedoms would not be curtailed.

The issue would then be down to whoever set the licensing conditions. That happens every day in the context of conservation. Licences are issued for interference with protected wild species, but the conditions have to be followed by the developers. I envisage the situation being the same for breeders. As I understand it, someone who wants to be a licensed breeder of cats in France must undergo a set piece of training, perhaps in a local college. There would be scope for younger people who wanted to work with animals to work at a breeding establishment, learn the tools of the trade and learn about cat welfare and the importance of vaccination. I have not mentioned vaccination yet, but it is hugely important from an epidemiological point of view.

Brian Whittle: In the petition, you say that you believe that a new approach is required because 10 per cent of cat owners do not have their cats neutered, despite appeals such as the snip and chip appeal. Are there other ways in which the benefits of neutering could be promoted by veterinarians and animal welfare charities?

Ellie Stirling: Thank you for the question. The approach that you have outlined—which could be summed up as the voluntary approach—is what I have relied on until recently. I and all my colleagues in front-line cat rescue have leant towards such an approach, which involves good advice and good veterinary intervention being taken on board by everyone who feels that they are a responsible cat owner. The trouble is that that voluntary approach seems to have gone as far as it can go.

10:30

The People's Dispensary for Sick Animals and eight other pet organisations are members of the UK-wide cat population control group, which produces a report each year that is a snapshot of cat ownership. Until the past two or three years, the group has been reporting a nudging up in the rate at which cat owners are getting their cats neutered, but that has now stalled. In 2016, we reached a 93 per cent neutered rate UK wide; it is back down to 90 per cent this year. The results are from a YouGov opinion poll, and those of you who are scientifically minded know that opinion polls measure public opinion; they do not go out and count cats. There is a huge difference. The people who sit at home, put their name on a panel and say that they are happy to be consulted by YouGov and answer its questions are connected up to the world. The people I meet are not connected up in that way, so the number of unneutered cats is probably hugely underestimated.

It is worrying that the voluntary approach has gone as far as it can go. The front-line cat rescue workers I meet confirm that. The people who do not have their cats neutered are perhaps socially marginalised and live without social resources such as email, or networks in which friends and family would encourage them to have their cats neutered. They may have lots of other social problems. I do not want to blame those people, but if we do not bring them on board, vets tell us that we risk a huge explosion—that is not my word—of the cat population, which brings with it the potential for an increase in unvaccinated cats. Most cats are unvaccinated, even the neutered ones, and feline diseases run rife when there is overpopulation. We are putting the neutered pet cats at risk—yours and mine at home are at risk because of the actions of the few people who do not yet neuter.

I thought hard about this and I thought about the people who smoked in public places until we reached the point where we said that it affects the health of us all, because we all breathe the smoke. A similar argument applies to people who are not neutering their cats. It is not just their cats that are suffering—and they are suffering; if you want to ask me later about any of the conditions, I will happily tell you—it increases the risks for the other 90 per cent of cats as a result of disease

transmission. There are still territorial fights, and cats that are wandering.

Brian Whittle: Is there the possibility of compulsory registration, not just of pet cats but of pet animals?

Ellie Stirling: I would suggest something similar to dog microchipping. All dogs now have to be microchipped and the microchip is registered on a managed database. If you are a breeder and your dog produces offspring, you are responsible for having those offspring microchipped. If we had the same system for cats, we would suggest that the offspring be neutered, as well as the cat. If your cat is producing offspring and you are not registered as breeder, you would presumably be quickly encouraged to register as a breeder and therefore you would be responsible for the neutering and microchipping of the offspring. That is the case for other pets. I know about the set-up for horses, although not in such detail. There are passport systems for horses that track the health of the horse. With cats, neutering and vaccinating are basic necessities for not just the health of the individual but the health of the population. That is the issue.

Rona Mackay: I should declare an interest. I am a member of the cross-party group in the Scottish Parliament on animal welfare.

I follow on the questioning from my colleague, Brian Whittle. In response to a written parliamentary question on the neutering, microchipping and registration of cats, the Cabinet Secretary for Environment, Climate Change and Land Reform said:

"We do not ... consider these actions should be compulsory for cats."—[*Written Answers*, 27 July 2017; S5W-10322]

What is your response to that?

