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Pàrlamaid na h-Alba

Public Audit Committee

Adult mental health

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Public Audit Committee

To consider and report on the following (and any additional matter added under Rule 6.1.5A)—

(a) any accounts laid before the Parliament;

(b) any report laid before or made to the Parliament by the Auditor General for Scotland; and

(c) any other document laid before the Parliament, or referred to it by the Parliamentary Bureau or by the Auditor General for Scotland, concerning financial control, accounting and auditing in relation to public expenditure.

2. No member of the Scottish Government or junior Scottish Minister may be a member of the Committee and no member who represents a political party which is represented in the Scottish Government may be convener of the Committee.


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Membership changes

Membership changes of the Public Audit Committee during the reporting period are:

- Sharon Dowey MSP (from 23 June 2021 - 08 February 2024)
- Jamie Greene MSP (from 8 February 2024 - present)

Conclusions and recommendations

Demand for adult mental healthcare

1. **The Committee heard compelling evidence that the demand for mental health care is continuing to rise, with the Covid-19 pandemic and cost-of-living crisis compounding the issues faced by an adult mental health system already under significant strain. To better understand and develop effective approaches to meet these demands, improvements in the collection of quality data is needed. We therefore ask the Scottish Government to work with its partners (including GPs) to put in place improved collection methods and reporting on the demand for adult mental health services.**

2. **The Committee is encouraged by the evidence it has heard that more people feel able to seek help for their mental health rather than suffering in silence. This however inevitably places even more strain on adult mental health services. Lower-level support, such as the Distress Brief Intervention (DBI) programme, is a critical way of responding to this demand and can help move some of the pressure away from other services. While the Committee notes that the pilot has now come to an end, we recommend that the Scottish Government continues to monitor how roll-out of the provision of DBIs across Scotland is working in practice.**

3. **The Committee is clear that it is not the role of police officers to "fill the gap" in the mental healthcare system. The Committee welcomes the benefits of local policing partnership initiatives in helping to reduce the impact on police resources. We also support Police Scotland's scoping exercise to identify initiatives that could be implemented at a national level and recommend that this work is completed as soon as possible. The Committee expects the Scottish Government to respond positively to the outcome of the scoping exercise.**

4. **The Committee notes the work the Scottish Government is progressing with its partners during 2024 in response to the HMICS Thematic Review of Policing Mental Health in Scotland. The Committee seeks further details of the Scottish Government's planned mental health and policing action plan to be produced, including timescales for its development and implementation.**

Accessing support

5. **The Committee recognises the key role that GPs play in supporting people with their mental health. We are concerned however that having to first explain their medical symptoms to a receptionist may deter some people from approaching their GP for help. We suggest that the Scottish Government works with NHS Health Boards to develop guidance for GP practices setting out options that can be used to support people wishing to make a GP appointment for their mental health.**

6. **While there are many forms of local support available to people seeking help for their mental health, we heard that those working in primary care services, including GPs, are not always aware of them. The Committee encourages the Scottish Government to review its guidance on available support, issued to primary care last year, and update it as necessary to ensure that it remains a reliable and up to date source of information.**

7. **We welcome the Scottish Government's ambition to achieve a more preventative primary care-based adult mental health service and its commitment to ensure that every GP practice has access to a mental health and wellbeing service by 2026. The Committee seeks the Scottish Government's assurances that it will provide sufficient funding to ensure greater progress is made against these commitments.**

8. **The Committee welcomes the Scottish Government's stated commitment to ensuring that people have a choice in the way in which they access services, whether that be digitally or in-person. We are concerned however, that not everyone who prefers face-to-face support is receiving it. The Committee also notes the significant variation among health boards in the number of face-to-face appointments versus remote appointments for psychological therapy. We recommend that the Scottish Government explores in more detail what is driving this variability and to report its findings to the Committee as soon as possible.**

9. **The Committee heard mixed views about the merits of the Trieste model of mental healthcare. We invite the Scottish Government to further consider the lessons that can be learned from this 24/7 person-centred form of support, particularly in relation to the development of 24-hour walk-in services, including how this approach could work in rural areas. The Committee recommends the Scottish Government makes its findings public.**

10. **The Committee recognises the benefits of peer-support and notes that there is scope to expand this form of support. The Committee echoes SAMH's call for the Scottish Government to set a national peer workforce target and set out clearer commitments to expand peer support infrastructure.**

11. **The Committee also recognises the vital role that community link workers play in supporting people with their mental health. The Committee notes the suggestion made by the National Association of Link Workers for a national campaign to raise awareness of the support that can be provided by community link workers. The Committee recommends that the Scottish Government takes this forward.**

12. **The Committee is concerned at the evidence heard regarding the limited oversight, transparency and accountability in relation to the performance of adult mental health services. We note the Scottish Government's plans for reform of governance structures through the National Care Service (Scotland) Bill and asks for information on how it will ensure greater**

accountability in relation to adult mental health care through this process.

