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SPICe Briefing
Mental Health in Scotland

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This briefing gives an overview of mental health in Scotland. It first discusses mental health within a global and European context, before focussing in more detail on the picture in Scotland. It reviews what is currently known regarding the prevalence of mental health conditions, the organisation of mental health services, the current legislative and policy framework that underpins mental health service provision, how these services are regulated and monitored, and finally, the costs and funding of mental health services.

The Scottish Parliament
Pàrlamaid na h-Alba

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EXECUTIVE SUMMARY

Mental health is a major public health challenge, and mental disorders are the primary contributor to the global burden of disease. In Europe, it is estimated that 83 million people experience a mental health condition every year, and, taken together, mental ill health is the leading cause of chronic illness, accounting for 40% of the European disability burden. Mental disorders are not evenly distributed across society, and are more common in socioeconomically deprived areas and regions where there is civil unrest. In addition, the reported prevalence of mental disorders is higher among women than men, with depression being twice as frequent in females.

In Scotland, one in four people will experience a diagnosable mental health problem each year. Anxiety and depression are the most common, but others include schizophrenia, personality disorders, eating disorders and dementia.

The rate of first-time admissions and readmissions to acute mental health hospitals in Scotland have both decreased over the last decade, as has the rate of GP consultations for anxiety and depression. However the number of consultations for dementia has increased over the same period. The rate of suicide has also decreased in the last decade, and latest figures suggest a drop of around 18% since 2000/02. Despite the recent decline, the rate of suicide in Scotland remains higher than that seen in much of Western Europe, and has been above the Western European average since 1993. Since the 1990's, approximately three-quarters of suicides have been men. Declines have been seen in depression and anxiety. However, this may be a result of a general improvement in the coding precision of these conditions by clinicians (ISD online), and is not necessarily a reflection of a decrease in the prevalence of these conditions in the general population.

Mental health services are delivered primarily through the NHS and local authorities in partnership with the voluntary and independent sectors, and the majority of NHS services for those with mental health problems are carried out in the community and are delivered through primary care and community mental health services. Generally, the workforce involved with mental health service provision has increased over the last decade or so, but this is not true for all types of staff across all sectors. The prescription of medicines for the treatment of depression, psychoses, Attention Deficit Hyperkinetic Disorder (ADHD) and dementia have all increased since 2003/04, while medicines for the treatment of anxiety have decreased.

The current legislative and policy framework for mental health service provision is multifaceted, and involves a wide range of different Acts, national policies and initiative. The current key policy for mental health in Scotland is the Mental Health Strategy for Scotland 2012–2015. This documents a number of key areas of focus and makes 36 commitments to further Scotland's mental health.

The Scottish Association for Mental Health estimated the total expenditure, in terms of both social and economic costs, of mental ill health in Scotland to be in the region of £10.7 billion for 2009/10. Estimating the total amount that is spent on mental health service provision is difficult. Generally, expenditure on acute services and staff has decreased while expenditure on community services and staff has increased over the last few years.

INTRODUCTION

Mental health is a major public health challenge on a global scale. Mental disorders affect people from all walks of society regardless of gender, race or social standing, and can severely impact the quality of life of both sufferers and their families. This briefing offers an overview of the mental health of the people of Scotland and the services that exist to aid them. It first discusses the current state of mental health in a wider global and European context before focusing on the prevalence of mental health problems and the provision of mental health services in Scotland.

A GLOBAL PERSPECTIVE

Mental disorders[1] are the primary contributor to the global burden of disease (Vos et al., 2012). In Europe, recent estimates suggest that approximately one third of the population, 83 million people, experience a mental disorder of some description every year, most commonly depression and anxiety (World Health Organisation (WHO), 2013a). Taken together, mental disorders are the leading cause of chronic illness, accounting for 40% of the total European disability burden, measured as the number of years lived with disability (YLDs[2]). Unipolar depression alone is the single leading cause of chronic illness in Europe, accounting for 13.7% of the total YLDs. Alzheimer's and other dementias are seventh (3.8%) while schizophrenia and bipolar disorder are in eleventh and twelfth position, each accounting for 2.3% (WHO, 2013a; 2013b). The incidence of dementia is likely to increase substantially as Europe's population ages (WHO, 2013b).

Mental disorders are not evenly distributed across either society or geography. Socioeconomic factors such as poverty, unemployment, poor working conditions and a lack of education can all affect an individual's mental wellbeing, and can increase the risk of developing a mental disorder. Thus, mental health is often worse among more deprived communities, where an elevated exposure to other lifestyle factors such as alcohol and drug use, poor diet, poor physical health and a lack of access to appropriate services further increase the prevalence of mental disorders (WHO 2013a).

Family circumstance and early years also play an important role in mental health – for example, the interaction between a mother and infant brought about through breastfeeding can have positive mental health implications for the child in later life (Oddy et al., 2010). Another important contextual factor on a global scale is war and civil unrest, which can negatively affect mental health outcomes for both war veterans and civilians (Murthy and Lakshminarayana, 2006).

Mental disorders also affect men and women differently. Generally, mental disorders are more common in women than in men, with depression being twice as prevalent among females (WHO, 2013b). But there are notable exceptions – for example, substance use disorders are about four times as common in men and about 80% of people who commit suicide are male (WHO online, 2014).

There are also substantial differences in the level of support that different countries provide for people with mental disorders. For example, Scotland and Finland allocate about 43% of social welfare benefits or disability pensions to people with mental disorders, but in the Republic of Moldova, one Europe's poorest countries, the proportion is 25% (WHO, 2013a).

[1] See Terminology overleaf for the definition of terms used in this briefing.
[2] Years Lived with Disability (YLDs) is defined as the number of years an individual lives with a chronic illness or
[2] Years Lived with Disability (YLDs) is defined as the number of years an individual lives with a chronic illness or disability. This can be summed across a population to give an indication of its burden of disease.

TERMINOLOGY

The various terms associated with mental health are often used interchangeably and can be confusing. This document uses the following definitions:

- **Mental illness** – any diagnosable illness which "significantly interferes with an individual's cognitive, emotional or social abilities" (NHS Scotland). Common examples include depression, anxiety and schizophrenia.
- **Mental disorder** – a broader classification that includes mental illnesses but also personality disorders and learning disabilities.
- **Mental health problem** – refers to any condition, temporary or otherwise, which may affect a person's mental wellbeing.
- **Mental wellbeing** – refers to *positive* mental health, reflecting the understanding that mental health should not only be a measure of the absence of mental health problems, but should also take into account the extent to which an individual or population feels happy. The WHO (2013b) defines positive mental health as "a state of mental wellbeing in which an individual is able to cope with the normal stresses of life, work productively, contribute to their community and generally realise their potential".

Similarly, rates of employment of people with mental disorders range from 18% to 30% among European countries (WHO, 2013a).

Worldwide, on average, spending on mental health is less than US $2 per person per year, and about half the world's population live in a region where there may be less than one psychiatrist for every 200,000 people (WHO, 2011). However, both funding and resources for mental health are inequitably distributed among world regions, and Europe is frequently the best provisioned region in terms of governance, funding, delivery of care, and the provision of resources both in terms of human resources and medicines (WHO, 2011).

MENTAL HEALTH IN SCOTLAND

Generally, the global and European trends in mental health outlined above are also representative of Scotland. However, the wealth of available health information for Scotland identifies a number of important trends regarding the mental health of Scotland's population. This section provides an overview of the current state of Scotland's mental health and, when possible, looks at how some mental health has changed over time.

COMMON MENTAL HEALTH PROBLEMS

The term mental health problems covers a wide range of different conditions and diseases, many of which have can have very different symptoms, causes and consequences. **Table 1** provides summary information for a selection of common mental health problems that affect the people of Scotland today. This list is by no means exhaustive and additional general information (including links to resources specific to certain conditions) can be found on the relevant webpages provided by the Scottish Association for Mental Health (SAMH), the Royal College of Psychiatrists and the Counselling Directory.

Table 1. General information for common mental health problems.

Disorder	Key symptoms	Further details
Depression	Feelings of sadness and worthlessness, a lack of energy and concentration, a loss of pleasure in activities that were previously enjoyed. Overall estimated prevalence of about 10% in UK adults.	There are a wide range of recognised depressive disorders which differ in their manifestation, severity and cause. **Bipolar disorder** (manic depression) – repeated episodes of extreme highs followed by intense lows. Estimated lifetime prevalence of 1–2%. **Postnatal depression** – manifests as a women's indifference to her newborn baby and an inability to provide appropriate care. About 10–15% mothers will experience some form of postnatal depression. **Seasonal affective disorder** (SAD) – episodes of depression triggered by a reduction in daylight. Estimated to affect about 7% UK population during winter months.
Anxiety	An acute fear of something happening. Overall estimated prevalence of about 9.2% UK population.	**Panic disorders** – panic attacks, hyperventilation and heart palpitations stemming from extreme anxiety. UK prevalence estimated at about 0.7%. **Phobias** – an irrational fear of an object or a situation. Estimated prevalence of about 2% UK adults, with women twice as likely to suffer as men. **Obsessive Compulsive Disorder** (OCD) – repetitive behaviour stemming from the fear that something bad will happen if that behaviour is not carried out. Estimated prevalence of around 1.2% UK population.
Personality disorders	Conditions in which a person significantly differs from an 'average' person in how they might think, feel, perceive, act or relate to others.	There are a wide range of personality disorders, including **paranoid personality disorder** (a general distrust of others and continued suspicion regarding others intentions), **borderline personality disorder** (mood instability and poor self-image) and **schizoid personality disorder** (extreme introversion) (Counselling Directory online, 2014).
Schizophrenia	A range of symptoms that lead to disturbances in an individual's thoughts, feelings and perceptions, often leading to an inability to distinguish between what is real and what is not.	**Paranoid schizophrenia** – auditory hallucinations (hearing voices), delusions about conspiracy or persecution. **Disorganised schizophrenia** – disruption of thought processes such that everyday activities are impaired. **Catatonic schizophrenia** – perturbations in movement, manifesting in either decreased or increased levels of movement and repetitive or imitative behaviour.
Eating disorders	Usually characterised by either eating too little or too	About 1.6 million people (86% female) in the UK suffering from eating disorders. **Anorexia**

	much, or the development of extreme negative associations with food, often leading to anxiety and depression.	**nervosa** – obsession with weight loss that may lead to depression and health problems associated with malnutrition. Estimated incidence of about 19 per 100,000 UK women. **Bulimia nervosa** – fear of gaining weight leading to a binge-purge cycle through obsessive exercising, taking laxatives or vomiting. Prevalence estimated at about 0.5–1% for young women.
Dementia	Age-related condition that leads to memory loss, impairment with communication and day-to-day living, and changes in mood or personality.	Affects more than 800,000 people in UK (two-thirds women). **Alzheimer's disease** is the most common form, caused by the build-up of damaged tissues in the brain called plaques that leads to cell death and loss of function of areas of the brain.
Others	—	A number of other mental disorders also exist, including sleep disorders, attention deficit hyperactivity disorder (ADHD), gender identity disorder, post-traumatic stress disorder (PTSD) and other mood and stress related disorders.

Sources: Counselling Directory online; Scottish Association for Mental Health online; Royal College of Psychiatrists online; Alzheimer's Society online.

PREVALENCE OF MENTAL HEALTH PROBLEMS

Overall, for all mental health problems combined, it is estimated that approximately one in four people in the UK will experience a diagnosable mental health condition in any given year (Mental Health Foundation online). However, the exact prevalence of mental health problems are difficult to estimate, primarily due to the numbers of people who do not seek treatment and difficulties in accurately recording them in a non-acute setting. Nonetheless, there are a number of available statistics based on hospital admissions, GP consultations and household surveys that provide insight into the mental health of the Scottish population. This section reviews the available information on the prevalence of a range of mental health conditions based on data from both acute and primary care settings.

Note regarding data

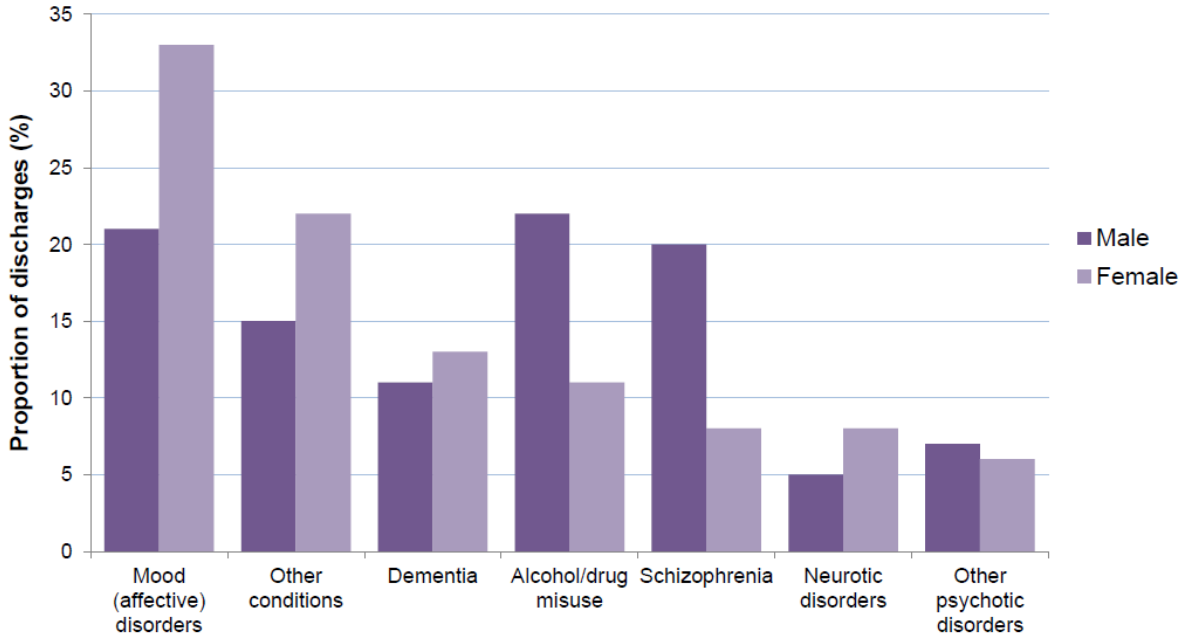
Throughout this briefing, trends over time have been provided for the maximum time period available with the data provided in the corresponding source document. Thus, not all time trends have the same start year. When data has been extracted from multiple (often archived) sources, information for the year 2004/05 was preferentially chosen as a comparative starting point. This was to allow for some overlap between this briefing and a previous SPICe Briefing (Payne, 2007), which generally covered the period up to 2005/06.

Hospital activity

During the year ending 31 March 2012, there were a total of 19,265 inpatient admissions to mental health (psychiatric) hospitals across Scotland (Information Services Division (ISD), 2012a). Just over half of these (55%) were readmissions (i.e. patients with a history of admission). **Figure 1** shows the proportion of discharges from mental health specialties by diagnosis and by gender for the year ending March 2012 (not including NHS Ayrshire and Arran[3]). In men, alcohol and drug related problems accounted for the greatest proportion of discharges (22%), followed by schizophrenia (20%). In women, mood (affective) disorders accounted for one third of discharges while dementia-related diagnoses accounted for 13%. Women account for the greater proportion of individuals for four of the seven diagnoses given. In terms of the length of stay, about 65% of all mental health discharges were in hospital for four weeks or less (ISD, 2012a).