Ellie Stirling: People in Government, quite genuinely, have not had time to process the statistics. I was shocked by the statistics and you have said that you were too. I have written a lot down; people do not always have time to read things in such depth. If someone read the evidence in depth, they would see the problem. You obviously have figures from me because you have asked the question. Whether there are under half a million or nearly a million unneutered cats in Scotland, the population is more than doubling every four years. That will take us to more than two million cats in four years' time. That has been happening for all of this time, and the number of homes for cats is not going up—if anything, it is going down. There are new issues, such as that one, to take on board.

I gave you the figures but I have not shown you the graph of the figures. I will leave the graph with you if you care to accept it. You probably cannot see my piece of paper, but the orange bars show the additional cats, year on year, on top of the current cat population, which is represented by the blue bars. That is a conservative estimate and does not take into account that the cats' offspring begin to have kittens the following year—if your cat has five kittens and two or three of them are female, they could each produce five kittens twice a year. I have not counted that in my figures; it that factor were included, the increase would be exponential.

The other thing to bear in mind is that a fair proportion of cat owners—maybe more than half of the 90 per cent of those who say that they neuter their cats—have already let their cats have litters before they neuter them. I have not counted those kittens either. The graph shows an exponential increase, but the increase is even greater than that. I hope that the Government has time to take on board those facts and statistics.

I also hope that the Government has time to consider updating its model of cat behaviour. I do not know whether that is covered in the animal welfare section or the conservation and wildlife section, but the model of cat behaviour needs to incorporate the understanding that they are a widely roaming species—probably as widely roaming as the wildcat—if they are not neutered. They are not under human control if they are unneutered; they cannot be expected to come back. The wildcat may be in the north of Scotland now, if there are any left, but domestic cats that become feral there can be neutered, so that number can be stabilised. However, domestic cats are roaming, being moved around in cars and being taken in by people. They will recolonise areas, as I have witnessed in the past 20 years.

If we think that neutering is so important to cat welfare, why do we neuter some cats but not all owned cats? It is important to their welfare, so why do we not neuter all cats? In doing so, we can also protect the Scottish wildcat.

Rona Mackay: Briefly, I ask for clarification on a second point. In the second part of your submission, you include a proposal from Anna Meredith from Scottish Wildcat Action. In answer to another parliamentary question, the Cabinet Secretary for Environment, Climate Change and Land Reform suggested that the proposal had

"not been submitted to the Scottish Government"—[*Written Answers*, 30 August 2017; S5W-10622.]

and thus no response was given. What is your understanding of whether, or how, the proposal was submitted to the Scottish Government? Do you know any background on that?

Ellie Stirling: I should say that I made a typing error in my submission. Professor Anna Meredith is the professor of zoological and conservation

medicine at the University of Edinburgh. She was invited to convene the cat population control group for Scottish Wildcat Action and put together a paper. That paper, which is fully referenced and totally up to date, was put to the Scottish Government in 2016. However, it was not about animal welfare, but about conservation and wildlife. The paper is with the Scottish Government, so I cannot explain what you have said, unless it is as simple as there being different sections of Government and one part of it not knowing what information the other part has got. The paper contains the research—authenticated and referenced—that I have presented to you in the best way that I could.

Rona Mackay: Thank you—that clears up that matter.

Angus MacDonald: You have listed five things—they are in the petition, so I will not list them—that you would like to see happen through any review of the code of practice. How would they be administered and enforced? Have you considered the cost of enforcement?

Ellie Stirling: I am not sure that I follow you.

Angus MacDonald: I am talking about the five items that relate to the code of practice—the native range guidance associated with the Wildlife and Natural Environment (Scotland) Act 2011. Would you like me to list the five things?

Ellie Stirling: Yes, please.

Angus MacDonald: Number 1 is that a neutered cat should be defined as being under human control and exempt from NNS legislation. Are you with me now?

Ellie Stirling: Thank you. I have got it now—that is at the bottom of the second page of my petition. What would you like me to explain?

Angus MacDonald: Will you explain how you would like to see the five asks happen through any review of the code of practice?

Ellie Stirling: You want to know about the practicalities of how all that would be done.