Mental health inequalities

13. **The Committee welcomes the Scottish Government's commitment to addressing mental health inequalities. However, the evidence we heard highlights that the Mental Health Transition and Recovery plan (MHTRP) lacked timescales and its progress has not been reviewed. We also heard that detail on specific actions is missing from the Mental Health and Wellbeing Strategy and associated delivery plan. We recommend that a review is carried out of progress being made against the MHTRP. This review should also consider where best to set out further detail on the specific actions the Scottish Government will take to address mental health inequalities and the timetable for delivering these actions.**

14. **One area of particular concern for the Committee is a reported lack of culturally appropriate services for minority ethnic communities seeking help for their mental health. We ask the Scottish Government to set out the steps it is taking to address this reported omission.**

15. **The Committee further shares the concerns raised by the Mental Health Foundation that there is currently a lack of provision for new lone parents with mild and moderate mental health problems. We recommend that the Scottish Government urgently undertakes an audit of the support currently available for this at-risk group and identify how any gaps in provision will be addressed.**

16. **The Committee considers that a whole-of-government approach is essential to ensure progress in addressing mental health inequalities. We heard that one way of doing this could be to require every Government decision to be assessed on its impact on mental health. The Committee invites the Scottish Government to consider how it can best support a whole-of-government approach to tackling this important issue.**

Data and outcomes

17. **Incomplete and poor-quality data in the public sector is a long-running concern for the Public Audit Committee. In the context of adult mental health services, we are concerned that this lack of data means there is no effective means of measuring outcomes or the impact that the substantial investment in these services is having on the ground. Significant gaps in data will have an impact on the ability to make well-informed decisions about the delivery of mental health services.**

18. **The Committee therefore welcomes the work the Scottish Government is progressing to address deficiencies in the quality and availability of adult mental health data. We note in particular Public Health Scotland's work to address a lack of information on primary care. The Committee asks the Scottish Government for an update and timetable for completion of this work.**

19. **To support transparency and scrutiny, we would like to see data relating to the performance of adult mental health services made publicly available. While the Committee welcomes the Scottish Government's involvement in the UK Benchmarking exercise, we urge it to publish as much information from this exercise as soon as possible.**

20. **The Committee also welcomes the Scottish Government's commitment to develop a Scottish mental health dashboard during 2024. This information should be made publicly available as soon as practicably possible following quality assurance.**

21. **We ask the Scottish Government to learn any lessons from NHS England and its health and social care partners in its development of such a 'dashboard' approach to demonstrate its performance against a series of mental health indicators.**

22. **The Committee notes the development of a child, adolescent and psychological therapies national dataset. We encourage the Scottish Government to work with Public Health Scotland to explore how this work can be replicated for adult mental health services.**

23. **The Committee supports the development of a NHS mental health workforce statistical publication covering all staff involved in providing mental healthcare. We agree with the Auditor General for Scotland and the Accounts Commission (the AGS/AC) report's findings that this would significantly improve the information available on, and understanding of, the mental health workforce in Scotland, enabling more effective planning and monitoring. We therefore seek assurance from the Scottish Government that this statistical publication will be progressed and made publicly available without further delay.**

Resources for adult mental health services

24. **It is vital that this Parliament is able to track the Scottish Government's commitment to increase spending on mental health. The Committee therefore agrees with the AGS/AC report's finding that Public Health Scotland should include spending by all services that provide adult mental healthcare when reporting NHS spending on adult mental health.**

25. **We note the Scottish Government's commitment to ensure that 10% of the front-line NHS budget is spent on mental health by 2026. We are disappointed at the evidence we heard that progress against this commitment is poor. We ask the Scottish Government to set out how it plans to make greater progress against this commitment, particularly against a backdrop of financial constraint.**

26. **The third sector plays a significant role in supporting people with their mental health. It is therefore of considerable concern to the Committee that the nature of this funding is fragile and unpredictable. While recognising that the Scottish Government itself does not receive multi-year funding settlements, we ask it to consider how more certainty can be provided to**

the third sector for the funding that it receives, such as providing outline multi-year spending plans. Not only will this enable organisations to plan their services more effectively, but crucially, it will provide reassurance to those using these services.