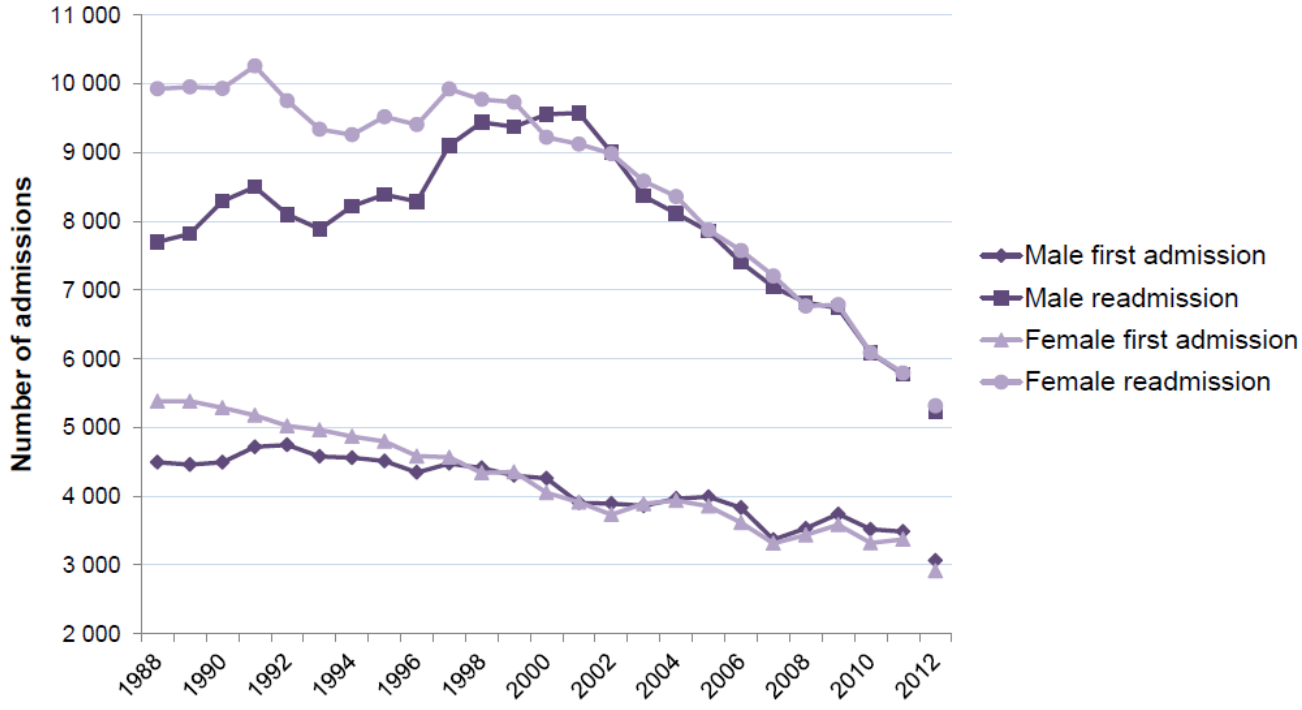
Time series data for the number of admissions and readmissions for both men and women since 1988 to 2012 is shown in Figure 2. This shows that both admissions and readmissions have declined overall since 1988. To some extent this may be due to the Scottish Government policy that advocates the provision of care in non-acute settings (Scottish Government online). In particular, the number of readmissions has declined substantially since around 2000, with an approximate 40% decrease seen for both men and women (ISD, 2012a).

Figure 1. Proportion of discharges from mental illness specialties in Scottish hospitals by diagnosis for the year ending 31st March 2012. NB: Does not include data for NHS Ayrshire and Arran.



[3] Due to the implementation of a new patient management system, data for NHS Ayrshire and Arran are not available for 2012/13 and are therefore not included. See ISD 2012a for further information.

Figure 2. Time series data for admissions and readmissions for men and women 1988 to 2012 in Scotland. NB: 2012 time point does not include data for NHS Ayrshire and Arran.



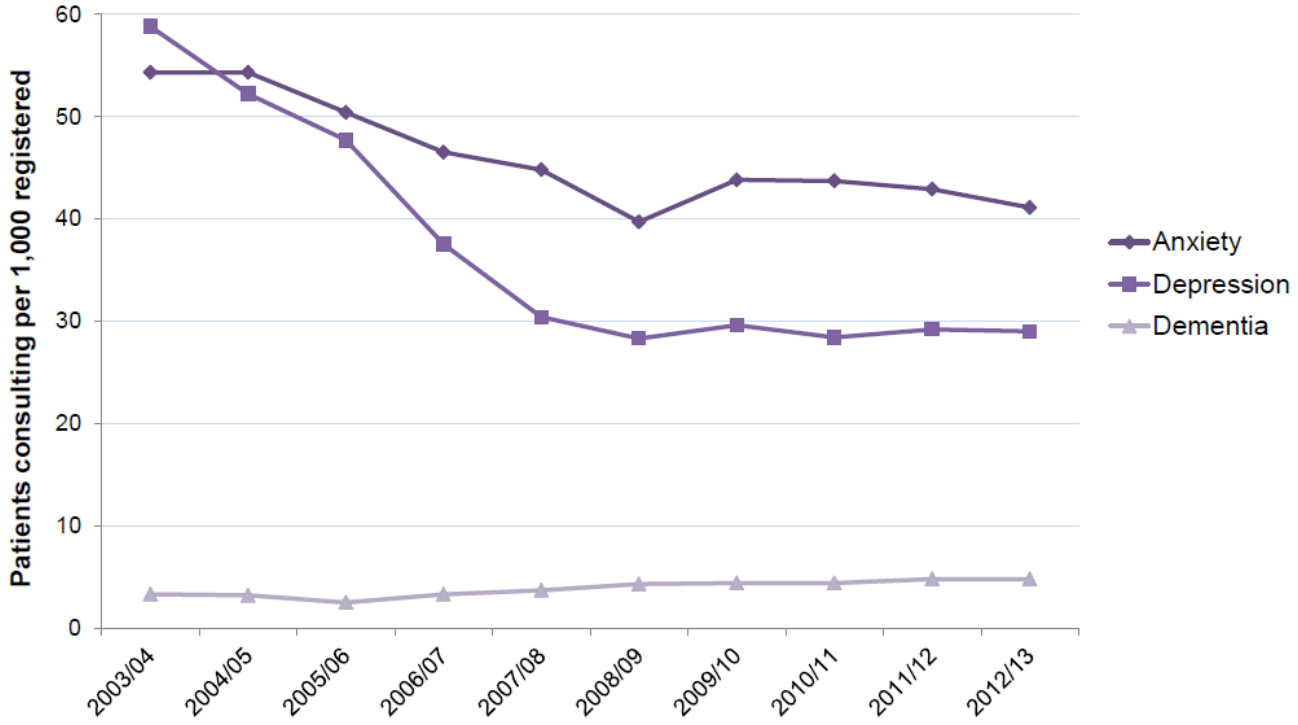
Practice Team Information

Information about GP consultations is available via the Practice Team Information (PTI) programme[4]. This programme uses data from a subsample (about 6%) of GP practices across Scotland to inform on the number of consultations between patients and either a GP or a practice-employed nurse. **Figure 3** shows data for the number of patients per 1,000 registered consulting for anxiety, depression and dementia over the period 2003/04 to 20012/13 (ISD, 2013b). Overall, the rate of consultation for anxiety has decreased from 54.3 to 41.1 per 1,000 registered patients (−24.3% change), and the rate of consultation for depression has also decreased from 58.8 to 29 per 1,000 patients (−50.7% change). However, the rate for dementia has increased by 45.5%, from 3.3 to 4.8 patients per 1,000.

The reason for the declines seen in depression and anxiety is most probably a result of a general improvement in the coding precision of these conditions by clinicians (ISD online), and is not necessarily a reflection of a decrease in the prevalence of these conditions in the general population. The increase seen in consultations for dementia is likely due to both the increasing average age of the Scottish population as well as the recent introduction of dementia targets (ISD online). In addition, the most recent PTI data all show a female bias across the four categories for which there is available data (anxiety, depression and dementia as above as well as eating disorders) (ISD, 2013b).

[4] 2012/13 is the final year for which PTI information will be collected; the programme is being superseded by a new national GP information system as of 2014/15 (see http://www.spire.scot.nhs.uk/).

Figure 3. Number of patients consulting a GP or practice nurse at least once in the year per 1,000 patients registered, by condition, for the period 2003/04 to 2012/13.



Mental health and wellbeing

The Mental Health Indicators Programme is an initiative run by NHS Health Scotland to establish a core set of mental health indicators for the purpose of comprehensive monitoring of Scotland's mental health and wellbeing. Two sets have been constructed, one for adults (containing 54 indicators) and another for children and young people (C&YP) (108 indicators) (Parkinson, 2007; Parkinson, 2012). These indicators cover a wide range of factors both directly and indirectly related to mental health (i.e. a range of contextual factors that play an indirect role in mental health). Importantly, the indicator sets also monitor mental wellbeing, or positive mental health, with the understanding that good mental health is not potentiated solely by the absence of mental ill health but also by the presence of positive mental factors such as happiness and satisfaction. Positive mental health is measured using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). The latest analysis of the adult indicator set was published in 2012 by NHS Health Scotland and the Scottish Public Health Observatory (ScotPHO) (ScotPHO, 2012), and for the C&YP set in 2013 (ScotPHO, 2013).

The Scottish Public Health Observatory in its report on mental health summarises the overall picture for adults over the last decade as “broadly stable, with a promising level of positive change and only a small, but important, number of negative trends” (ScotPHO, 2012, p 6). Suicide rates have improved while life satisfaction and common mental health problems have remained stable. However, alcohol dependency and deaths due to psychoactive substance use have worsened.

The report on children and young people (defined here as aged 17 or under) concludes that “overall, the mental health of C&YP has improved or stayed broadly constant over the past decade or so. Improvement was seen across most domains, particularly around substance use (e.g. drug use and smoking – both in school pupils and during pregnancy), poverty and homelessness which have all shown steady improvement over the reportable time periods” (ScotPHO, 2013, p 97).

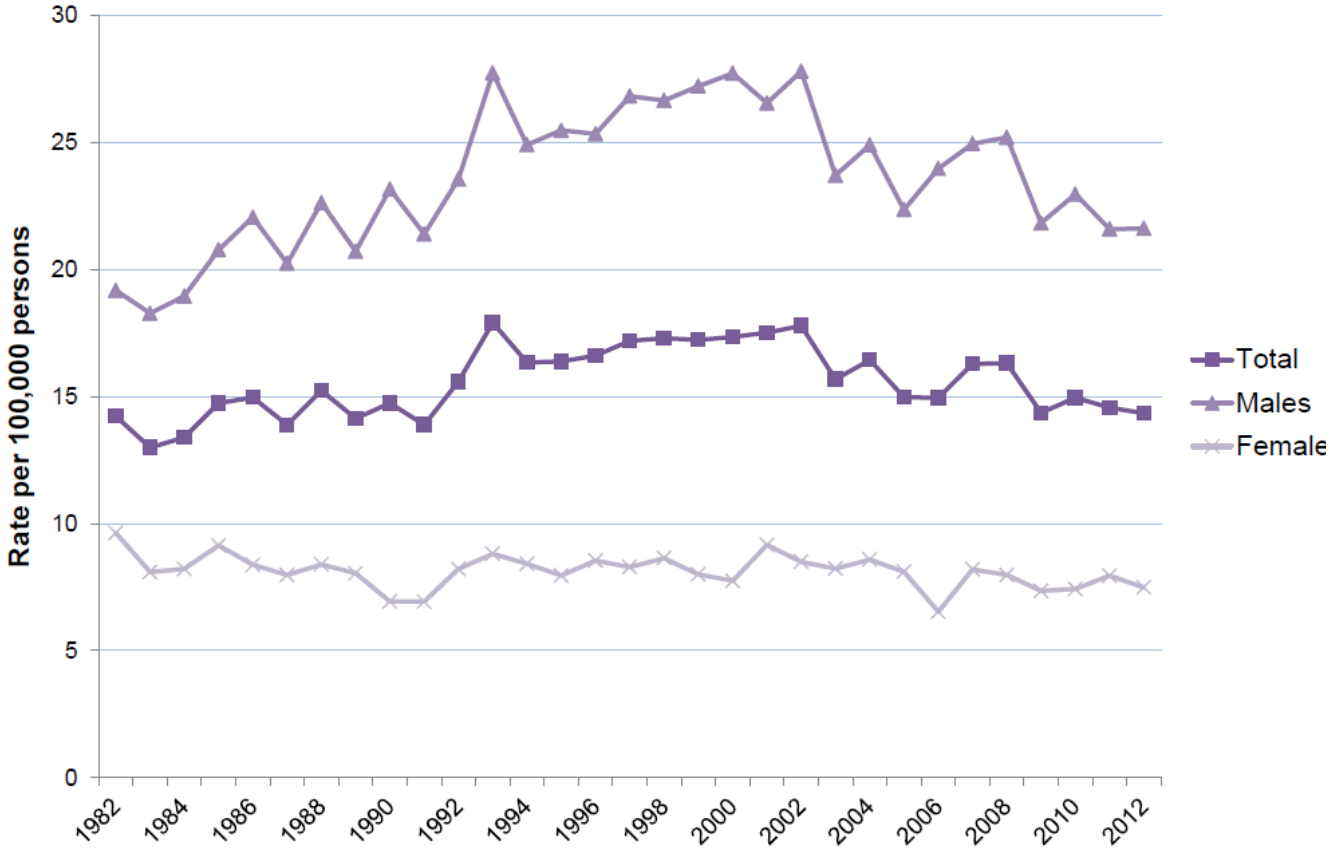
Suicide

There were 830[5] suicides[6] registered in Scotland in 2012, 608 of which were men (73%) (ISD, 2012b; ISD, 2013c). These values translate into a rate per 100,000 of the population of 23.6 and 8.1 for males and females respectively, and an overall (males and females) rate of 15.6 per 100,000. This suggests that the rate of suicide among men is approximately three times that of women. In addition, suicide is known to be the leading cause of death of under 35's in Scotland.

The rate of suicide for males and females over the time period 1982 to 2012 is shown in **Figure 4**. This shows that the rate for males increased from 1982 to 1993, where it remained reasonably high until its peak in 2002 (27.1 per 100,000). From then the rate has been steadily declining, although is still higher than that seen in the early 1990's. The rate for females has been more stable, with a high in 1982 of 9.7 per 100,000. Since 1990 between 72% and 77% of all suicides have been male. The national HEAT target[7] is for a 20% reduction in the suicide rate between 2000/02 and 2011/13; currently, the three-year rolling average estimates the reduction up to 2010/12 to be about 18%.