Angus MacDonald: Yes, and whether you have considered the cost of enforcement.

Ellie Stirling: Right. We have possibly already covered number 1. There could be a simple redefinition in the code of practice so that an owned cat is defined not as being under human control but as being expected to return to its owners. In addition, cats should, preferably, be neutered and ID chipped. That would require not a change in law but an amendment to the code of practice. That way, we could not be accused of trying to criminalise people, because we just want to redefine the code of practice.

The second proposal is that all owned cats be neutered, microchipped and registered, with the cost to be borne by the owner. The majority of people bear the responsibility of that cost already. In the past two to three years, cat welfare organisations and generic pet welfare organisations have told me that neutering is such an important priority for them that they provide neutering for free, so that service is available if people need it for their pets. People do not have to go through a demeaning income assessment test and they are not asked questions. If they need it, they can get the cat neutered. People can make a £5 donation to some of the schemes if they want to, but they do not have to.

Cost is mostly not an issue. There might be an issue were there to be an immediate surge in the demand on veterinary professionals to provide neutering—that situation would need to be thought about, because that would lead to a surge in the amount of financial resources being used by the charities providing the service. However, all the charities that I know require neutering and do not sign over cats or kittens until they are neutered. Therefore, people can access free neutering for their cats. I cannot imagine that a huge flood of people would come forward in one go, especially if the process were staged over the next one or two years.

At one stage, I did some costings, but I have not brought them with me. If everybody went at once, there would be a cost implication.

I turn to the licensed exemption scheme. In the case of microchipped dogs, people are classed as breeders if their dog has offspring and they register with the Kennel Club. It would be really helpful if thought could be given to what body could do that in relation to cats. It should not be local authorities, which is the approach that is being considered in England. They do not have the resources. In England, the discussion on cat population control seems to have led to local authorities being asked to suss out the repeat sellers of kittens and ensure that they become registered as breeders. I do not think that Scottish local authorities would be terribly comfortable about being asked to take on that role, even if they have the resources, because they would be almost being asked to take on a policing role in relation to the system.

The approach should not be seen as policing bad behaviour; it should be seen as trying to get everybody on the side of good behaviour—that is the psychologist in me talking. It is really important in Scotland because we have the wildcat to think about, and also because we care about our cats—full stop.

10:45

Angus MacDonald: Of course, it is not just Scotland that has the wildcat. Are you aware of any other countries in northern Europe that have a similar problem? Have any countries in northern Europe already implemented what you are asking for?

Ellie Stirling: In terms of mandatory neutering?

Angus MacDonald: Yes.

Ellie Stirling: You mentioned northern Europe; certainly in some of the states in America, mandatory neutering has been introduced. It has also been introduced in Australia, and there are restrictions on keeping pets altogether in some areas of Australia because of the decimation and complete loss of native wildlife.

In northern Europe, there are various policies in different countries. There are certainly places in Europe where no culling of feral and homeless cats has been introduced and a trap, neuter, return policy has been adopted. Italy, for example, has a no cull policy and a very pro trap, neuter, return policy. There is a study somewhere in one of the papers that shows that such a policy works only if you work at it positively and turn off the tap at the other end by stopping people breeding more kittens. I could not tell you whether the law in Italy requires people to be registered as breeders and otherwise prevents people from keeping unneutered cats. However, they have found that their approach works and it is the humane approach to cat control.

The Convener: Thank you very much for that evidence. It has been useful and interesting. Do members have a view on what action we might want to take on the petition?

Brian Whittle: It would be useful to seek the views of organisations such as the Royal Society for the Prevention of Cruelty to Animals to get their perspective.

The Convener: We will contact animal welfare organisations—Cats Protection, among others. I am interested in the conservation side, so we should perhaps contact the conservation bodies as well. Any other suggestions?

Rona Mackay: We should also contact veterinary bodies.

Michelle Ballantyne: We should write to the Scottish Government again specifically around the confusion about whether the report was read. We might want to write to people who are involved in a number of the policy areas and see what their commentary is.

The Convener: If we write to the minister, it becomes an obligation to draw the different aspects together rather than having them compartmentalised in the way that they have been.