27. **The Committee recognises that community link workers are a critical part of the primary care services workforce. Indeed, they will play an integral role in supporting the Scottish Government's commitment to ensure that every GP practice has access to a mental health and wellbeing service by 2026. We therefore welcome the additional funds secured to protect the Glasgow Link Workers service and seek assurances regarding the funding of community link workers across all areas of Scotland, urban and rural.**

28. **It is crucial that the Scottish Government publishes a costed delivery plan setting out the wider funding and workforce that will be needed to achieve its aim of establishing sustainable and effective mental health and wellbeing in primary care services (MHWPCS) across Scotland by 2026. This should include the number of community link workers that it will recruit. We ask whether the Scottish Government is on course to produce a costed delivery plan by November this year as planned.**

29. **The Committee is deeply concerned by the workforce crisis facing psychiatrists in Scotland. It is also troubling to hear that there is an over-reliance on locum psychiatrists. This approach represents poor value for money and poses a risk to the quality of the services provided. We note that the Scottish Government told us that it is actively working to increase the number of psychiatry training places, which is welcome. As part of its wider workforce considerations, the Committee recommends that the Scottish Government undertakes a longer-term review and costed workforce financial plan of the recruitment and retention of psychiatrists in Scotland, as suggested by the AGS during oral evidence.**

Introduction

30. Through its scrutiny of reports prepared by the Auditor General for Scotland (AGS) and Audit Scotland, the Public Audit Committee examines whether public funds are being spent wisely and holds to account those who are charged with spending public money. As part of this work, we aim to make a difference to the quality of public services in Scotland.

31. The joint AGS and Accounts Commission (AC) report, "Adult mental health" (referred to as "the AGS/AC report") was published on 13 September 2023 and made a wide range of recommendations to the Scottish Government, Integration Joint Boards (IJBs), Health and Social Care Partnerships (HSCPs), NHS Boards and councils.

32. The Committee took oral evidence on the AGS/AC report from the AGS and the AC on 28 September 2023. Following this evidence session, the Committee held three roundtable evidence sessions with relevant stakeholders to explore the issues raised in the report—

    - **9 November 2023**, the Committee heard from mental health organisations and charities representing people experiencing or who are at risk of poor mental health.

    - **16 November 2023**, the Committee heard from stakeholders representing professions and organisations directly responsible for supporting people with their mental health. In noting that the number of police incidents relating to mental health has increased significantly since 2018, Police Scotland was also represented at the meeting.

    - **23 November 2023**, the Committee heard from stakeholders representing public bodies who have a role in addressing some of the key recommendations in the AGS/AC report.

33. At its meeting on 14 December 2023, the Committee took oral evidence from the Chief Executive of NHS Scotland and Director-General Health and Social Care (referred to as "the Chief Executive of NHS Scotland" in this report) on the issues raised at the earlier evidence sessions.

34. This report sets out the Committee's key observations, recommendations and conclusions based on the evidence that has been gathered in relation to its scrutiny of the AGS/AC report.

Demand for adult mental healthcare

35. The AGS/AC report highlighted that funding for adult mental health services has increased significantly since 2017. For example, there has been a 16% real terms increase in NHS board spend and a 14% real terms increase in council spend. The Scottish Government's Mental Health Directorate budget has also increased by 356% in real terms since 2017.[i] The report stated however that a lack of data makes it hard to see what the impact of this public expenditure has been.

36. The AGS/AC report refers specifically to the lack of data that is held by the Scottish Government, IJBs and others "to fully understand demand for mental healthcare" and that "comprehensive, good-quality data is essential for assessing demand and planning services".

37. The report further stated that information about demand for mental healthcare in Scotland only covers those already accessing or attempting to access some mental health services. Examples of current data gaps in relation to demand for mental healthcare in Scotland cited in the AGS/AC report include—

- The number of people with a severe and enduring mental health condition.
- Information to accurately assess demand for mental health support in primary care.
- Information on referrals and caseloads for community mental health teams, who provide specialist mental health services.
- Information on psychiatric services including the number of referrals, the number of people on waiting lists, how long people are waiting for treatment and the length of treatment.

38. While referrals to psychological therapies and admissions to inpatient mental healthcare have remained broadly stable since 2017/18, the AGS/AC report concluded that there are indications that demand for mental healthcare has increased as follows—

- The number of people detained using the Mental Health Act because of an urgent need for treatment for a mental health disorder increased from 104 to 120 per 100,000 people between 2017/18 and 2021/22. It peaked in 2020/21 during the pandemic.
- The Scottish Association for Mental Health (SAMH) reported a 50% increase in demand for its information service during the pandemic.
- The number of calls to NHS 24's 111 Mental Health Hub increased by 436% between 2019/20 and 2022/23, from an average of 2,136 calls per month, to an average of 11,457 calls per month. The increase can partly be explained by its expansion from operating eight hours per day to 24 hours per day from July 2020.

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i More detailed information about spending on adult mental health can be found in the "Resources for adult mental health services" section of this report.

39. The Committee sought to explore the demand for adult mental healthcare in Scotland, and in particular, how the Covid-19 pandemic and the more recent cost-of-living crisis have impacted on this demand.