There is considerable variation in the suicide rate across NHS Board areas, but this is mainly due to the fluctuations seen year by year. Between 1983/87 and 2008/12, there was no statistically significant difference between NHS Boards or local authorities (ISD, 2013c). In 2008/12, Perth and Kinross showed a significantly lower suicide rate than elsewhere (ISD,

Figure 4. Rate of suicide, per 100,000 population, for Scotland 1982 to 2012. NB: 2011 and 2012 values are estimated using the old coding system to ensure continuity with previous years.



[5] Based on a new coding introduced by the National Records of Scotland (NRS) in 2010; under the old coding system, the value is 762 (68 fewer). The Scottish Government plans to continue to use the old coding rules for comparative purposes in showing longer term trends (Scottish Government, 2013d, p 4).
[6] Defined as deaths from intentional self-harm and events of undetermined intent combined.
[7] HEAT targets are a core set of Ministerial objectives, targets and measures for the NHS. HEAT targets are set for a three year period and progress towards them is measured through the Local Delivery Plan process.

Comparisons with other countries

Despite the recent decline, the rate of suicide in Scotland remains higher than that of most of Western Europe. For both males and females, the rate has been above the Western European average since 1993 (Glasgow Centre for Population Health (GCPH), 2012).

The Scottish suicide rate is also higher than that seen in England and Wales: in 2010, the rate for males was about 73% higher while for females it was almost double (GCPH, 2012).The rate for men is comparable to that seen in Sweden and Northern Ireland, higher than many Southern European countries but lower than Finland, Hungary and Poland. For females, the rate is comparable to that seen in countries such as Norway, Denmark, France and Ireland, slightly lower than Sweden, Finland and Hungary but higher than that seen in Poland and Southern European countries (GCPH, 2012; ISD, 2012b).

Contact with health services

Over the two year period 2009/10, there were 890, 485 and 135 cases of suicide where the individual had been discharged from a general acute hospital at least once within the previous five years, 12 months and 30 days respectively (ISD, 2012b). The most frequent reason for admission for these patients is self-inflicted injury in all cases (24.5%, 26.8% and 40% for the three time periods given above, respectively).

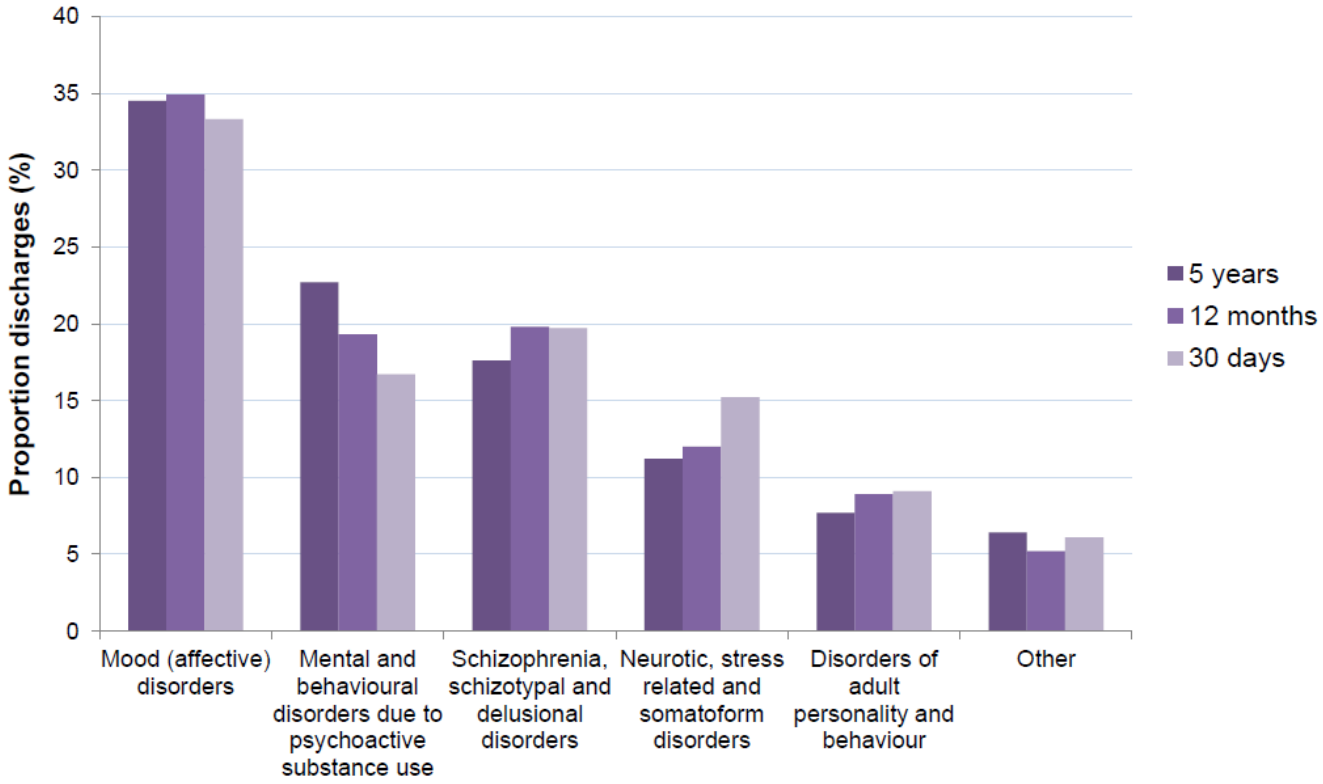
Similarly, the proportion of individuals who had been psychiatric inpatients within five years, 12 months and 30 days prior to death was 20.9%, 12.8% and 4.4% respectively (ISD, 2012). Thus the remaining 79.1% did not have any record of discharge from a psychiatric hospital at least within five years prior to death. The primary reason for admission to a psychiatric hospital is shown in **Figure 5**. This shows that the primary diagnosis for the three time periods is mood (affective) disorders. Psychoactive substance misuse appears to be the next most common diagnosis over the five year period but schizophrenia is the more frequent over 12 months and 30 days prior to death. Over the five year period, the vast majority (90.7%) of these admissions were informal (i.e. voluntary) (ISD, 2012b).

Of the 757 individuals included in ScotSID in 2010, 56% (424 individuals) had been dispensed a mental health prescription within the 12 months prior to death (ISD, 2012b). Of these 424 individuals, 80% had been prescribed antidepressants, 64% had been prescribed treatments for anxiety and 30% had a prescription for antipsychotics[8]. The ISD report states that the high level of anxiety prescriptions "may represent increased levels of anxiety and/or agitation in individuals at greater risk of self-harm or suicide and is consistent with studies reporting high rates of benzodiazepine[9] use associated with suicide or self-harm" (ISD, 2012b, p 25).

[8] The total is greater than 100% since a given individual may have more than one prescription.

[9] Benzodiazepines are drugs to treat anxiety, agitation and restlessness, particularly for people in hospital, epileptic seizures/fits, mania, alcohol withdrawal and sleeping problems (Royal College of Psychiatrists online)

Figure 5. Proportion of patients discharged from a mental health specialty within the last five years, 12 months and 30 days before death, by main diagnosis, 2009/10.



Inequalities in mental health

Scotland's mental health is not equally distributed across society. Those living in deprived areas have a generally lower level of mental wellbeing, and have more GP consultations for conditions such as depression and anxiety. For example, data for 2010/11 shows that the number of people from the most deprived areas presenting with anxiety was twice that compared to the least deprived areas[10] (62 and 28 per 1,000 patients respectively), and for the period 2007/11, the suicide rate in the most deprived areas was 26.4 persons per 100,000 population compared to 7.1 per 100,000 in the least deprived areas (Audit Scotland, 2012; ScotPHO, 2012).

Extensive gender differences also exist in mental health. For example, in 2010/11 the number of women consulting a GP for depression or anxiety was more than twice that of men (Audit Scotland, 2012). Conversely, the suicide rate is three times higher for men than women, and this difference is further exacerbated in deprived areas. Interestingly, despite gender differences being evident in a number of indicators concerned with mental health problems, there were no differences found for indicators of mental wellbeing (i.e., positive mental health) (ScotPHO, 2012). Although further work is needed in this area, this might suggest that factors that influence positive mental health (such as optimism, self-esteem, happiness etc.) are more evenly distributed between men and women.

Inequalities are also evident in other areas that are likely to impact on mental health, such as alcohol and drug misuse. Alcohol misuse in men is approximately twice that in women, and alcohol-related deaths and hospital discharges are about seven times higher in the most deprived areas compared to the least deprived (221 versus 1,615 per 100,000[11] discharges for

[10] Comparisons refer to people living in the one-fifth most deprived and one-fifth least deprived areas, as calculated by the Scottish Index of Multiple Deprivation (SIMD).
[11] Given as the European Age Standardised Rate (EASR). This takes into account the age-structure of the population in question and allows for comparisons to be made across geographical areas and time periods.

2011/12) (ISD, 2013a). A similar pattern is evident for drug misuse, which is three times higher in men and 16 times higher in deprived areas (Audit Scotland, 2012).

ORGANISATION OF MENTAL HEALTH SERVICES

Mental health services are delivered primarily through the NHS and local authorities, in partnership with the voluntary and independent sectors (e.g. charities and other not-for-profit organisations). NHS Boards are responsible for the treatment of those with mental health problems either in community or acute settings, whilst local authorities are responsible for securing social care and support services (e.g. housing, day care services etc.) in the community, as well as providing a range of mainstream services to support recovery. The principle behind delivery is that care should be organised through a partnership approach to ensure that the needs of the whole person are met, and not just their medical requirements. In addition to these services, there is a regulatory and monitoring framework designed to safeguard the rights of those with mental health problems and ensure they receive good quality services.

The majority of NHS services for those with mental health problems are carried out in the community and are delivered through primary care (e.g. GPs) and community mental health services (e.g. community psychiatric nurses psychiatrists, occupational therapists, psychologists etc.). However, NHS Boards also provide in-patient units in general hospitals and psychiatric hospitals for those patients requiring more intensive care.

This section gives an overview of the current structure of mental health services in Scotland at all levels of care from the third sector through to acute services. Information on primary and acute services workforce and drug usage are provided to give an overview of the level of service provision in these care settings.

Third sector organisations

The third sector, which includes charities, voluntary and other not-for-profit organisations, plays an important role in the provision of services, support and information for people with mental health conditions. The key third sector organisations for mental health in Scotland are given below, but it should be noted that this is by no means an exhaustive overview of the range of third sector services that are available.

- Scottish Association for Mental Health (SAMH) – SAMH is Scotland's leading mental health charity, and provides help, information and support for people with mental ill health, their families and carers, campaigns on behalf of those with mental health needs and raises money to fund mental health services. Together with the MHF below, SAMH delivers the 'See me' anti-stigma and discrimination national programme (discussed in Current Initiatives below).
- Mental Health Foundation (MHF) – the MHF aims to "reduce the suffering caused by mental ill health and to help everyone lead mentally healthier lives" (MHF online). It carries out research, develops practical solutions to improve mental health services, campaigns to reduce stigma and discrimination, promotes better mental health and serves as a source of information for mental health conditions.

In addition, there are a number of organisations that provide for people with specific mental health conditions, such as Support in Mind (support for people with serious mental health conditions such as schizophrenia), Depression Alliance (a UK wide charity for people with depression), National Self-Harm Network (a UK wide charity in support of people affected by self-harm), Bipolar Fellowship Scotland (supports people affected by bipolar disorder in Scotland) and Beat (UK charity in support of people affected by eating disorders).

Primary and Community mental health services

Mental Health Officers

Mental health officers[12] (MHOs) have a number of statutory duties under the 2003 Act, and are responsible for making decisions about when a person may be detained under the 2003 Act if they are deemed to be a risk to either themselves or others.

The number of MHOs from 2008 to 2012 (**Table 2**) has increased overall in both headcount and WTE of about 2.1%, from 622.2 WTE in 2008 to 635.4 WTE in 2012 (Scottish Social Services Council, 2013). This corresponds to a rate of approximately 0.92 MHOs per 1,000 of the Scottish population. MHOs are split into specialist and non-specialist mental health teams and a breakdown of MHOs in specialist teams shows that the number in community mental health specialist teams is down since 2008, but that MHOs in other teams have increased.

Table 2. Number of MHO's 2008 to 2012.

Number of MHOs[a]		2008	2009	2010	2011	2012	% Change
Specialist teams	WTE Headcount	325 352	346.4 366	358.9 381	356.8 383	350.1 384	7.7% 9.1%
Community mental health	WTE Headcount	167.8 182	186.5 197.5[b]	192.4 205.3	186.8 201	158.3 173	−5.7% −4.9%
Specialist social work	WTE Headcount	70.4 76	68.1 74	102.1 106.8	71.7 77	80.8 90	14.8% 18.4%
Old age psychiatry / dementia	WTE Headcount	10.8 12	17 17.5	16.1 17.3	18.3 20.5	16.9 19	56.5% 58.3%
Managerial across several teams	WTE Headcount	14.6 15	28.8 29	24.8 25	27.5 28	32.2 33	120.5% 120%
Other specialist team	WTE Headcount	61.4 67	46 48	23.4 26.5	52.5 56.5	62 69	1% 3%
Non-specialist teams	WTE Headcount	297.2 322	296.6 316	308.9 345	331 345	285.3 304	−4% −5%
TOTAL	**WTE** **Headcount**	**622.2** **674**	**643** **682**	**667.8** **726**	**687.8** **728**	**635.4** **688**	**2.1%** **2.1%**

Source: SSSC, 2013.
[a] As of 31 March each year.
[b] Some MHOs are split between teams.