Angus MacDonald: I hate to be pedantic, convener, and I do not like to contradict my colleague Brian Whittle, but can we make it the Scottish Society for the Prevention of Cruelty to Animals rather than the RSPCA that we contact?

Brian Whittle: You are quite right.

The Convener: I will say, first, that you do like to contradict him and, secondly, that you are quite right in this regard.

Ellie Stirling: If I may be allowed to speak, it is an important difference. There has been some good publicity supporting the proposal—the *Sunday Herald*'s environment correspondent did a special report some time back; he did some good investigative journalism and spoke to the SSPCA. However, you could speak to the RSPCA as well, because it is on the cat population control group and it has done a lot of work at the UK level. Also, in 2014, the RSPCA produced the first report that caught my attention, which said that we have a catastrophe looming because of the increasing cat population and the levelling off in the number of available homes, which is a recipe for disaster. However, nobody has looked at the continuing trends since.

The cat population control group has various organisations on it apart from the RSPCA, including the PDSA, so you might want to contact the PDSA as well.

The Convener: If there are further suggestions, we will take them on board, but the key thing is that we are trying to draw together the expertise in both animal welfare and conservation from the different bodies that were identified. Also, we need to emphasise to the minister that it is not just about one thing or the other; it is about the connection between the two.

Michelle Ballantyne: It would be good to write to the PDSA, because it picks up some of the issues from charitable point of view. It will probably have a view on how the issue of a surge would be coped with.

Ellie Stirling: It would also make sense to write to the PDSA because it commissions the annual YouGov reports, so it has the data at its fingertips.

The Convener: The clerks can ensure that we get a wide range of views, and we can make sure that the information that you were displaying during your answers is circulated to members. Again, thank you for your attendance—that was a useful session.

10:50

Meeting suspended.

10:53

On resuming—

Prescription (Scottish Law Commission Report) (PE1672)

The Convener: PE1672, by Hugh Paterson, calls on the Scottish Parliament to urge the Scottish Government to consider remedial action in terms of the law relating to prescription and limitation. Members have a copy of the petition and a Scottish Parliament information centre briefing.

The background information on the petition outlines that the petition relates to prescription and principally to negative prescription, which extinguishes legal rights after the passage of time. The petition expresses concern about how the current law of negative prescription applies to some claims for damages where the purchase of a property has gone wrong and the purchaser has not received good legal title to all or part of it.

The relevant legislation on prescription is the Prescription and Limitation (Scotland) Act 1973. Aspects of the law of negative prescription under the act have recently been reviewed by the Scottish Law Commission and a report was published in July of this year recommending various reforms to the Scottish ministers. The Scottish Government is taking forward those recommendations through a commitment to a bill on prescription as set out in this year's programme for government.

Members may wish to note that the petitioner responded to the Scottish Law Commission's discussion paper, which informed the recommendations in the final report. Although the commission considered the issue that the petitioner raised, a decision was made not to recommend changing the law in that area.

Do members have any comments or suggestions for action?

Michelle Ballantyne: This is an interesting petition. The legal terminology is quite complicated, but there are good reasons why the provisions are in place. I have some sympathy with the petitioner, but I also have some sympathy with the position of the commission.

When I was going through the papers, it occurred to me that there could be a simple solution that does not require a change in the law. One of the problems with the changes that are occurring with land registration is that, when someone buys a property and it is registered, they do not receive notification of that registration—when someone has a mortgage, the title deed goes to the mortgage holder. The simple solution might be to ensure that, at the time of registration, the purchaser receives a letter specifying what has gone into the land register, which would let them know immediately whether the title has been adequately registered. That would enable the purchaser to challenge it at that time rather than find out that the registration was not complete only when they come to sell the property 25 or 30 years down the line.

We could ask the Government to consider that concept, which would not require any change to negative prescription but which would prevent the possible failure of registration.

The Convener: The Scottish Government has highlighted that, instead of someone undertaking a court claim for damages, a complaint could be made against a solicitor.

Michelle Ballantyne: Solicitors might not even be there at that point. I have recently been dealing with a few problems with transfer of properties, and I know that it is extremely difficult and costly to take an action against a solicitor, especially 25 years down the line. If someone has purchased a property and done all the right things, including paying a solicitor to do the job, it is unfair if, 25 years down the line, they have to fight something that happened all that time ago. We need a much simpler solution.