40. At the Committee's first roundtable evidence session, SAMH outlined the possible extent of the demand for adult mental healthcare in Scotland following the Covid-19 pandemic—

> During the pandemic, the Centre for Mental Health produced a report that suggested that the NHS will need two to three times its current capacity to adequately meet and treat the expected increase in mental health problems resulting from the pandemic. That was a report for England and Wales, but one can expect something similar for Scotland. [1]

41. At this same roundtable evidence session, the Poverty Alliance explained that a snapshot survey conducted with its members on general issues around accessing adult mental health found that the Covid-19 pandemic has had an impact on demand for support—

> Before the pandemic, about 15 per cent of those organisations were always dealing with mental health issues. That meant that, when individuals presented, there was always a component of mental health in the reason for their presentation. Now, 40 per cent of the organisations said that they see people presenting with mental health issues every time. [1]

42. This survey, the Poverty Alliance further noted, identified that the increasing cost of living is negatively affecting the population's mental health.

43. In oral evidence, The Royal College of Psychiatrists (RCPsych) also highlighted the increase in demand for adult mental health services stating—

> We have seen a consistent increase in the demand for mental health services over the past three years, since the onset of the pandemic and, subsequently, as a result of the cost of living crisis. There has been a specific increase in certain conditions, such as neurodivergent disorders—autism and attention deficit hyperactivity disorder. In some cases, there has been an increase in the number of referrals of between 700 per cent and 1,000 per cent. [2]

44. The RCPsych further stated that the impact of the Covid-19 pandemic and the cost-of-living crisis have been felt the most by people with pre-existing mental health conditions—

> The cost of living crisis has hit people with mental health conditions harder than it has hit most other people. People with long-term severe mental health conditions are among the most vulnerable people in our society. They already struggle from a financial perspective, so, as I said, the cost of living crisis has had a huge impact. What that leads to on the ground is an increased need for support for people with pre-existing mental health conditions or severe mental health disorders, alongside an increase in the use of services. [2]

45. Penumbra Mental Health echoed some of the points made by the RCPscyh, and suggested the combined effect of the two crises had increased the number of people requiring mental health interventions—

> Without a doubt, the cumulative effect of Covid and the cost of living crisis is having a major impact on people's mental health and wellbeing. We have only to look at the considerable increase in the number of people with whom we, as an organisation, work and engage. Last year, for instance, 12,649 people required mental health interventions. [2]

46. In both oral and written evidence to the Committee, the Mental Health Foundation (MHF) highlighted its Thriving Learners study on student mental health in the UK which showed—

> ...a rise in levels of distress during the pandemic... Towards the end of the pandemic, we saw that those levels of distress had not come down to pre-pandemic levels...
>
> We also did a bit of polling of the population on the cost of living crisis, and, when we asked people about that, they reported that the increasing cost of living is negatively affecting their mental health. That does not surprise us, because financial stress is a clear risk factor for poor mental health. [1]

47. Young Scot also provided a further perspective on the impact of the Covid-19 pandemic and the cost-of-living crisis on young people during oral evidence—

> With the post-Covid cost of living crisis, we have been hearing from young people about secondary mental health issues. They are witnessing their parents and carers going through really challenging times, and that is having an impact. A survey that we did in December found that more than 70 per cent of young people are concerned about the financial pressures on their parents or carers and the associated stress and impact on their own mental and physical health. [1]

48. The Committee also heard from Chris's House, as regards their observations of the impact of both the Covid-19 pandemic and the cost-of-living crisis—

> ...there is the social anxiety and shame that people feel because of the financial impact and the difficulties that they face in that regard. We are seeing many more people with very high levels of anxiety leading to depression and suicidal ideation. That is a result of the hopelessness that the pandemic has left. [2]

49. East Ayrshire HSCP also offered a perspective on how the Covid-19 pandemic and the cost-of-living crisis has increased demand for services—

> There have been significant increases in the demand for acute admission and referral to a community mental health team and in the use of detention. There is also a group of people in the middle who are distressed and are not coping with life. We would not describe them as having a mental illness, but all parts of our system are aware of the challenge in meeting the needs of those people. Some of that is definitely linked to the cost of living and the challenges with heating, housing and eating. [3]

50. During oral evidence, the Chief Executive of NHS Scotland recognised the impact of the cost-of-living crisis on mental health stating—

> ...the cost of living crisis and the stress that is involved in people trying to manage their budgets adds to the impact of poor mental health and creates mental distress. A lot of our work has been focused on trying to support not only alleviation and prevention but early intervention in those areas. [4]

Police Scotland incidents relating to mental health

51. The AGS/AC report highlighted that a further measure to demonstrate an increasing demand for mental healthcare is that the number of police incidents relating to mental health increased by 62% between 2018 and 2022.

52. In October 2023, HM Inspectorate of Constabulary in Scotland (HMICS) published a "Thematic Review of Policing Mental Health in Scotland". [5] The review highlighted a "perceived increase in demand, to support vulnerable people (particularly people experiencing poor mental health)" amongst officers, who believed that this has become the most significant aspect of their work.

53. As part of its scrutiny of the AGS/AC report, the Committee explored the police's involvement in supporting people with their mental health.