Community mental health nurses

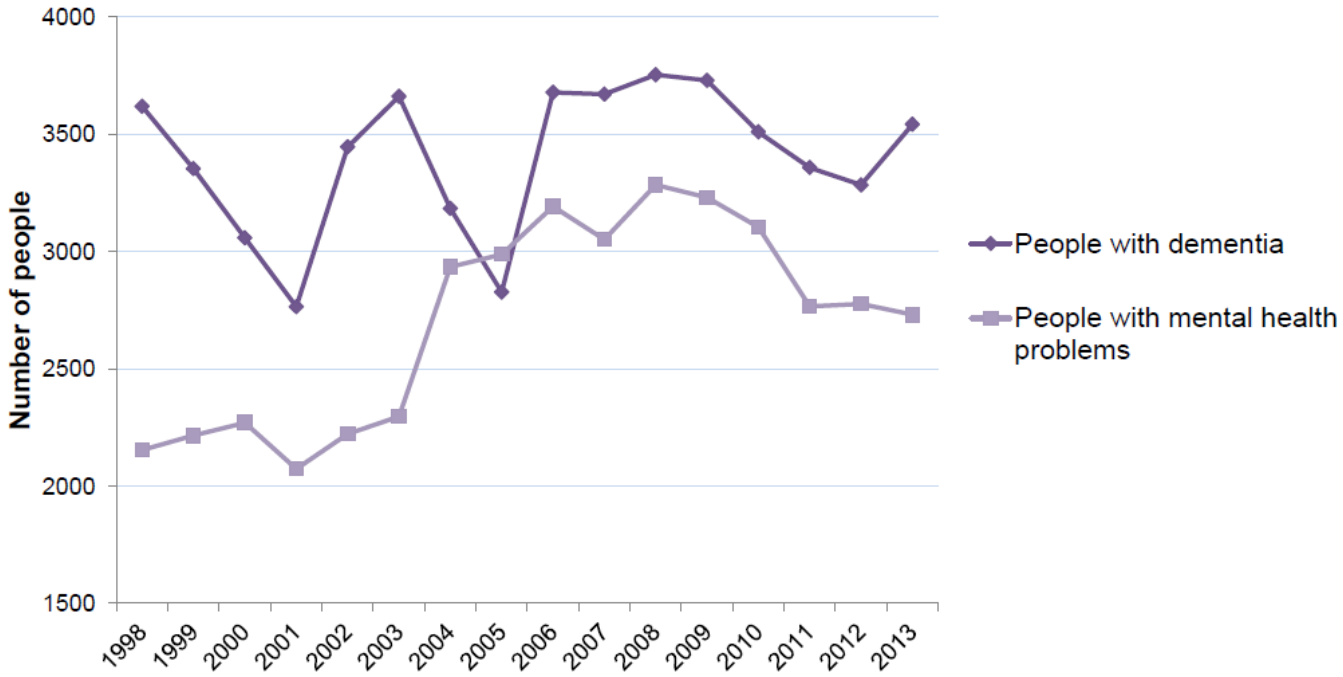
In December 2013 there was a total of 10,188 nursing staff under the specialty of mental health (9429.4 WTE) (ISD data table, 2014). Approximately 25% (2,518 individuals) of these staff were defined as mental health nurses working in the community, while a further 2% (206 individuals) are listed as combined hospital and community nurses. The annual percentage change from 2012 for community nurses shows a marginal increase of 2.7%. It should be noted that due to some concerns regarding this workforce data, NHSScotland and various associated bodies are currently undertaking a data quality improvement project (ISD, personal communication).

[12] Mental Health Officers are Social Workers with specialist training in mental health.

Home care

Social care statistics are available through the annual Social Care Census carried out by the Scottish Government. This includes information on the number of clients using Home Care services within each local authority by client group, including people with mental health problems and people with dementia, shown in **Figure 6** (Scottish Government, 2013) (Social Care Information, 1998 to 2013). From 1998 to 2013, the overall change in the number of people with mental health problems receiving home care has increased by 26.8%, from 2,154 in 1998 to 2,731 in 2013. For people with dementia, however, this figure has fallen by 2.1% from 3,619 to 3,543 over the period. However, it can be seen that the number of people with dementia receiving home care has fluctuated substantially year on year, particularly between 2001 and 2005, while the majority of the change in the number of clients with mental health problems occurred during the early 2000's.

Figure 6. Home Care data for people with mental health problems and people with dementia, 1998 to 2013.



Acute mental health services

Psychiatry services workforce

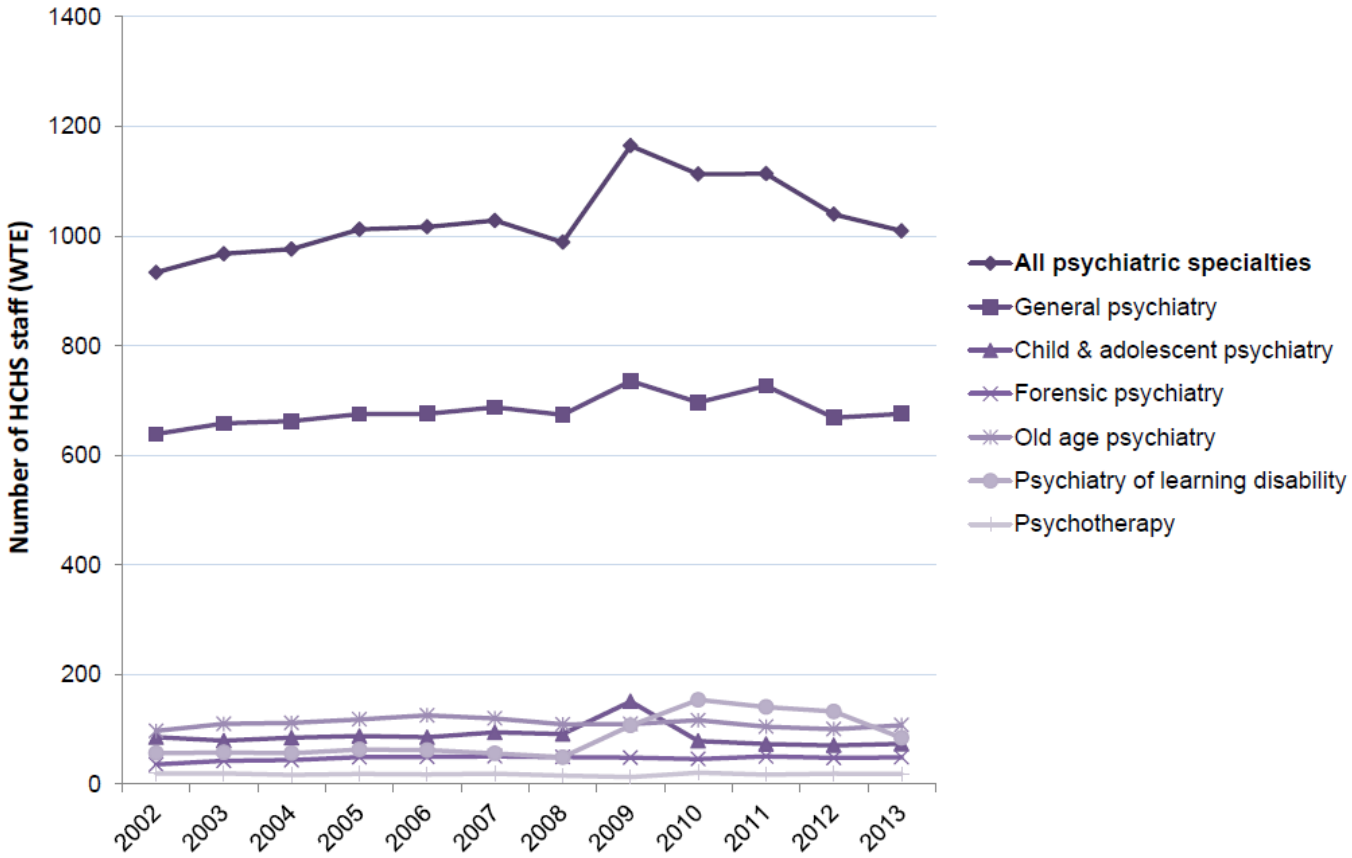
Psychiatry is the medical field concerned with the diagnosis, treatment and prevention of mental health conditions (NHS Choices online). Psychiatrists are medically qualified doctors who have chosen to specialise in the field of psychiatry, and have the authority to prescribe medicines and recommend other forms of treatment. Psychiatrists often work with patients diagnosed with more severe mental illnesses, such as schizophrenia, who often require some sort of medical treatment (Royal College of Psychiatrists online).

Figure 7 shows the total number of hospital, community and public health service (HCHS) psychiatric staff over the period 2002 to 2013 (ISD data table, 2014b). This includes both medical and nursing staff as well as community based psychiatric health staff, and therefore allows for an overview of how the mental health workforce across all settings changes through time. Overall, this shows an overall increase of 8.1% across this period, from 933.5 WTE in 2002 to 1009.2 WTE in 2013. There have been some substantial yearly fluctuations, however, particularly the sharp increase seen between 2008 and 2009, followed by a more gradual decrease. The spike in 2008/09 is likely to be at least in part driven by the increase seen in the

number of consultant psychiatrists within the specialty of psychiatry of learning disability (ISD data tables 2011 and 2014b). In addition, not all specialties have seen an overall increase in WTE staff numbers. General psychiatry, forensic psychiatry, old age psychiatry and psychiatry of learning disability have increased by 5.8%, 36.5%, 10.8% and 49.2% respectively, while child & adolescent psychiatry and psychotherapy staffing have decreased by 14% and 3.5% respectively.

Information is also available for the number of consultant psychiatrists over the same period (2002 to 2013) (ISD data tables 2011 and 2014b). Taken together, the number of consultant psychiatrists across all specialties has increased by about one third, from 395.6 WTE in 2002 to 526.9 WTE in 2013. All specialties show an increase over the period, however the most noticeable increase is seen for consultant psychiatrists of learning disability – this specialty witnessed an approximate five-fold increase between 2008 and 2009, and although it has recently dropped, still represents an 164% increase overall.

Figure 7. Hospital, community and public health service (HCHS) psychiatric staff by specialty, 2002 to 2013.



Clinical nurse specialists workforce

A clinical nurse specialist is a registered nursing professional who has acquired additional knowledge, skills and experience, together with a professionally and/or academically accredited post-registration qualification (if available) in a clinical specialty (ISD online). They practice at an advanced level and may have sole responsibility for care episode or defined client/group.

The WTE number of mental health associated clinical nurse specialists (CNS) over the period 2009[13] to 2013 is given in **Table 3** (ISD data table, 2013b). Most recent data shows there were 34.9, 7.4 and 30.2 WTE nurses in the specialties of children and adolescent mental health

[13] Comparisons before 2009 are problematic because of changes in the way workforce data have been recorded for CNS due to the introduction of Agenda for Change.

(CAMH), cognitive and behavioural therapy (CBT) and mental illness respectively in 2013. This represents WTE percentage increases of 252.5%, 111.4% and 13.5% for CAMH, CBT and mental illness, respectively.

Table 3. Clinical nurse specialists 2009 to 2013.

Specialty		2009	2013	% Change
CAMH[a]	WTE	9.9	34.9	252.5%
	Headcount	12	40	233.3%
CBT[b]	WTE	3.5	7.4	111.4%
	Headcount	4	8	100%
Mental illness	WTE	26.6	30.2	13.5%
	Headcount	30	33	10%

Source: ISD data table, 2013b.
[a] Children and adolescent mental health.
[b] Cognitive and behavioural therapy.

Psychology services workforce

The field of psychology is concerned with how people think, feel and interact (NHS Careers online). A clinical psychologist working in an NHS setting provides psychological therapies (such as cognitive behavioural therapy) to patients with a range of mental health conditions (Royal College of Psychiatrists online). Thus, the principal difference between a psychologist and a psychiatrist is that a psychologist is not usually medically trained and cannot prescribe medication (NHS Choices online).

As of the end of December 2013, there were 706.3 WTE (838 headcount) clinical and other applied psychologists employed in NHS Scotland (ISD, 2014a). This is approximately twice that of 2003 (371 WTE). Of the total of 706.3 WTE, 653.5 (777 headcount) are clinical psychologists and the remaining 52.7 WTE (61 headcount) are defined as other applied psychologists, which includes staff from counselling psychology, health psychology, forensic psychology and neuropsychology. This total represents a national staffing level of one applied psychologist per 7,523 of the general Scottish population (ISD, 2014a).

Psychiatric beds

Current Scottish Government policy is for "as many people as possible [to] be treated in the community, avoiding hospital admission or a lengthy stay in hospital unless really necessary" (Scottish Government online). **Table 4** shows the change in the number of psychiatric beds over the period 2004 to 2013.

Since 2004, the overall number of psychiatric beds in acute units has fallen from 6,950 beds to 4,613 beds (a 34% reduction), while the bed occupancy rate[14] (BOR) has also decreased from about 83% to 79% (ISD data table, 2013c). This trend is mainly driven by decreases in beds designated for general psychiatry (mental illness) and psychiatry of old age, which have seen decreases in the number of beds of 35% and 37% respectively. In contrast, the number of beds for adolescent and forensic psychiatry have both increased (31% and 43% respectively), while the number of beds of child psychiatry has remained the same (9 beds) (ISD data table, 2013c). The overall decrease in the number of beds available for those with mental illnesses most likely

[14] Bed occupancy rate (BOR) is defined as the percentage of available staffed beds that were occupied by inpatients during a given year.

reflects the move towards community care and the increase in the number of individuals being cared for in non-acute settings.

Table 4. Psychiatric bed numbers and occupancy 2004 to 2013.

Specialty		2004	2013[a]	% Change
General psychiatry	Number[b]	3,172	2,064	−34.9%
	BOR	84.5	81.7	−5.1%
Psychiatry of old age	Number	3,545	2,222	−37.3%
	BOR	82.1	75.4	−8.2%
Forensic psychiatry	Number	193	276	43%
	BOR	78.7	85	8%
Adolescent psychiatry	Number	32	42	31.3%
	BOR	85.2	89.8	5.4%
Child psychiatry	Number	9	9	None
	BOR	51.9	62.5	20.4%
TOTAL	**Number**	**6,950**	**4,613**	**−33.6%**
	BOR	**83.1**	**78.9**	**−5.1%**

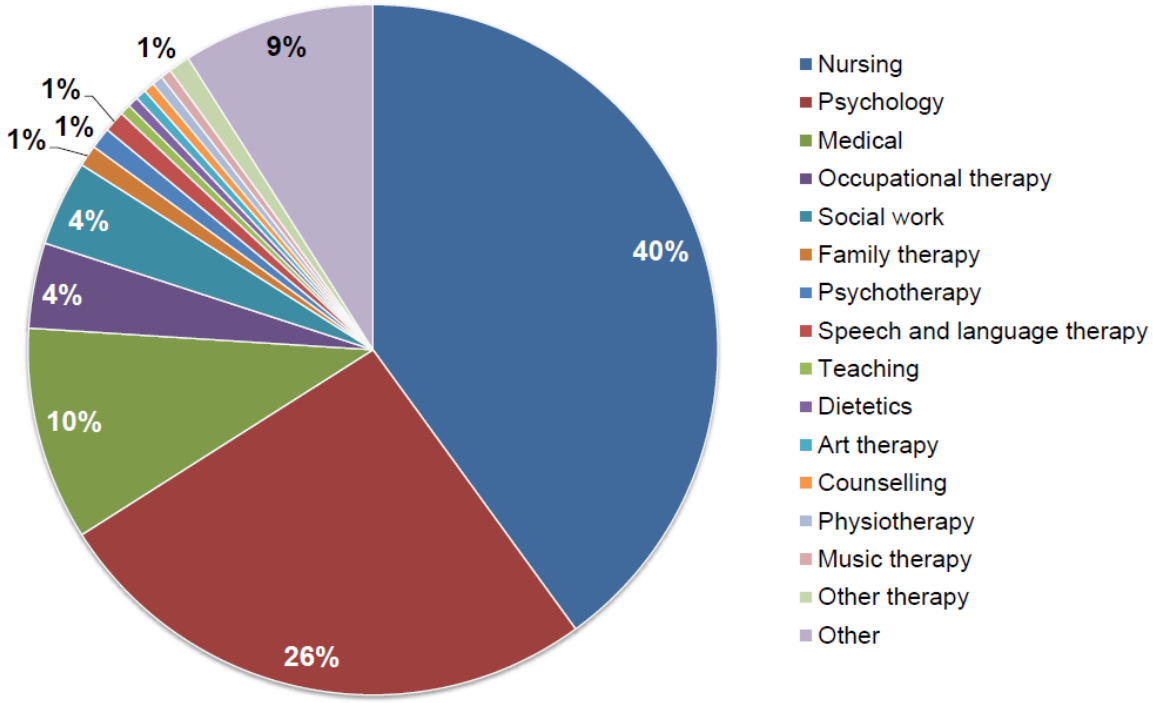
Source: ISD data table, 2014a.
[a] 2013 values as of September 2013.
[b] Defined as the average available staffed beds for that year.