Brian Whittle: This is an interesting petition, as Michelle Ballantyne said. I agree with her that we should look for a solution that does not require a massive change to the law. We should write to the Scottish Government, but I would also quite like to know what the view of the Scottish Legal Complaints Commission is, because there is obviously an issue with taking court action 20 or 50 years down the line.

The Convener: I wonder whether the Scottish Government might be the sensible place to go first. The Scottish Law Commission's job is to consider the issues and give advice, and the Scottish Government has decided to heed the advice that it should not act in accordance with the suggestions of the petition. It might be useful to get a sense of the thinking behind that decision. Presumably, people have spent some time thinking about the issue and trying to get the balance right. It would be useful to get a sense from the Scottish Government of why it has taken that view.

Michelle Ballantyne: There are good reasons for negative prescription. We cannot have an open-ended situation in which people can always go back and revisit things; we need an end point, and 20 years is a pretty long end point, by anyone's standards. The issue is about ensuring that obvious things do not go missing, which is why, as I say, I have sympathy with both sides.

There is a need for negative prescription so that we have a close date.

The Convener: Do we agree to write to the Scottish Government so that we can get a sense of what its thinking was on the final conclusions and, in that letter, to highlight the suggestion that Michelle Ballantyne has made? The issue is not one that people come across every day so, at one level, it is quite technical. However, for the people who are caught up in it, it is far from technical. It is an interesting issue for us to ask the Scottish Government for its views on. Is that agreed?

Members *indicated agreement.*

Continued Petitions

Judiciary (Register of Interests) (PE1458)

10:59

The Convener: The fourth and final item today is consideration of five continued petitions. The first petition for consideration under this item is PE1458, from Peter Cherbi, on a register of interests for members of Scotland's judiciary

We last considered the petition in June, when we took evidence from Lord Carloway, the Lord President. We agreed to reflect on that evidence and we have a briefing note that summarises the issues that came up in that evidence session. We also have two submissions from the petitioner that convey his response to the evidence and provide information about additional developments in relation to the recusal of judges.

As members are aware, the petition has been under consideration for five years and we have a good understanding of the arguments for and against the introduction of a register of interests for judges. There has been some movement on that.

Do members have any comments on what we should do next?

Angus MacDonald: As you say, convener, the petition has been on-going for five years. It is worth noting that it was originally based on the consideration of the Register of Pecuniary Interests of Judges Bill in New Zealand, which was dropped after we started to take evidence on Peter Cherbi's petition.

We have taken extensive evidence on the petition over the past five years, including from the former Lord President, Lord Gill, the current Lord President, Lord Carloway, as well as the former Judicial Complaints Reviewers Moi Ali and Gillian Thompson. We appreciate the time that they have all given to the committee.

The petition has already secured a result, to the extent that there is more transparency because judicial recusals are now published, which did not happen previously. It is worth pointing out that that still does not happen in England, Wales and Northern Ireland. We should be proud that the petition has achieved that.

However, I note that the petitioner has suggested that we take evidence from Baroness Hale, President of the UK Supreme Court, as well as from the new Judicial Complaints Reviewer. It would stretch the bounds of the petition to take evidence from Baroness Hale, as the petition urges the Scottish Government to create a register of judicial interests in Scotland. I am not sure that

our remit extends to the UK Supreme Court. Mr Cherbi should perhaps take that aspect of the matter to the UK Parliament Petitions Committee, which may have the remit.

The Convener: I sense that we have agreement to the approach outlined by Angus MacDonald, which is not to take further evidence, but to bring together our conclusions and write to the Scottish Government, recognising that there has been some progress. Do we agree to draft a letter on our conclusions in private, although the final letter will be in the public domain?

Members *indicated agreement.*

Angus MacDonald: I agree, but we must move forward. We have been considering the petition for five years and Mr Cherbi's latest submission shows a degree of frustration, which I share.

The Convener: We understand that, but there should also be recognition of the fact that there has been some progress.

Do members agree to send the letter to the Lord President as well as the cabinet secretary?