54. In written evidence, Police Scotland provided data to demonstrate its increasing role in responding to incidents relating to mental health. The evidence collected though Police Scotland's Mental Health Dashboard indicates that although overall incident demand is decreasing, the number and proportion of incident demand relating to mental health is increasing, and that the ratio of those incidents from which no crime is recorded, is currently over 87%.

55. The Committee also explored the amount of police time spent on mental health incidents, including the extent to which police officers are spending their entire shift sitting with people in accident and emergency (A&E) and therefore unable to deal with other cases.

56. In oral evidence, Police Scotland acknowledged that police officers often take people experiencing a mental health problem into hospital. However, the high demand for NHS services means that police officers are often met with capacity issues, which can lead to long waiting times at A&E. Police Scotland stated that taking people to hospital demonstrates that it is "investing in the safety and protection of vulnerable individuals". [2]

57. Police Scotland also highlighted that the Police and Fire Reform (Scotland) Act 2012 states that Police Scotland's purpose is to "improve the safety and wellbeing" of individuals. It further explained that it is considering how and whether to define "wellbeing" in its service provision, and, if so, what this would mean for its partners' service provision. Police Scotland acknowledged however that there is an element of providing unscheduled care in its remit and that it would be reluctant to adopt approaches taken in England where certain areas have stepped back from responding to mental health incidents. Police Scotland further explained—

> We think that our legislative purpose is different. However, we will have to work with our partners to find out where that line stops. At some point, we will have to remove ourselves and go back to what I would call traditional core policing requirements. [2]

58. The RCPsych echoed Police Scotland's concerns about adopting the approach seen in England, citing the more collaborative working relationships between Police Scotland and its partners compared to that seen in England. The RCPsych also stated that it had—

> ...grave concerns about any move towards the unilateral approach that was adopted by the Met Police to withdraw and then look at what needs to be put in place. That puts people at real risk, and those are some of the most vulnerable people. [2]

59. The Committee also sought witnesses' views on the "right care, right person approach" [2] developed in England in response to the question of who is best placed to deal with people who have mental health problems. The Committee noted that Humberside Police has adopted this approach which it reports has saved 1,400 officer hours every month.

60. The RCPsych provided its views on the "right care, right person approach" [2] stating—

> The difference with the Humber example is that the investment in mental health services, as a proportion of overall health spend, is about 13 per cent, which is almost exactly double what is spent by some of the health boards in Scotland, where the average is about 6.57 per cent. You get what you pay for. Ultimately, that is the challenge. [2]

Responding to demand through partnership working

61. The HMICS Thematic Review of Policing Mental Health in Scotland reported that Police Scotland is filling gaps in the system, and that demand is being passed from partner organisations to the police. The review stated that a whole-system response is required to ensure the best possible service and outcomes for those experiencing poor mental health.

62. Unison suggested that capacity issues amongst partner organisations explains why police officers are filling the gaps in the system—

> A lot of our people are quite upfront about the fact that they do not have the capacity, numbers or range to help people before they reach the crisis point that involves the police. Indeed, they are getting involved with people only after incidents and behaviours that have involved the police. [2]

63. Unison also explained how demand on police time in dealing with mental health incidents can be reduced—

> If you want to reduce demand on the police, there is a strong case for interventions to be made downstream, so to speak, in services such as housing and the various psychological therapies and so on that people have been talking about. We should not have police involvement to the extent that we do, because we should not have as many people in crisis as we do, and there are ways to prevent that, if we are serious about it. [2]

64. The AGS/AC report highlighted that the estimated cost to policing of incidents relating to mental health in Scotland is £14.6 million per year. In oral evidence, the AGS told the Committee that the 62% increase in police response to mental health incidents not only poses a significant increase in their focus and attention but—

> is also relevant to the financial position of the police and the prioritisation that that organisation will have to make as it, too, looks to deliver a changing service and meet its budget priorities. [6]

65. During oral evidence, Police Scotland explained that it was holding a workshop with partners in November 2023 to help inform a new model for Police Scotland. It further explained—

> We realise that, with the funding envelope that Police Scotland has and the reducing police numbers based on that, we need to come up with a model not only for mental health but for efficiencies across the board, and we are doing that. That step...is important because we cannot design that service without professionals from other bodies. [2]

66. The Chief Executive of NHS Scotland referred to this workshop during oral evidence and confirmed that "all the boards and mental health systems were represented". They went on to state that the Scottish Government is—

> ...committed to carrying on working with the police to improve joint risk management, which is crucial, as there are sometimes different perceptions of risk. An individual who presents to the police in distress may be regarded by the mental health service as safe because they are well known to it and they have a care plan in place, but the police may feel uncomfortable leaving that person there. Better joint management of that risk could lead to further improvements. [4]

67. Police Scotland highlighted that it is difficult to achieve a consistent partnership approach to responding to mental health incidents due to the number of health boards and third sector organisations involved in the provision and delivery of mental health services. It recognised however that there are examples of local initiatives which could be built upon, including the NHS Forth Valley risk assessment process which allows police to "take an individual to hospital and then to move back based on the assessment". Police Scotland explained that it is considering whether that model could be scaled up and piloted by other geographical areas during 2024.