Children and adolescent mental health services

In 2009, the Scottish Government committed to expanding the children and adolescent mental health service (CAMHS) workforce (ISD, 2014b). Since then, the CAMHS workforce has increased from a total of 764.6 WTE (883 headcount) to the current level of 909.9 WTE (1065 headcount) as of December 2013, an increase of about 20% (ISD, 2014b). Over this time period, the staff groups with the largest increases have been psychology (143.8 WTE to 240 WTE, 67% increase) and nursing (320.4 WTE to 363 WTE, 13% increase). The total of 909.9 WTE represents an average of 17.1 CAMHS clinical workers per 100,000 of the Scottish population (ISD, 2014b).

Figure 8 shows the breakdown of staff in post as of December 2013 (i.e., of the 909.9 WTE total as above). This shows that two-thirds of all CAMHS staff comprises either nurses (40%) or psychologists (26%) (ISD, 2014b). The remaining one third of all staff consists of 14 other occupational titles, highlighting the multidisciplinary nature of the CAMHS workforce.

Figure 8. Multidisciplinary nature of the CAMHS workforce in Scotland, as of December 2013. Totals of < 1% are omitted from the chart.



Treatments

There exist a range of available treatments for mental health conditions, including talking and occupational therapies as well as medication.

The talking therapies (also referred to as counselling services, psychological treatments and psychotherapies) play an important role in the treatment of mental health problems. They allow for an assessment of an individual's thoughts and feelings in the presence of a trained mental health professional and are available either on the NHS or from a number of third and independent sector organisations. A range of different forms of talking therapy exist, including cognitive and behavioural therapy (CBT), dialectic behavioural therapy (DBT) and psychodynamic therapy (see the Mental Health Foundation online for further details).

Centralised information regarding the use and provision of talking and occupational therapies for the treatment of mental health problems in Scotland across all sectors is not available, although a recent study on the provision of voluntary sector counselling services in Scotland is discussed below. However, there is a range of data regarding the usage and prescription of medicines used in the treatment of mental health conditions. This information and its implications are discussed below.

Voluntary sector counselling services

A 2003 review of voluntary counselling services[15] in Scotland estimates that there were approximately 2,100 counsellors working in 204 voluntary sector agencies in Scotland at the time the study was conducted (May 2001 to March 2002) (Bondi et al., 2003). These services delivered an estimated 189,000 face-to-face counselling sessions per year to approximately 37,000 clients. In addition, this study found that more than three quarters (76%) performed counselling services without payment (Bondi et al., 2003).

[15] A broad definition of counselling was used that included psychotherapy (see Bondi et al. 2003, p 4).

Prescription of medicines

Drugs used for treatment of mental health problems come under one of five general categories (ISD, 2013e):

- Hypnotics and anxiolytics – used to treat insomnia (inability to acquire a sufficient amount of sleep despite there being the opportunity) and anxiety respectively.
- Antipsychotics and related drugs – used to treat psychoses and related disorders, such as schizophrenia.
- Antidepressants – used to treat depressive disorder (depression).
- Drugs used for Attention Deficit Hyperactivity Disorder (ADHD) – also used for the treatment of Attention Deficit Disorder (ADD), defined as a range of problems associated with a poor attention span.
- Drugs for dementia – used to inhibit the progression of the various types of dementia, e.g. Alzheimer's disease or vascular dementia.

The prescription and usage information for these categories for the year 2012/13 is given in **Table 5** (ISD, 2013e). The most consumed drug is antidepressants, both in terms of number of dispensed items and number of patients. However, it should be noted that antidepressants are also prescribed for a range of other conditions, such as migraine, chronic pain and myalgic encephalomyelitis (ME) – thus, the usage of antidepressants is unlikely to directly correspond to the number of patients with prescriptions for depression (see ISD, 2013e p 6).

Table 5. Prescription and usage information for drugs used in mental health treatments, 2012/13.

Drug	Number of dispensed items	Number of patients[a]	DDD (per 1,000)	Gross ingredient cost (£ million)	% Change since 2003/04
Hypnotics and anxiolytics	2.08 million	358,273 (64% female)	29.1	£8.8	−22%
Antipsychotics	836,756	80,479 (54% female)	10.3	£19.8	23%
Antidepressants	5.2 million	747,158 (67% female)	122.9	£29.5	52%
Drugs for ADHD and ADD	90,885	7,918 (19% female)	6.7	£4.3	103%
Drugs for dementias	183,176	19,763 (65% female)	15.6	£10.2	229%

Source: ISD, 2013e.

[a] All NHS patients have a unique Community Health Index (CHI) number that allows for the identification of which prescriptions have been dispensed to which patient. However, not all prescriptions have a valid CHI attached, thus the data above may be an underestimate. See ISD 2013e page 9 for further details.

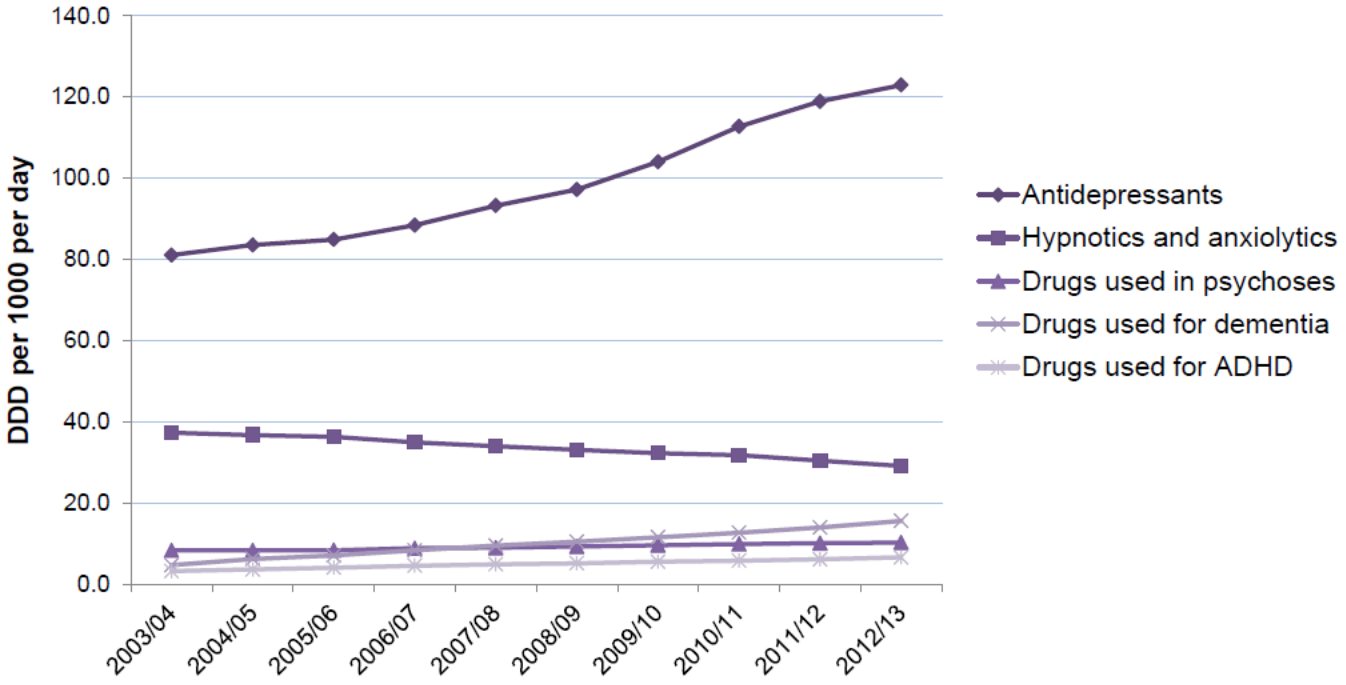
A common measure of drug usage is the Defined Daily Dose (DDD), given as "the assumed average maintenance dose per day used for its main indication in adults" (ISD, 2013e p 9). It is an approximation of drug consumption in terms of the proportion of the population making daily use of the drug[16]. Based on this metric, approximately 12% of the population of Scotland use an antidepressant every day. This compares to the other 4 drug types, which range in usage from approximately 0.7–3% of the population.

Three of the drug categories show a substantial female bias in terms of the number of patients prescribing. Hypnotics and anxiolytics, antidepressants and drugs for dementia all have an approximate two-thirds female bias. Antipsychotics are roughly equal between men and woman, and only drugs for ADHD show a strong male bias (81% male patients).

Figure 9 shows the usage time-trends (in DDDs) for the last 10 years (the period between 2003/04 to 2012/13) for the five categories of treatments given above. It should be noted that the DDD gives an approximation of drug consumption, and cannot determine underlying causes. For example, an increase in DDD over time may be due to an increase in the number of users or an increase in the dosage of that drug (or a combination of both).

Overall, all treatments have seen an increase in DDD with the exception of hypnotics and anxiolytics, which decreased by about 22%. The trend shown by this group shows this decrease to be both gradual and approximately linear. The usage increase shown in other groups ranges from a modest 23% increase in antipsychotics to a 229% increase in drugs used for dementia. Part of this substantial increase in usage may be down to the recent availability of Memantine, used to treat moderate to severe dementia (ISD, 2013e).

Figure 9. Medicines used in the treatment of mental health conditions, 2003/04 to 20012/13.



The usage of antidepressants has increased by about 52% over the 10 year period. However, this increase is likely to be due to a complex range of underlying reasons, including the increased success of campaigns to raise awareness for depression and the use of more appropriate doses and durations of medications (e.g., longer courses for newly diagnosed patients (as per clinical guidelines[17]) and increased numbers of patients on long term treatment courses (Morrison et al., 2007; Moore et al., 2009).

[16] For example, a DDD of 10 per 1,000 people corresponds to a daily usage of 1% of the population.
[17] NICE clinical guidelines on the prescription of antidepressants in available at NICE online.

A national HEAT target to reduce the rate of prescriptions of antidepressants was not met in 2009/10 (Scottish Government online). However, a recognised aspect of the increase in the prescription of medication is the lack of access to alternative therapies such as counselling services or exercise referral schemes (SAMH online). A current HEAT target aimed at countering this is for the reduction in waiting times for referral to treatment for psychological therapies (Scottish Government online).

LEGISLATIVE FRAMEWORK

The rights of those with mental health problems, and the provision of mental health services to aid them, are covered by a wide range of legislation enacted over many years. In Scotland, the key piece of legislation is the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13) (referred to as 'the 2003 Act').

However, the 2003 Act is only one aspect of the legislation that is in place for those with mental health problems. A full breakdown of the legislative framework for mental health in Scotland is provided in **Annex A**, along with the main provisions that each piece of legislation contributes towards the area of mental health.

A BRIEF HISTORY OF THE 2003 ACT

The 2003 Act was passed by the Scottish Parliament on 20 March 2003, received Royal Assent on 25 April 23 and came into force in October 2005. It was the result of the 2001 report of the Millan Committee, which reviewed the previous mental health legislation for Scotland[18] and made recommendations based around the central feature that both the law and practice relating to mental health should be driven by a set of ten principles, relating in particular to minimising interference in peoples' liberty and maximising involvement of service users in any treatment (Millan Report, 2001, p18-21).

The 2003 Act is a rights-based piece of legislation that gives an individual the right to express their views about their care and treatment. This is supported through the right to independent advocacy, the right to submit an advanced statement that states the individual's wishes and the right to choose a named person who can make decisions on the individual's behalf. This new legal entity was created to attempt to overcome problems experienced with next of kin having automatic rights when a person became mentally ill and enabled carers to also have their voice heard in their own right at Tribunal. The 2003 Act redefined the role and functions of the Mental Welfare Commission for Scotland and established the Mental Health Tribunal as the principal forum for approving and reviewing compulsory measures for the detention, care and treatment of mentally disordered persons[19].

In 2008 the Scottish Government commissioned a limited review of the 2003 Act. The McManus Report was published in 2009 and identified five key areas (advance statements, independent advocacy, named persons and medical matters) for improvement of the 2003 Act (see Scottish Government online for further details). The Scottish Governments response to the McManus Report (Scottish Government, 2010c) forms the basis of the changes set out in the Mental Health (Scotland) Bill 2014 (discussed later).

[18] Namely the Mental Health (Scotland) Act 1984 that the 2003 Act subsequently replaced.
[19] Previously, decisions regarding the compulsory treatment of mentally ill persons were made through the sheriff court.

CURRENT STRATEGIES

This section outlines the current national strategies for mental health, suicide and dementia in Scotland. The policy context, from which these strategies were developed, is given in Annex B.

Mental Health Strategy for Scotland 2012–2015

The current national strategy, Mental Health Strategy for Scotland: 2012–2015 was published by the Scottish Government on 10 August 2012 (Scottish Government, 2012). This document succeeds Delivering for Mental Health (Scottish Government, 2006) and Towards a Mentally Flourishing Scotland (Scottish Government, 2009), and builds on the policies and service improvements outlined in those documents. It sets out the Scottish Government's key commitments concerning the improvement of the nation's mental health and wellbeing, and for ensuring the continued improvement in services and outcomes for both individuals and the communities in which they live.

The strategy identifies seven key themes that have general application across the mental health work programme for promotion, prevention, treatment, care and recovery. These themes are:

1. Working more effectively with families and carers.
2. Embedding more peer to peer work and support.
3. Increasing the support for self-management and self-help approaches.
4. Extending the anti-stigma agenda forward to include further work on discrimination.
5. Focusing on the rights of those with mental illness.
6. Developing the outcomes approach to include, personal, social and clinical outcomes.
7. Ensuring that we use new technology effectively as a mechanism for providing information and delivering evidence based services.

In addition, the strategy also identifies four 'Key Change Areas' for continued improvement:

1. Child and adolescent mental health.
2. Rethinking how we respond to common mental health problems.
3. Community, inpatient and crisis services.
4. Other services and populations.

Across this wide spectrum of key themes and areas, the strategy recognises a total of 36 commitments designed around the three Quality Ambitions[20] for Scotland, that dictate that health and care must be safe, person-centred and effective. The 36 commitments are reproduced in **Annex C**.

There are currently two national HEAT targets regarding aspects of mental health service provision. These are to reduce the waiting times for referral to treatment in both CAMHS and psychological therapies to 18 weeks by the end of December 2014 (Scottish Government online).

[20] The three Quality Ambitions were developed from the Institute of Medicine's six dimensions of Quality, and all healthcare policy is aligned towards the delivery of these ambitions.