Members *indicated agreement.*

Prescribed Drug Dependence and Withdrawal (PE1651)

The Convener: The next continued petition is PE1651, by Marion Brown, on prescribed drug dependence and withdrawal. We last considered the petition on 29 June 2017, when we agreed to write to the Scottish Government, the British Medical Association, the Westminster all-party parliamentary group for prescribed drug dependence, the Scottish Association for Mental Health and the Samaritans. Responses and a written submission from the petitioner have now been received and that information is included in our meeting papers.

The Scottish Government's written submission highlighted that the significant rise in the number of people being prescribed antidepressants can be attributed to a reduction in stigma attached to mental health, better diagnosis and treatment of depression and that it reflects the sustained rise in demand for mental health services across Scotland.

The petitioner re-emphasised her concerns that people are taking antidepressants over a longer period of time because they have not been supported to come off them safely. The petitioner also highlighted that although SIGN—Scottish intercollegiate guidelines network—guidelines recommend initial alternatives to antidepressants in all but the most severe cases of depression, those alternatives are often not available and that waiting times for non-pharmacological treatment

"make a mockery of the application of the SIGN guidance".

Members will recall from previous consideration of the petition that the British Medical Association published an analysis report focused on prescription drugs with an established dependence potential and withdrawal effects. One of the recommendations in the report is for the UK Government to work with the devolved nations to introduce a national 24-hour helpline for prescribed drug dependence. The Scottish Government has indicated that it does not have the resources available to fund such a helpline.

The committee might also wish to note that the Welsh Assembly is currently considering a similar petition and that a number of recent news articles have highlighted the issues that are raised in the petition. The petitioner has also brought to our attention the recent publication by the NHS Information Services Division of statistics for death by suicide in the period from 2009 to 2015. In relation to the 5,119 individuals who died from suicide in that period, the report notes:

"Over half (59%) had at least one mental health drug prescription dispensed within 12 months of death. Over four out of five ... of these individuals were prescribed an antidepressant drug, alone or in combination with other medication."

The report also notes:

"The most common form of recorded contact with health services was a mental health drug prescription".

It would perhaps be interesting to connect this to our earlier discussion. When I read the Scottish Government submission, I was concerned that it implied that more prescriptions suggests that there is more awareness, when it might be that people are just more likely to be prescribed inappropriately. We do not know what the truth is, but a correlation is not necessarily the same as a causal link. Do members have any comments?

Brian Whittle: Those kind of conclusions are anecdotal at best. There is good work being done, but there are also more things to be explored. With an earlier petition, we discussed bringing in the Minister for Mental Health, so perhaps we could ask her about this one at the same time.

Michelle Ballantyne: It would be good to have her here to cover both, but the petitions should not be taken together. We should take them separately, because one very much relates to children and young people—it is about how we work with them and the services for them. I do not know whether the minister could cope with dealing with one petition after the other, but it would be logical to do that.

The Convener: They should be scheduled one after the other, with plenty of time for the minister to address the questions. There is a connection, in that people, through whatever circumstances, end

up being prescribed prescription drugs but there is no means by which they can be supported to come off the drugs. I do not pretend to be able to properly interpret the statistics that the petitioner highlighted, so it would be useful to have that conversation with the minister.

Michelle Ballantyne: Obviously, the issues are strongly linked because, as we heard earlier, the majority of problems start in adolescence and some problems will be a continuation of those that were not solved in the first place. Perhaps we should allow the whole meeting for that.

The Convener: The minister would be able to bring along the relevant officials to ensure that that is addressed.

Rona Mackay: It is a hugely important issue, so it would be good to have the minister along to allow us to ask the relevant questions.

The Convener: The information that was provided by the petitioner gives us a lot of food for thought about why the petition matters so much to her. We need to tease out the issue about appropriate prescription because—this was said earlier but it is important to underline it—it is necessary for some people to be prescribed drugs and there ought not to be stigma about that, but there is a question about whether people are being supported to come back off the drugs or whether they are inappropriately prescribed in the first place.

Is the committee agreed?

Members *indicated agreement.*

The Convener: Thank you, and I thank the petitioner again for her interest.