68. During oral evidence, NHS Lothian provided a further example of a local initiative, where a Mental Health Assessment Service (MHAS) is available 24/7 in Lothian. This includes a "professional-to-professional" line on which the police can call the MHAS before they bring a person into hospital. NHS Lothian further explained—

> If the person is well known to us and we have a safety plan for them, we will have a discussion with the police and the person and make a decision about what needs to happen for the next 12 hours until the day shift starts. If a person is known to community mental health staff or their GP, a safety plan will be put in place that allows the police to leave the person safely. [3]

69. In written evidence, NHS Lothian provided further examples of joint working with the police, including—

- Between the Intensive Home Treatment Team and the police, including the facilitation of urgent mental health assessment for the police, either in-person or over the phone
- CAMHS Unscheduled Care interface with Police Scotland. Police officers can contact the service to request advice or an assessment for a young person they are concerned about. [7]

70. The National Association of Link Workers provided details of a local community justice partnership programme link workers are involved in—

> We have a massive example in the Highlands, where custody link workers work with the police under a community justice partnership programme... Link workers are taking referrals from the police. [2]

71. Chris's House also highlighted the relationship it has established with the police in Lanarkshire—

> I am very lucky, in Lanarkshire, that the police are aware of us. The police will often bring in people who have been dismissed after being on a train line, for instance. The police will have taken them to the hospital and brought them back in, but they are deemed fit and deemed to have capacity. [2]

72. In written evidence, Police Scotland explained that it has carried out a scoping exercise to determine the extent of local policing partnership initiatives across the country, aimed at reducing the impact on police resources and improving the service provided to people in mental health crisis or distress. The exercise also sought to determine the impact of these initiatives and their suitability for implementation nationally and are currently being assessed by Police Scotland. [8]

HMICS Review: Scottish Government action

73. In response to the Committee's concerns regarding the amount of police time being spent at A&E, the Scottish Government's Principal Medical Officer, Mental Health Division stated during oral evidence that—

> We absolutely acknowledge the problem and we have been working with the police on the report that His Majesty's Inspectorate of Constabulary in Scotland published recently. [4]

74. The Principal Medical Officer also referred to work it is progressing with Police

Scotland to free up police time including—

- The development of an enhanced pathway to enable police to contact the NHS 24 MH hub "in situ with an individual, with the hope being that this will reduce the need to convey the person to hospital". [4]

- Local work with liaison groups with hospitals and the police including NHS Lanarkshire, which has achieved a 73 per cent reduction in the rate of police conveying people to hospital through joint working with the police and the mental health emergency assessment service there.

75. In November 2023, the Scottish Parliament's Criminal Justice Committee heard oral evidence from HMICS on its review. Following this evidence session, that Committee wrote to the Cabinet Secretary for Justice and Home Affairs and the Minister for Social Care, Mental Wellbeing and Sport [9] seeking views on the issues raised in the review, in addition to the Mental Welfare Commission for Scotland's report, "The role of police officers in mental health support." [10]

76. The response from the Cabinet Secretary accepts the findings of the HMICS review and commits to drive forward the vision and actions set out in the joint Scottish Government and COSLA Mental Health and Wellbeing Delivery Plan and the Workforce Action Plan, in addition to the suicide prevention action plan by working jointly with the police, local clinical leaders, and social care.

77. The response also states that following the publication of the HMICS Review, a working group has been established by the Scottish Government, Scottish Police Authority (SPA) and Police Scotland "to develop and take forward activity relating to all the recommendations made". It further states—

> Our officials have discussed with SPA and Police Scotland the ways in which Scottish Government can provide leadership and add value and continue to improve how we are addressing the issues currently experienced by frontline officers and alleviate demands placed on them, while improving support for those experiencing emotional distress and mental ill health. [11]

78. The Cabinet Secretary's response to the Criminal Justice Committee's letter also provides details of work the Scottish Government is progressing with its partners during 2024 including—

- Developing guidance "to help articulate the behaviours, principles and culture to support services to work together" to identify the most appropriate support for those seeking help for their mental health.

- Hosting workshops to develop protocols for A&E handover and facilitating meetings and events for good practice to be shared.

- Seeking agreement from partners represented on the Mental Health Unscheduled Care Network that it facilitates a national review of Psychiatric Emergency Plans.

79. The response highlights that through this work, it will "be in a position to develop a mental health and policing action plan which will set out measurable actions and as far as possible accompanying timescales".