Suicide Prevention Strategy 2013–2016

The current national strategy for the reduction of the rate of suicide in Scotland, Suicide Prevention Strategy 2013–2016, was published in 2013 (Scottish Government, 2013d).

The current strategy focuses on suicide prevention activities in communities and in services, and is structured around five themes that contribute to the delivery of the National Outcome[21] to enable people to live longer, healthier lives. These five themes are:

1. Responding to people in distress.
2. Talking about suicide.
3. Improving the NHS response to suicide.
4. Developing the evidence base.
5. Supporting change and improvement.

Across these themes, the strategy recognises 11 commitments towards the continued reduction in the rate of suicide in Scotland and towards the achievement of a 20% reduction by the period 2011/13.

The national HEAT target is for a 20% reduction in the suicide rate in Scotland by 2013. Based on three-year rolling averages (to account for yearly fluctuation), the latest available figure shows a reduction of about 18% since 2000/02 (Scottish Government online).

Scotland's National Dementia Strategy: 2013–2016

Dementia is a national priority for the Scottish Government (Scottish Government, 2013a). The current national strategy for dementia, Scotland's National Dementia Strategy: 2013–16, was published in 2013 (Scottish Government, 2013a). It builds on the work of the 2010 strategy, which focused on the improvement of dementia services through the development of better dementia diagnosis and better care and treatment, particularly in hospitals. Since 2010 there has been an increase in the diagnosis rates in Scotland, with around 64% of dementia sufferers in Scotland now being successfully diagnosed (Scottish Government, 2013a).

The current strategy identifies seven key outcomes, given as:

1. More people with dementia living a good quality life at home for longer.
2. Dementia-enabled and dementia-friendly local communities, that contributes to a greater awareness of dementia and therefore helps to reduce the stigma of dementia.
3. Timely, accurate diagnosis of dementia.
4. Better post-diagnostic support for people with dementia and their families.
5. Increased involvement from dementia sufferers, their carers and their families in the provision of their care.
6. Better respect and promotion of rights in all settings, together with improved compliance with the legal requirements in respect of treatment.
7. People with dementia in hospitals or other institutional settings always being treated with respect and dignity.

[21] National Outcomes cover a range of national objectives that describe what the Government wants to achieve over the next ten years.

The national HEAT target for dementia, due for delivery by 2015/16, is for all people newly diagnosed with dementia to have a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan (Scottish Government online).

CURRENT INITIATIVES

This section highlights a number of national initiatives that have been established. For a more comprehensive list of current initiatives see the policy content page published by ScotPHO online.

Choose Life

To help support implementation of Scottish Government policy and strategy on suicide prevention, NHS Health Scotland run their Choose Life programme which – amongst other things – provides leadership and guidance to local suicide prevention coordinators around the country; training on suicide prevention action; and awareness-raising work with the media on suicide and its prevention. Other agencies closely involved in suicide prevention action include local authorities, NHS Boards, the Police and the voluntary sector.

Scottish Recovery Network

Launched in 2004, the Scottish Recovery Network is an initiative with the aim of engaging communities across Scotland to raise awareness about and support recovery from long-term mental health problems.

See Me Scotland

See me is Scotland's programme for ending mental health stigma and discrimination. In 2009, 58% of people who had suffered a mental health problem had experienced stigma or discrimination at some point in the previous five years, although this is an improvement from 2007 where the corresponding value was 82% ('see me' National Plan 2011–2014, p 4). Started in 2002, the vision of this initiative is given as "a Scotland where people with experience of mental ill-health, and those who support them, are fully equal and included" (See me online). To this effect, it outlines three primary aims:

1. To improve public understanding, attitudes and behaviours.
2. For organisations to treat people with mental health problems, and those who support them, with respect and equality.
3. For people with lived experience of mental ill-health have increased capacity to take action against stigma and discrimination.

A re-founded 'See me' programme awarded to the Scottish Association for Mental Health (SAMH) and the Mental Health Foundation took effect from November 2013. £1.5m per year is available for the next 3 years to tackle discrimination and stigma against mental illnesses in Scotland.

Breathing Space

Breathing Space is a national phone line service established initially in 2002. It is a "free, confidential phone and web based service for people in Scotland experiencing low mood, depression or anxiety". The service provides a safe and supportive atmosphere through

listening and offering advice and information. Its aim is to provide assistance at an early stage in order to try and prevent problems from escalating (Breathing Space online).

Scottish Centre for Healthy Working Lives

Healthy Working Lives is a programme designed to promote health improvement among working age people through the workplace. It includes a component designed to give employers the understanding, knowledge and skills to address a wide variety of issues relating to employment and mental health.

MENTAL HEALTH FUNDING

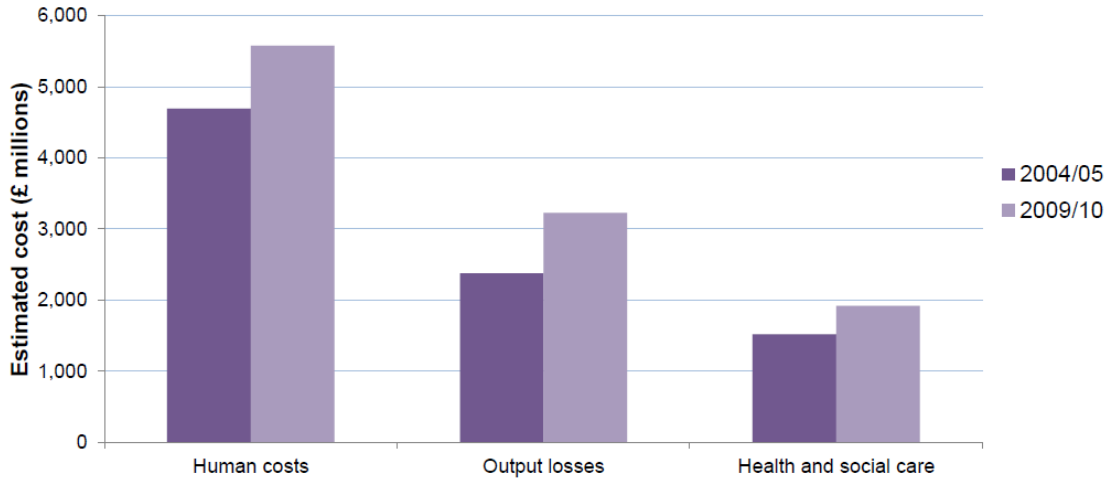
This section reviews the available data on two financial aspects of mental health: firstly, the estimated total costs of mental health and secondly the amount of money that is spent on various aspects of mental health service provision. While both costs and spending are difficult to ascertain precisely for various reasons discussed below, the following sections aim to provide an overview of the mental health 'cost book' in Scotland.

HOW MUCH DOES IT COST?

The Scottish Association for Mental Health (SAMH) have previously estimated the total expenditure, in terms of both social and economic costs, of mental health problems in Scotland at two different time points, first in 2004/05 and again in 2009/10 (SAMH, 2006; SAMH, 2011). These reports split the total cost into three major components, defined as health and social care (the cost of health and social care for people with mental health problems), output losses (the cost of output losses from the Scottish economy that are the result of the adverse effects of mental health problems on the Scottish workforce), and human costs (a monetary estimate of the less tangible but important human costs of mental health problems, including the impact on factors such as quality of life) (SAMH, 2006).

Figure 10 shows the estimated value of these three categories for the years 2004/05 and 2009/10. The total for 2004/05 is £8.6 billion, which is more (by about £0.9 billion) than the total expenditure by the NHS in Scotland on all health conditions combined for the same financial year (SAMH, 2006). The comparative total for 2009/10 is £10.7 billion, representing an overall increase of about 24% reflected by an increased cost in all three categories (SAMH, 2011).

Figure 10. Total costs of mental health in Scotland, 2004/05 and 2009/10.



A further breakdown of the most recent costs for 2009/10 is given in

Table 6, along with the percentage change relative to the equivalent cost calculated for 2004/05. This shows substantial increases in all sectors, ranging from about 14% increase (costs of drug prescriptions) to about 57% (cost of worklessness) (SAMH, 2011). Human costs account for the largest proportion of the total, accounting for just over half (52%).

Table 6. **Costs of mental health in Scotland 2009/10.**

Sector[a]			Cost (£ million)	% Of total	% Change from 04/05
Health and social care	NHS and social care services	NHS hospital and community services	£891	8%	31.4%
		GP consultations	£219	2%	16.2%
		Drug prescriptions	£114	1%	14.6%
		Local authority social care services	£114	1%	22.8%
	Informal care		£475	4%	26.3%
	Other		£107	1%	25.9%
	Sub-total:		**£1,920**	**18%**	**26.3%**
Output losses	Worklessness		£1,440	13%	57.4%
	Losses of unpaid work		£954	9%	22.2%
	Sickness absence		£439	4%	22.3%
	Premature mortality		£395	4%	35.7%
	Sub-total:		**£3,228**	**30%**	**35.7%**
Human costs	Household population – adults		£4,321	40%	18.8%
	Premature mortality		£803	7%	18.8%
	Household population – children		£314	3%	18.9%
	Institutional population		£138	1%	19.0%
	Sub-total:		**£5,576**	**52%**	**18.8%**
TOTAL			**£10,724**	**100%**	**24.8%**

Source: SAMH 2006.
[a] For full definitions of each sector and other information, please refer to SAMH 2006 p 10–15.

Mental health and employment

The studies by SAMH highlight an important interaction between employment and mental health. It is noted that:

> "It is no exaggeration to say that mental ill health is now the dominant health problem of working age. This is partly because mental health problems are very common, but also because the burden associated with these problems falls mainly on people during their working lives." (SAMH, 2011, p 14)

Overall, employment is good for mental health. Notwithstanding some important work-related mental health problems that can arise from issues such as excessive hours and overworking, generally people have better mental health when in employment than when jobless, and a return to work can have positive effects on mental health as much as unemployment can worsen it (SAMH, 2011). Contrary to popular belief, most people with mental health problems

are in employment and the probability of a sufferer having a job is only marginally less compared to those who do not have a mental health problem[22] (SAMH, 2011).

Broadly, the costs to society that result from the negative effects of poor mental health on work and employment can be divided into those incurred due to mental health problems among people in employment and those due to people who do not have a job. Among those who do have a job, the cost to Scottish employers due to the effects of mental ill health is estimated to be about £2.15bn a year (SAMH, 2011). In addition, the cost to society due to the lack of employment (i.e. worklessness) among people with mental health problems is estimated to be approximately £1.44bn per year (SAMH, 2011).

HOW MUCH IS SPENT?

Because the majority of spending on mental health services comes from the generic funds given to each NHS Board and local authority by the Scottish Government, an exact value for the amount of public finances spent on mental health services is difficult to estimate. It is at the discretion of the individual Boards and local authorities how much is spent on mental health service provision, depending on the needs of their local populations.

It is also difficult to assess how much each Board or local authority allocates towards mental health, primarily because the definition of what falls under the remit of 'mental health' can vary between Boards and it is difficult to calculate the total cost of all mental health services spent by a given body.

However, there is a range of available data on a number of different aspects of mental health expenditure that allow for an insight into the extent of mental health funding across localities in Scotland. This includes information on community psychiatric teams and clinical psychologists by Board and expenditure on long-stay psychiatric specialties and staff in the acute sector. In addition, it is possible to ascertain the funding provided by local authorities towards social work services for adults with mental health needs.

Staff expenditure

Information on staff costs for psychiatric specialties is shown in **Table 7** (ISD data tables R720). Over the period 2004/05 to 2012/13, the total staff expenditure for general, adolescent, child and geriatric psychiatric specialties have all increased. This corresponds to a 3.4% increase in the psychiatric workforce across the same time period. In absolute terms, adolescent psychiatry has seen the largest increase by almost 50%, while geriatric psychiatry has increased the least (about 6%). In real terms, however, taking into account the rate of inflation over the period, these changes correspond to a 23.5% increase for adolescent psychiatry and a 4.4% increase for general psychiatry, but a 7.1% and a 12.4% decrease for child and geriatric psychiatry respectively.

Interestingly, the proportion of the total specialty cost spent on staff has decreased across all specialties, despite there being an increase in both staff (WTE) and staff expenditure.

[22] While this is true for mild to moderate mental health problems, the rate of employment for individuals with more severe mental health illnesses is considerably lower (SAMH, personal communication).

Table 7. Expenditure (£ thousand) on medical and nursing staff by psychiatric specialty.

Specialty	2004/05		2012/13		% Change		
	Total[a]	Prop[b]	Total	Prop	Total	Total (Real[c])	Prop
Adolescent Psychiatry	£4,344	64.1 %	£6,501	54.1 %	49.7 %	23.5%	−15.7 %
Child Psychiatry	£3,296	61.4 %	£3,712	52%	12.6 %	−7.1%	−15.4 %
General Psychiatry	£159,977	56.1 %	£202,305	53.9 %	26.5 %	4.4%	−3.9%
Geriatric Psychiatry	£97,827	55%	£103,817	53.8 %	6.1%	−12.4 %	−2.1%
Total / Average	£265,444	59.2 %	£316,335	54%	19.2 %	−1.7%	−9.3%

Source: ISD data tables R720.
[a] Given as total expenditure (£ thousand) on all psychiatric medical and nursing staff.
[b] Prop = proportion – given as staff expenditure as a proportion (%) of gross specialty cost.
[c] Real term change taking into account of inflation.

Expenditure on long-stay psychiatry specialties

The net expenditure by Board on all long-stay psychiatric specialties (i.e. general, adolescent, child and geriatric combined) for all patient types (i.e. inpatient, day care and outpatient combined) for the period 2006/07 to 2012/13 is given in **Table 8** (ISD data tables R04LSX). The year 2006/07 was chosen as a comparative starting point since this is the oldest year for which the number of NHS Boards has been consistent (at 14 Boards).

Over all Boards, expenditure has increased from about £679.7 million to £729.7 million in cash terms. This increase is not reflected in all Boards however, with approximately half showing a decrease across the period. In particular, NHS Orkney has seen spending decrease from about £1.5 million to £98,000 (−93.5%), and NHS Shetland has similarly decreased its spending on long-stay psychiatric specialties from £2.8 million to £0.7 million, a decrease of about three-quarters. Increases are generally smaller, ranging from 0.6% (NHS Forth Valley) to 34% (NHS Tayside). Real term changes are also given.

Table 8. Expenditure (£ thousand) on all long-stay psychiatric specialties for all patient types, by Board.