Forestry (Regulation) (PE1654)

The Convener: The next petition is PE1654, by Ian Munn, on forestry regulation. At our previous consideration of the petition, on 22 June 2017, we agreed to write to the Scottish Government, Confor, Forestry Commission Scotland, the Forestry Contracting Association, the Scottish Timber Trade Association, the Woodland Trust, the Royal Scottish Forestry Society and relevant local authorities. Responses have been received from them, as well as a written submission from the petitioner, and that information is included in our meeting papers.

The committee asked the Scottish Government what progress has been made on the road by sea timber transport initiative and what the benefits and limitations are of such initiatives. The Scottish Government's response highlighted that it provides a subsidy for the timberlink service, which moves 80,000 to 100,000 tonnes of timber by sea from Argyll to Ayrshire, removing up to 1 million lorry miles per year from the road network. The Scottish Government's response recognised that, in the majority of cases where timber is shipped to market, at least some part of the rural road network will need to be used.

The committee also asked the Scottish Government whether it intends to introduce measures on consultation in the forestry sector in either primary or secondary legislation with the introduction of the Forestry and Land Management (Scotland) Bill. The Government's written submission confirmed that it has no plans to do so, reporting the strong culture of collaborative working that currently exists between local authorities and the forestry sector on a non-statutory basis, as well as the high level of consultation and guidance within the sector. That was also reflected in the majority of written submissions received. However, the petitioner re-emphasised the importance of including timber transport in the bill, as the industry has been shown to be either unable or unwilling to self-regulate.

I thank the local authorities and others who have sent substantial responses, which have helped the committee's thinking.

Do members have any comments?

Angus MacDonald: I understand the petitioner's frustration on the matter, but judging by the responses that we have received from stakeholders—albeit some of them have a vested interest in the industry—it would appear that, thanks to schemes such as the Scottish strategic timber transport scheme, significant progress is being made. Given that the majority of respondents do not support or recognise the need for the introduction of statutory measures, there is a strong argument to close the petition under rule 15.7 of standing orders.

Rona Mackay: I support Angus MacDonald's point. We have had a fantastic response and from it I can only conclude that there is a strong argument to close the petition. It is clear that, when it comes to forestry routes and so on, local authorities have the power to sort things out by imposing traffic restrictions. That has been working and so there is no need to introduce statutory measures.

Michelle Ballantyne: I have huge sympathy with the petitioner, because I live in a rural area that experiences a lot of timber transport movements. There is no doubt that he has real frustration, which is shared by much of the population. However, we cannot introduce legislation that would solve most of the problems. Agreements have to be made place by place and it cannot be one size fits all. We need individual solutions for each area and much of that is

achieved through relationships, negotiations and agreement. That is the only way to do it, so we must encourage that. The excellent response that the committee had is indicative of the work that is going on behind the scenes.

The petitioner mentions damage to private property and I would remind him that he has the same rights to claim against that as one would have for any damage to private property. That can be difficult sometimes, but that is what people need to do. I understand that much of the damage that he refers to is verge ripping, which is difficult to address and is a result of the nature of our narrow roads. That will be an on-going problem that we will keep working on—it is the reality of the world that we live in.

I support the view that there is nowhere to go with the petition at the moment and that we should close it.

Brian Whittle: I agree, given that the Scottish Government has indicated that it has no plans to do anything in that respect. There is nowhere left to go.

The Convener: I was struck by two things. First, the petitioner was sceptical about whether the responses had been co-ordinated. However, whether or not they have been co-ordinated, there was a strong feeling that the petition should not be taken forward, particularly the idea of recognising responsibility in the form of a levy. Secondly, however, closing the petition would not close the opportunity for individual members of the Parliament to lodge amendments to the Forestry and Land Management (Scotland) Bill to test the issues further and see whether a legislative route is available. That is another possible action for the petition, although not one that the committee would be able to undertake—it would be up to individual members who have been presented with the case to consider whether they want to do that.

I sense that there is agreement that we should close the petition under rule 15.7 of standing orders, on the basis that the majority of written responses received do not support the action called for in the petition, but we thank the petitioner again for highlighting the issues and getting a response that seeks to reassure around the responsibility for the industry to work together with local authorities and others. Is that agreed?

Members *indicated agreement.*

11:15

Angus MacDonald: When we write to the petitioner advising him of our decision, will there be a section in the letter giving him the advice that one option is to attempt to secure amendments to the Forestry and Land Management (Scotland) Bill?