More people seeking help

80. The Committee heard that more people are now willing to seek help for their mental health which had led to an uptick in demand. This, SAMH explained, was partly due to the Covid-19 pandemic bringing “mental health and wellbeing into sharp focus for all of us." [1]

81. During oral evidence, the Scottish Government’s Principal Medical Officer, Mental Health Division, stated—

> Our population is now much happier than it was 15 or 20 years ago to talk about mental health, to recognise mental health issues and to come forward and seek mental health support. [4]

82. Argyll and Bute Integration Joint Board (IJB) supported this position, stating—

> Some of the demands that we are seeing are from people who, 20 or 30 years ago, would have tried to manage at home or to hide how they were feeling. It is a wonderful sign of changes in our society and culture that more people are coming forward and telling us that they are having difficulties, but we have to be able to match that with appropriate support. [3]

83. East Ayrshire HSCP also highlighted the increased demand for support that is emerging for mental health teams—

> A lot more people need help to understand the neurodivergence in themselves and their families. That is new work; it is not what mental health teams were originally built, funded or trained for. We are doing a lot of work to understand the size of that need, and it is significant. We need to think about the best way to address that that does not further overwhelm existing specialist teams. [3]

84. As regards the provision of appropriate support, the National Association of Link Workers highlighted during oral evidence that it is important that life issues are not “overmedicalised”. It further stated—

> Mental health issues that are caused by social determinants need a different approach... we all have mental health as well as physical and emotional health. What we are talking about is the state that people are in. For some people, that health is poor, but they do not yet have a mental illness. [2]

85. East Ayrshire HSCP also stated during oral evidence—

> we have got to a point at which anything to do with mental wellbeing is considered the job of mental health services, and that is not sustainable. [3]

86. During oral evidence, the Scottish Government's Principal Medical Officer, Mental Health Division recognised the need for providing different levels of support—

> We need to find ways to develop services that allow people to easily access lower-level support, which will mean that more specialist services will be able to focus their attention on those with the highest levels of need and the most complex issues. That is where we are at the moment with regard to our strategy and delivery plan: we are trying to get the balance right between those two very difficult calls on current capacity. [4]

Distress brief intervention programme

87. One particular example of lower-level support for people experiencing distress and who do not require an emergency medical response is the Distress Brief Intervention (DBI) programme, developed by the Scottish Government. The AGS/AC report outlined how the DBI programme operates—

> "The DBI programme takes a two-level approach. Level 1 interventions are provided by trained front-line staff from primary care, Police Scotland, the Scottish Ambulance Service (SAS), Accident and Emergency departments (A&E) and NHS 24. Level 1 interventions aim to help people to cope with their immediate distress and offers the opportunity to be referred within 24 hours to a Level 2 intervention.
>
> Level 2 interventions are provided by trained third sector staff who work with individuals, for up to 14 days, to provide support and a personalised action plan for distress management. During the intervention, staff can help people access other services for follow-up support". [12]

88. In written evidence, Police Scotland highlighted that it has been a core partner of the DBI programme since its inception and is responsible for 12.2% of referrals to the programme. HMICS recommends that all officers should receive DBI training. As of August 2023, 1,372 officers have received the training which equates to around 8% of the police officer workforce. [13]

89. The AGS/AC report referred to a broadly positive independent evaluation of the DBI programme pilot which reported that DBIs work well for most people, with distress decreasing during the DBI for 90% of people.

90. During the roundtable evidence sessions, participants representing SAMH, Chris's House and the Scottish Borders HSCP all highlighted the benefits of the DBI programme. Penumbra Mental Health also indicated its support for the programme, stating that it has been valuable in diverting people away from requiring police involvement.

91. The AGS/AC report further explained that the DBI programme is being rolled out nationally, and that all NHS boards are expected to embed the programme by March 2024. However, the Scottish Government will no longer provide dedicated funding to local areas, meaning that this will be expected to be funded through existing budgets. The report suggests that this could result in varying quality and availability of the DBI service in different areas.

92. SAMH also raised concerns about removal of the dedicated funding for the programme—

> Our concern is that the moment you remove dedicated funding, you open up the opportunity for 32 different versions of what is, in essence, already proven to be a very effective programme of supporting somebody who is in a distressed situation. Our concern is how to retain the effectiveness of the programme that has been piloted over the last period when you do a national roll-out. Removing the dedicated funding suggests that it might then be open to interpretation. [1]

93. In response to concerns about the removal of this dedicated funding, the Scottish Government's Principal Medical Officer, Mental Health Division, told the Committee—

> The DBI programme was very clearly set up with an end point, and the pilot programmes had initial investment that allowed them to get things off the starting blocks. That will come to an end at the end of March 2024. [4]

94. The Principal Medical Officer went on to highlight—

> There will be continued funding for the DBI national programme, which allows people access through NHS 24 and the police and ambulance services, as well as some central support for the local areas. All the areas that have had temporary funding now have plans in place to continue the service beyond the end of that initial central funding. [4]