NHS Board	2006/07	2012/13	% Change	
			Absolute	Real[a]
NHS Ayrshire & Arran	£53,822	£49,695	−7.7%	−20.2%
NHS Borders	£13,338	£13,124	−1.6%	−14.9%
State Hospital	£33,222	£35,003	5.4%	−8.9%
NHS Fife	£56,622	£54,612	−3.5%	−16.6%
NHS Greater Glasgow & Clyde	£161,008	£186,874	16.1%	0.3%
NHS Highland	£41,754	£33,697	−19.3%	−30.2%
NHS Lanarkshire	£51,435	£52,596	2.3%	−11.6%
NHS Grampian	£52,231	£53,692	2.8%	−11.1%
NHS Orkney	£1,505	£98	−93.5%	−94.4%
NHS Lothian	£87,224	£106,274	21.8%	5.3%
NHS Tayside	£62,385	£83,765	34.3%	16.1%
NHS Forth Valley	£37,861	£38,102	0.6%	−13%
NHS Western Isles	£2,818	£2,686	−4.7%	−17.6%
NHS Dumfries & Galloway	£21,634	£18,740	−13.4%	−25.1%
NHS Shetland	£2,792	£695	−75.1%	−78.5%
Total	**£679,650**	**£729,654**	**7.4%**	**−7.2%**

Source: ISD data tables R04LSX.
All values are net expenditure (£ thousand).
[a] Real term change taking into account of inflation.

Expenditure on community services, by Board

Information is collected by each NHS Board on a number of main services provided by community staff. Expenditure on community psychiatric teams and clinical psychologists by NHS Board are shown in

Table and Table 10 for the period 2006/07 to 2012/13. Again, 2006/07 was chosen as a comparative starting point since this oldest year for which the number of NHS Boards has been consistent (at 14 Boards).

Overall, spending on both community psychiatric teams (ISD data tables R500) and clinical psychologists (ISD data tables R510) has increased in the six years given. Spending on community psychiatric teams has increased from about £125.5 million to about £195 million (52%), while spending on clinical psychologists has increased from £15.8 million to £20.8 million (31.5%).

Table 9. Net Expenditure (£ thousand) on community psychiatric teams, by NHS Board

NHS Board	Community psychiatric teams			
	2006/07[a]	2012/13	% Change	
			Cash	Real[a]
NHS Ayrshire & Arran	£7,019	£14,465	106.10%	78.10%
NHS Borders	£4,949	£5,735	15.90%	0.20%
NHS Fife	£3,765	£6,353	68.70%	45.90%
NHS Greater Glasgow & Clyde	£43,189	£68,204	57.90%	36.50%
NHS Highland	£9,167	£9,924	8.30%	−6.4%
NHS Lanarkshire	£9,302	£25,407	173.10%	136.10%
NHS Grampian	£10,614	£10,492	−1.2%	−14.6%
NHS Orkney	£180	£286	58.60%	37.30%
NHS Lothian	£17,521	£29,247	66.90%	44.30%
NHS Tayside	£11,152	£11,543	3.50%	−10.5%
NHS Forth Valley	£3,022	£6,811	125.40%	94.80%
NHS Western Isles	£585	£972	66.10%	43.60%
NHS Dumfries & Galloway	£4,291	£4,527	5.50%	−8.8%
NHS Shetland	£794	£937	18.10%	2.00%
Total	**£125,551**	**£194,903**	**55.20%**	**34.20%**

Sources: ISD data tables R500

[a] Real term change taking into account of inflation.

Table 10. Net Expenditure (£ thousand) on clinical psychologists, by NHS Board

NHS Board	Clinical psychologists			
	2006/07	2012/13	% Change	
			Cash	Real[a]
NHS Ayrshire & Arran	£2,707	£1,024	−62.2%	−67.3%
NHS Borders	£1,193	£1,402	17.60%	1.60%
NHS Fife	£1,396	£1,936	38.70%	19.90%
NHS Greater Glasgow & Clyde	£1,620	£4,262	163.10%	127.40%
NHS Highland	£1,397	£2,348	68.10%	45.30%
NHS Lanarkshire	£2,023	£4,207	108%	79.80%
NHS Grampian	£534	£185	−65.4%	−70.1%
NHS Orkney	—	£99	—	—
NHS Lothian	£868	£374	−56.9%	−62.8%
NHS Tayside	£1,308	£3,457	164.30%	128.50%
NHS Forth Valley	£1,217	£1,217	0.10%	−13.6%
NHS Western Isles	—	—	—	—
NHS Dumfries & Galloway	£1,614	£85	−94.7%	−95.4%
NHS Shetland	—	£284	—	—
Total	**£15,877**	**£20,881**	**31.50%**	**13.70%**

Sources: ISD data tables R510.

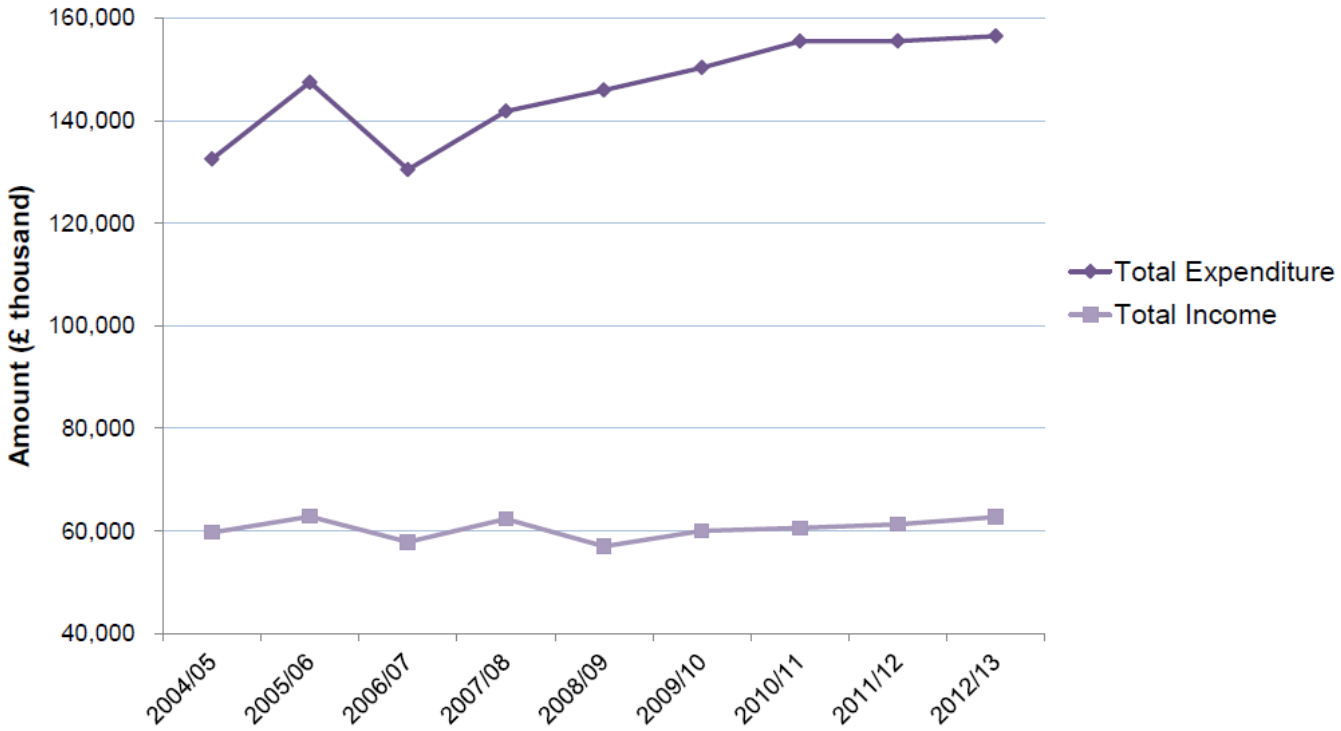
[a] Real term change taking into account of inflation.

However, as shown in Tables 9 and 10, there is substantial variation among the different Boards. Only NHS Grampian showed a decrease in spending on community psychiatric teams over the period (−1.2%). The others all showed an increase, ranging from 3.5% (NHS Tayside) to 173% (NHS Lanarkshire). Spending on clinical psychologists is even more variable among Boards. In 2006/07, NHS Orkney, Western Isles and Shetland had no budget for this area in 2012/13 this had reduced to only NHS Western Isles. The majority of Boards show an increase in spending, although four (NHS Ayrshire and Arran, Grampian, Lothian and Dumfries and Galloway) have seen decreases of 62%, 65%, 57% and 95% respectively.

Local authority spending

Information on local authority spending towards social work services for adults with mental health needs over the period 2004/05 to 2012/13 is available from the Scottish Local Government Financial Statistics publications, and is given in **Figure 11**. This shows both the total expenditure and the total income for this service, and the difference between these values is the amount of revenue for a given financial year that must be accounted for through grants, non-domestic rates, council tax and balances (the net revenue expenditure).

Figure 11. Local authority spending on social services for adults with mental health needs.



The time trend for total expenditure shows a period of fluctuation between 2004/05 to 2006/07, followed by a steady increase that appears to be plateauing. The trend for the total income is generally flatter with a higher degree of fluctuation. Overall, the total expenditure and income have both increased, by 18.1% and 5.0% respectively. Correspondingly, the net revenue expenditure has also increased by 28.8%.

REGULATION AND MONITORING OF SERVICES

The statutory regulation of most health professions is largely reserved to the UK Parliament. Regulation of healthcare professionals is undertaken by UK bodies such as the General Medical Council and the Health and Care Professions Council. The following section outlines the organisations that have some responsibility for the regulation and monitoring of mental health services in Scotland.

THE MENTAL WELFARE COMMISSION FOR SCOTLAND

The Mental Welfare Commission for Scotland (MWCS) has a wide ranging role in the regulation of mental health services. It was created by the Mental Health (Scotland) Act 1984 (c. 20), and is often referred to as the mental health 'watchdog'. It is an independent organisation which works to safeguard the rights and welfare of anyone with a mental illness, learning disability or other mental disorder. Its duties are now set out by the 2003 Act.

The overarching aim of the MWC is "to ensure that care, treatment and support are lawful and respect the rights and promote the welfare of individuals with mental illness, learning disability and related conditions" (MWCS online). To this effect, it has specific duties regarding the monitoring of the 2003 Act and the promotion of best practice, as well as particular investigative powers. The main functions of the Commission are described in **Table 1**.

Table 11. Primary functions of the Mental Welfare Commission for Scotland.

Function	Definition
Visits	The MWC visits individual users of mental health and disability services, service providers, advocacy workers, voluntary organisations and other agencies to check that the care and treatment that people are receiving is in line with the law, policy and best practice. The MWC produces reports and recommendations regarding these visits for the immediate and longer term improvement of these services.
Monitoring of the Acts	Monitoring of the Mental Health (Care & Treatment) (Scotland) Act 2003 and the welfare parts of the Adults with Incapacity (Scotland) Act 2000. The MWC must be informed when a person is detained under the 2003 Act, detained without the consent of a mental health officer, placed under a compulsory treatment order or given care and treatment that is not in line with his or her advance statement. It is the duty of the MWC to check for serious problems in these cases. The Annual Monitoring Report for 2012/13 is available at MWCS online.
Investigations	The MWC has the power to investigate cases where there is reason to believe a person with a mental illness or learning disability is not getting the right care and treatment.
Information and advice	The MWC provides information regarding an individual's rights concerning the 2003 Act and the Adults with Incapacity (Scotland) Act 2000.
Influencing and challenging	In addition to its 'watchdog' role, the MWC also works to help Scottish Ministers and service managers shape policy, and promote best practice across different service providers and organisations. The MWC has representation on the Scottish Parliament's Mental Health Cross Party Group and Learning Disability Cross Party Group.

Source: MWCS online.

THE MENTAL HEALTH TRIBUNAL

The Mental Health Tribunal was established under section 21 of the 2003 Act and came into being on the 5 October 2005. Its main function is to "consider and determine applications for compulsory treatment orders (CTOs) under the 2003 Act and to operate in an appellate role to consider appeals against compulsory measures made under the 2003 Act. The Tribunal also plays a monitoring role by periodic review of compulsory measures" (Mental Health Tribunal online).

OTHER REGULATORY BODIES

The Care Inspectorate

The Social Care and Social Work Improvement Scotland (SCSWIS), otherwise known as the Care Inspectorate, continues the work of the now obsolete Care Commission that was established under the Regulation of Care (Scotland) Act 2001. The overall role of the Care Inspectorate is to independently scrutinise and regulate a wide range of care services (including mental health services) in Scotland, to ensure that services meet the National Care Standards set out by the Scottish Government, and that service users receive high quality care. Care services cannot operate without registration to the Care Inspectorate (SCSWIS online).

Healthcare Improvement Scotland

Healthcare Improvement Scotland (HIS) works to support healthcare providers deliver high quality, evidence based, safe, effective and person-centered care. It also has a scrutiny role for healthcare services (HIS online).

Part of HIS is the Healthcare Environment Inspectorate (HEI) which was established, in April 2009, to undertake announced and unannounced inspections of acute, community and non-acute hospitals. HIS is also responsible for regulating and inspecting independent hospitals and private psychiatric hospitals. HIS also assesses the standard of care for older people in acute hospitals.

HIS has an improvement role and has undertaken work in the area of mental health including the development of integrated care pathways[23] and undertaken programmes of work on services such as intensive psychiatric care units and services for children and young people with attention deficit and hyperactive disorders (ADHD).

The Scottish Intercollegiate Guidelines Network (SIGN) develops evidence-based clinical practice guidelines for the NHS in Scotland. SIGN has produced guidance on subjects such as the management of schizophrenia and the management of perinatal[24] mood disorders.

Scottish Social Services Council

The role of the Scottish Social Services Council (SSSC) is to raise standards of practice, strengthen and support the social services workforce and increase the protection of people who use services. The SSSC establishes registers of key groups of social service staff, publishes Codes of Practice for the 191,000 social service workers across Scotland, and regulates and promotes the education and training of this workforce (SSSC online).

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[23] An integrated care pathway is a system of care encompasses how care is organised, co-ordinated and governed.

[24] Perinatal is the period before and after birth; definitions as to when the perinatal period starts and ends vary but range form 20 weeks gestation to four weeks after birth.

Scottish Public Sector Ombudsman

Although not a regulator, the Scottish Public Sector Ombudsman (SPSO) is an important body for those who wish to make a complaint about a public agency, including those involved in the delivery of mental health services. It was set up in 2002 and charged with investigating complaints about most organisations providing public services in Scotland, including councils, the NHS, housing associations, the Scottish Executive and its agencies and departments, universities and colleges and most Scottish public authorities (SPSO online).

It looks into complaints where a member of the public claims to have suffered injustice or hardship as a result of maladministration or service failure. It generally only investigates cases where the complainant has already exhausted the formal complaints procedure of the organisation concerned (SPSO online).

RECENT DEVELOPMENTS

MENTAL HEALTH (SCOTLAND) BILL (2014)

The Scottish Governments legislative programme for the year 2013/14 included a Mental Health Bill. A consultation, to seek views on proposals for a draft bill, was launched on 20 December 2013 and ran until 25 March 2014 (Scottish Government, 2013b).

Since the introduction of the 2003 Act many people believe that there are some aspects of the legislation that could be made more efficient and effective. The purpose of the draft Mental Health Bill is to address these issues, with the overarching aim of the draft Bill being:

> "… to ensure that people with a mental health disorder can access effective treatment quickly and easily. Subject to the Bill successfully completing the parliamentary process, it will provide an improved legislative framework to help treat and care for people with a mental disorder whilst at the same time increasing the efficiency and effectiveness of existing procedures and processes for both the patient and practitioner alike" (Scottish Government, 2013b, p 4).