The Convener: Yes, we can do that.

Michelle Ballantyne: The bill is at stage 2.

The Convener: Somebody might take up the issue at stage 2, but it could certainly be done at stage 3.

The Convener: I believe that the bill was at committee yesterday for stage 2, so time is really tight.

Angus MacDonald: I did not realise that.

The Convener: It would be slightly more difficult to secure an amendment as suggested at stage 3, but that is an option. It should be remembered that a forestry and land management strategy will come out of the bill, so the petitioner might want to influence the shape of that strategy.

Elected Members (Threats or Assaults) (PE1656)

The Convener: The next petition is PE1656, by Rob McDowall, on threats or assaults on sitting members of Parliament, their staff and families. We last considered the petition on 22 June 2017 and agreed to write to the Scottish Government, the Crown Office and Procurator Fiscal Service, the Faculty of Advocates, the Law Society of Scotland, Police Scotland and the Scottish Sentencing Council. Responses have now been received and are included in our meeting papers.

The majority of responses received highlighted that the existing common law and statutory legislation provides for the prosecution of assaults and threatening behaviour committed against anyone, including parliamentarians, their staff and families. Police Scotland's written submission highlighted that the statutory aggravations being called for by the petitioner could complement the existing protective security measures to mitigate risk to parliamentarians. However, the Scottish Government is of the view that there would be significant challenges in setting out in statute all the aggravating and mitigating factors for a court to consider in sentencing an offender.

Do members have any comments?

Michelle Ballantyne: I have not changed my view. I think that the law sufficiently covers already what the petition seeks and that it is a question of applying it and not creating new laws.

Rona Mackay: Agreed. The existing law covers what the petition outlines and the responses that we have received make that clear. We should therefore close the petition, because I do not think that there is anywhere else for it to go.

Brian Whittle: I think that the same conclusions have been reached for other public servants, such as those in the police, the fire service and the ambulance service, which is that the existing law adequately covers them with regard to what the petition outlines.

The Convener: I remember that, when the Emergency Workers (Scotland) Bill went through, it was felt that there was a need to signal the value that we place on people running towards danger. We looked at examples such as firefighters being assaulted as they ran towards a fire or somebody going to a road traffic accident being assaulted, but the point was made that everybody who works in the emergency services can be at risk.

I suppose, on balance, in terms of the risk to elected representatives, I would be comforted by the existing law. We might think more about issues such as making sure that our staff are safe. It is legitimate to assess security risks to our staff and any risks that we take on. When I was first elected, I would do surgeries on my own in a place where nobody was keeping an eye on me, but that just would not happen now. A lot of progress has been made on protecting people against incidents, which is maybe as important as ensuring that, if an incident takes place, the court takes it seriously.

Michelle Ballantyne: It is important that we do not end up with a siege mentality, because the majority of people are decent. We have quite robust laws around how people behave; the issue is how we implement them.

The Convener: My sense is that the petitioner was motivated by recognising that parliamentary staff in particular can be vulnerable and be seen as a target. Certainly, on all too many occasions, front-line staff answering the phone can be subject to abuse. That is probably true for the public sector generally, but staff ought not to be treated that way.

We therefore recognise the motivation for the petition, but I think that we agree that we should close it, under rule 15.7 of standing orders, on the basis that existing legislation and common law are considered to provide sufficient protections for elected members, their staff and family members. Is that agreed?

Members *indicated agreement.*

Pluserix Vaccine (PE1658)

The Convener: The final petition on our agenda is PE1658, by Wendy Stephen, on compensation for those who suffered a neurological disability following administration of the Pluserix vaccine between 1988 and 1992. The petitioner has requested that we defer consideration of the petition until a future meeting—I understand that she would like to attend a meeting and observe our discussion of her petition—and we might want to get further comments on the petition before we consider it. I have agreed that we should consider her request that the petition be deferred. Are members content to defer consideration of the petition until our meeting on 21 December?

Members *indicated agreement.*

The Convener: With that, I thank members for their attendance and close the meeting.

Meeting closed at 11:21.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

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

The Scottish Parliament
Pàrlamaid na h-Alba