At the time of writing, the proposed changes to improve the operation of the 2003 Act are namely in relation to named persons, advance statements, medical matters and suspension of detention provisions. In addition, the draft bill includes a proposal to introduce a notification scheme for victims of mentally disordered offenders. For further details regarding the proposals set out in the draft Bill, please refer to the consultation document (Scottish Government, 2013b) and its supporting material.

SCOTTISH PARLIAMENT ACTION

The Health and Sport Committee is considering the issue of mental health through a visit to a mental health service on 2 June 2014 and in a roundtable evidence session on 10 June 2014.

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ANNEX A: LEGISLATIVE FRAMEWORK

Legislation	Main provisions
Social Work (Scotland) Act 1968 (c. 49)	Placed the organisation and provision of welfare services for "persons in need" (including those with a mental health problem) with Social Work Departments. Introduced local authority duty to promote social welfare. Provided the basic structure for contemporary social work in Scotland. This Act (as amended) largely forms the basis of community care regulations, together with the amendments of the NHS & Community Care Act 1990.
Chronically Sick and Disabled Persons (Scotland) Act 1972 (c.51)	Extends sections 1 and 2(1) of the Chronically Sick and Disabled Persons Act 1970 to Scotland. This provides local authorities with a duty to obtain information on those with chronic illnesses and disabilities who live in their areas. It also provided a duty on local authorities to, after assessment, support anyone covered by the legislation with practical assistance, including adaptations and equipment at home.
Housing (Scotland) Act 1978 (c. 26)	Compelled local housing authorities to consider the needs of chronically sick and disabled people (including people with mental health problems) when allocating accommodation.
National Health Service and Community Care Act 1990 (c. 19)	The 1990 Act was the first piece of legislation to introduce a specific statutory framework for community care and it forms the cornerstone of community care law. It aimed to oversee the policy aim of shifting the balance of care from hospitals and institutions to community based settings. It was also an attempt to bridge the gaps in community care law. It placed a duty on local authorities to assess the need for "community care services" and enhanced their duty to secure the provision of welfare services. It applied to the elderly, disabled and those suffering from mental/physical health problems, and so extended provision to those omitted from the Chronically Sick & Disabled Act 1970.
Children (Scotland) Act 1995 (c. 36)	Provided legislation for children comparable with that covered for adults in the Social Work (Scotland) 1968 Act. The underpinning principle was that local authorities have a general duty to promote the upbringing and welfare of 'children in need'. It extended the duty beyond disabled children to children affected by the disability of a family member.
Community Care (Direct Payments) Act 1996 (c.30)	Gave local authorities the power (but not the duty) to make direct payments to individuals who could then purchase services and facilities themselves.
Adults with Incapacity (Scotland) Act 2000 (asp 4)	Provides for decisions to be made on behalf of adults who lack legal capacity to do so themselves because of mental disorder or inability to communicate. The decisions concerned may be about the adult's property or financial affairs, or about their personal welfare, including medical treatment.
Regulation of Care (Scotland) Act 2001 (asp 8)	Overhauled the registration and inspection of social and independent health care services together with the social services workforce. Established the Scottish Commission for the Regulation of Care (the Care Commission) and the Scottish Social Services Council. Gave Ministers the power to produce National Care Standards for care services. NOTE: On 1 April 2011 the work of the Care Commission passed to a new body, the Care Inspectorate. Regulation of independent healthcare passed to Healthcare Improvement Scotland (HIS).
Community Care and Health (Scotland) Act	Part 2 of this Act gave Scottish Ministers the power to introduce regulations that enabled flexibility for joint working between NHS Boards and local authorities, by permitting them to make payments to one another,

2002 (asp 5)	delegate functions and pool budgets. It also provided Ministers with intervention powers to direct NHS Boards and local authorities to enter into joint working arrangements where poor joint working prevails.
Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13) ('the 2003 Act')	Followed the recommendations of the Millan Committee Report in 2001 and came into effect on 5th October 2005. It contains a wide range of provisions including: • Compulsory powers – setting out when people can be legally required to go into hospital, or to accept services or treatment that they may not want. • New rights and safeguards, including a right to access independent advocacy services. • Establishment of the Mental Health Tribunal – which will hear cases under the Act. • Powers of the Mental Welfare Commission. • New duties on Health Boards and local authorities.
Adult Support and Protection (Scotland) Act 2007 (asp 10)	Part 1 of the Act introduced new provisions for the protection of adults at risk of abuse, including those with mental health problems. The provisions included inspection and investigation powers for local authorities and a range of interventions. Part 2 of the Act amended the Adults with Incapacity (Scotland) Act 2000 (asp 4), with the aim of simplifying and streamlining the protections for adults with incapacity and improving access to them. Part 3 made an amendment to the 2003 Act in order to ensure that Mental Health Tribunal reviews take place every 2 years, as was the original attention of the Act.
Public Services Reform (Scotland) Act 2010 (asp 8)	The overarching purpose is to simplify and streamline the public bodies landscape in Scotland to deliver improved public services and better outcomes for the people of Scotland. Part 7 amends the Mental Health (Care and Treatment) (Scotland) Act 2003 to make provision in relation to the Mental Welfare Commission for Scotland, focusing its role as a protective body, ensuring joined up working arrangements with the new scrutiny bodies and making changes to its structure.
Social Care (Self-directed Support) (Scotland) Act 2013 (asp 1)	Makes provisions relating to the arrangement of care and support in order to provide a range of choices to individuals as to how they are to be provided with their support. It requires authorities to provide information and assistance to individuals in order that they can make an informed choice about the options available.

ANNEX B: POLICY CONTEXT

Policy	Year	Main points of consideration
Scotland's National Dementia Strategy 2010	Scottish Government (2010)	A three-year strategy focussing on improving the quality of dementia services through more timely diagnosis and on better care and treatment, particularly in hospital settings. It began the process of the transformation of care across all sectors in anticipation of the growing number of people with dementia.
Realising Potential – An Action Plan for Allied Health Professionals in Mental Health	Scottish Government (2010)	A three-year action plan that set out a blueprint for maximising the allied health professions (AHP) contribution to supporting people with mental health problems, both within mental health services and in mainstream settings. Identified five key areas for action: • Early intervention and timely access for service users and carers. • Supported self-management and recovery. • Promoting physical health and mental well-being. • Designing and delivering psychological interventions. • Integrating vocational rehabilitation in mental health.
Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011	Scottish Government (2009)	Set out the Scottish Government's vision for improving population mental health and wellbeing to 2011 and identifies six strategic priorities to improve mental health. These are: • Mentally healthy infants, children and young people. • Mentally healthy later life. • Mentally healthy communities. • Mentally healthy employment and working life. • Reducing the prevalence of suicide, self-harm and common mental health problems. • Improving the quality of life of those experiencing mental health problems and mental illness.
Delivering for Mental Health, 2006	Scottish Executive (2006)	Set out a number of targets and commitments towards the continued development of mental health services and the improvement of Scotland's mental health to 2010.
National Programme for Improving Mental Health and Wellbeing, 2003-2006	Scottish Executive (2003)	Launched in 2001, the National Programme was established to support further action in areas of mental health. Its four key aims were: • Raising awareness and promoting mental health and wellbeing. • Eliminating the stigma and discrimination of mental disorders. • Promoting and supporting recovery from mental illness. • Suicide prevention.

Choose Life: A National Strategy and Action Plan to Prevent Suicide in Scotland	Scottish Executive (2002)	National strategy that aimed to address the rising rate of suicide in Scotland. Was the first phase of a 10-year plan with the overall goal of reducing the Scottish suicide rate by 20% by 2013 (a national HEAT target). Latest available figures for the three-year period 2010/12 show a reduction of about 18% since 2000/02.

ANNEX C: MENTAL HEALTH STRATEGY COMMITMENTS

Commitment
Commitment 1: The Scottish Government will commission a 10 year on follow up to the Sandra Grant Report to review the state of mental health services in Scotland in 2013. The review report will be published in 2014.
Commitment 2: We will increase the involvement of families and carers in policy development and service delivery. We will discuss how best to do that with VOX and other organisations that involve and represent service users, families and carers.
Commitment 3: We will commission a short review of work to date in Scotland on peer support as a basis for learning lessons and extending the use of the model more widely.
Commitment 4: We will work with the management group for see me and the Scottish Association for Mental Health, who host see me, and other partners to develop the strategic direction for see me for the period from 2013 onwards.
Commitment 5: We will work with the Scottish Human Rights Commission and the Mental Welfare Commission to develop and increase the focus on rights as a key component of mental health care in Scotland.
Commitment 6: During the period of the Mental Health Strategy we will develop a Scotland-wide approach to improving mental health through new technology in collaboration with NHS 24.
Commitment 7: In 2012 we will begin the process of a national roll out of Triple P and Incredible Years Parenting programmes to the parents of all 3-4 year olds with severely disruptive behaviour. We will include more information about the delivery of this commitment in our Parenting Strategy which will be published in October 2012.
Commitment 8: We shall make basic infant mental health training more widely available to professionals in the children's services workforce. We shall also improve access to child psychotherapy (a profession which specialises in parent infant therapeutic work) by investing in a new cohort of trainees to start in 2013.
Commitment 9: We will work with a range of stakeholders to develop the current specialist CAMHS balanced scorecard to pick up all specialist mental health consultation and referral activity relating to looked after children.
Commitment 10: We will work with clinicians in Scotland to identify good models of Learning Disability CAMH service delivery in use in different areas of Scotland or other parts of the UK which could become or lead to prototypes for future testing and evaluation.
Commitment 11: We will work with NHS Boards to ensure that progress is maintained to ensure that we achieve both the 2013 (26 week) and the 2014 (18 week) access to CAMHS targets.
Commitment 12: In addition to tracking variance and shorter lengths of stay, we will focus on reducing admissions of under 18s to adult wards, with a new commitment to reduce figures across Scotland to a figure linked to current performance in the South of Scotland area.
Commitment 13: We will continue our work to deliver faster access to psychological therapies. By December 2014 the standard for referral to the commencement of treatment will be a maximum of 18 weeks, irrespective of age, illness or therapy.
Commitment 14: We will work with NHS Boards and partners to improve monitoring information about who is accessing services, such as ethnicity, is consistently available to inform decisions about service design and to remove barriers to services.
Commitment 15: We will work with partners, including the Royal College of General Practitioners and Long Term Conditions Alliance Scotland, to increase local knowledge of social prescribing opportunities, including through new technologies which support resources such as the ALISS system which connects existing sources of support and makes local information easy to find. We will also raise awareness, through local health improvement networks, of the benefits of such approaches.
Commitment 16: NHS Health Scotland will work with the NHS, local authorities and the voluntary sector to ensure staff are confident to use Steps for Stress as an early intervention

approach to address common mental health problems. □

Commitment 17: We will work with NHS Boards and partners to more effectively link the work on alcohol and depression and other common mental health problems to improve identification and treatment, with a particular focus on primary care. □

Commitment 18: We will develop an approach to support the better identification and response to trauma in primary care settings and support the creation of a national learning network. □

Commitment 19: We will take forward work, initially in NHS Tayside, but involving the Royal College of General Practitioners as well as social work, the police and others, to develop an approach to test in practice which focuses on improving the response to distress. This will include developing a shared understanding of the challenge and appropriate local responses that engage and support those experiencing distress, as well as support for practitioners. We will develop a methodology for assessing the benefits of such an approach and for improving it over time.

Commitment 20: We will take forward the recommendations of the psychological therapies for older people report with NHS Boards and their statutory and voluntary sector partners and in the context of the integration agenda. Access to psychological therapies by older people will be tracked as part of the monitoring of the general psychological therapies access target, which applies to older people in the same way that it applies to the adult population. □

Commitment 21: We will identify particular challenges and opportunities linked to the mental health of older people and will develop outcome measures related to older people's mental health as part of the work to take forward the integration process. □

Commitment 22: We will work with the Royal College of GPs and other partners to increase the number of people with long term conditions with a co-morbidity of depression or anxiety who are receiving appropriate care and treatment for their mental illness. □

Commitment 23: We will identify a core data set that will allow effective comparison of the effectiveness of different models of crisis resolution/home treatment services across NHS Scotland. We will use this work to identify the key components of crisis prevention approaches and as a basis for a review of the standards for crisis services. □

Commitment 24: We will identify the key components that need to be in place within every mental health service to enable early intervention services to respond to first episode psychosis and encourage adoption of first episode psychosis teams where that is a sensible option. □

Commitment 25: As part of the work to understand the balance between community and inpatient services, and the wider work on developing mental health benchmarking information, we will develop an indicator or indicators of quality in community services. □

Commitment 26: We will undertake an audit of who is in hospital on a given day and for what reason to give a better understanding of how the inpatient estate is being used and the degree to which that differs across Scotland. □

Commitment 27: Healthcare Improvement Scotland will work with NHS Boards to deliver the Scottish Patient Safety Programme – Mental Health. □

Commitment 28: We will continue to work with NHS Boards and other partners to support a range of health improvement approaches for people with severe and enduring mental illness, and we will work with the Royal College of Psychiatrists in Scotland and other partners to develop a national standard for monitoring the physical health of people being treated with clozapine. □

Commitment 29: We will promote the evidence base for what works in employability for those with mental illness by publishing a guidance document which sets out the evidence base, identifies practice that is already in place and working, and develops data and monitoring systems. Change will require redesign both within health systems and the wider employability system to refocus practice on more effective approaches and to realise mental health care savings. □

Commitment 30: We will build on the work underway at HMP Cornton Vale testing the effectiveness of training prison staff in a 'mentalisation' approach to working with women with borderline personality disorder and women who have experienced trauma. The pilot will be extended in that prison and also introduced in HMP Edinburgh. □

Commitment 31: We will also work with NHS Lothian to test an approach to working with women with borderline personality disorder in the community by extending the Willow Project in Edinburgh. We will use the learning from the test to inform service development more widely across Scotland.

Commitment 32: We will promote work between health and justice services to increase the effective use of Community Payback Orders with a mental health condition in appropriate cases.

Commitment 33: We will undertake work to develop appropriate specialist capability in respect of developmental disorders as well as improving awareness in general settings. As part of this work we will review the need for specialist inpatient services within Scotland.

Commitment 34: We will continue to fund the Veterans First Point service and explore roll out of a hub and spoke model on a regional basis, recognising that other services are already in place in some areas. We will collaborate with the NHS and Veterans Scotland in taking this work forward and will also explore with Veterans Scotland how we can encourage more support groups and peer to peer activity for veterans with mental health problems.

Commitment 35: We will work with COSLA to establish a local government mental health forum to focus on those areas of work where local government has a key role, including employability, community assets and support and services for older people, and make effective linkages with the work to integrate health and social care.

Commitment 36: To support progress on this agenda the Scottish Government will put in place arrangements to coordinate, monitor and performance manage progress on the national commitments outlined in this strategy. In doing this we will build on the successful experience of managing the implementation of the dementia strategy.

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