95. **The Committee heard compelling evidence that the demand for mental health care is continuing to rise, with the Covid-19 pandemic and cost-of-living crisis compounding the issues faced by an adult mental health system already under significant strain. To better understand and develop effective approaches to meet these demands, improvements in the collection of quality data is needed. We therefore ask the Scottish Government to work with its partners (including GPs) to put in place improved collection methods and reporting on the demand for adult mental health services.**

96. **The Committee is encouraged by the evidence it has heard that more people feel able to seek help for their mental health rather than suffering in silence. This however inevitably places even more strain on adult mental health services. Lower-level support, such as the DBI programme, is a critical way of responding to this demand and can help move some of the pressure away from other services. While the Committee notes that the pilot has now come to an end, we recommend that the Scottish Government continues to monitor how roll-out of the provision of DBIs across Scotland is working in practice.**

97. **The Committee is clear that it is not the role of police officers to "fill the gap" in the mental healthcare system. The Committee welcomes the**

benefits of local policing partnership initiatives in helping to reduce the impact on police resources. We also support Police Scotland's scoping exercise to identify initiatives that could be implemented at a national level and recommend that this work is completed as soon as possible. The Committee expects the Scottish Government to respond positively to the outcome of the scoping exercise.

98. **The Committee notes the work the Scottish Government is progressing with its partners during 2024 in response to the HMICS Thematic Review of Policing Mental Health in Scotland. The Committee seeks further details of the Scottish Government's planned mental health and policing action plan to be produced, including timescales for its development and implementation.**

Accessing support

The role of GPs

99. The AGS/AC report highlighted that “people typically access mental health support in Scotland by visiting GPs for support and onward referral to specialist services.” During oral evidence, the Poverty Alliance reinforced the importance of GPs as “the initial gateway into receiving help." [1] SAMH also indicated that around 75% of people tend to use their GP as the main gateway to access support.

100. At the Committee’s third round table evidence session, COSLA reinforced the importance of GPs being “a first port of call for the majority" [3] for people seeking help with their mental health.

101. The Committee also heard that many people felt uncomfortable having to explain to a GP receptionist the reasons for wishing to make an appointment with their GP. During the first roundtable evidence session, Voices of Experience (VOX) Scotland told the Committee—

> A lot of our members are reporting a situation in which it feels like the receptionist is the gatekeeper, and you have to get past them and prove why you need an appointment. Of course, it is very difficult and a bit humiliating to have to talk about that with a receptionist. [1]

102. The Royal College of General Practitioners Scotland (RCGPS), highlighted that the Covid-19 pandemic resulted in changes to the way in which people made a GP appointment and the impact this could have on those seeking help for their mental health—

> Right from the start of the pandemic, messages were communicated across society, and some immediate changes were needed with regard to access to services... In general practice, for example, people were used to being able to walk up to the reception desk or ask for an appointment without being questioned on what it was about. That was particularly important for mental health, because people do not always feel able to talk to a member of reception staff or somebody with whom they are not yet comfortable about mental health, especially if there is stigma involved. [2]

103. Asked specifically whether having to explain your situation to a receptionist puts people off seeking help from their GP, RCGPS responded—

> It does not put a lot of people off, but it drives frustration and negative experience. [2]

104. The Committee also heard evidence that GPs should not always be the entry point for people seeking help with their mental health. For example, during oral evidence, SAMH stated—

> On whether GPs are the only gateway to getting mental health support, they should not be. We think that community-based direct-referral supports should be widely available, and we have been calling for supports of that kind for some time. [1]

105. Unison supported this position stating—

> If we are to create a sustainable set of mental health services, we need to get away from the idea that everybody must always see a doctor, even—I suspect—initially. You might need a doctor to go down the social prescribing route of the link workers... but you do not always need a doctor to deal with everything. [2]

106. VOX Scotland also recognised the role of GPs, while highlighting the importance of other forms of support—

> Some of our members have reported that they have a brilliant GP who still takes the time to talk to them, and that their regular appointments with them keep them well. Alternatively, the person might be a community link worker or a peer support worker. It is not necessarily always about seeing a psychiatrist or psychologist; it is about being able to connect with a trusted person who maintains an empathetic attitude, and that sort of thing is not available to everyone across the country when they need it. [1]

107. A VOX Scotland member further added—

> Our members see a mismatch between supply and demand, and that you are spending money on the old paradigm, not the new Convention on the Rights of Persons with Disabilities paradigm. Our members might think that you spend too much on the biomedical model and the psychological stuff, and not enough on the social side of what works in mental health. [1]

Primary care mental health services

108. The AGS/AC report referenced the 2018 general medical services contract in Scotland , published by the Scottish Government and the Scottish GP Committee, British Medical Association in November 2017. It stated that there would be a refocus of GPs' roles as expert medical generalists which would "require some tasks currently carried out by GPs to be carried out by members of a wider primary care multi-disciplinary team" including with regard to community mental health services.

109. The importance of wider teams based in primary care providing mental healthcare was highlighted in the AGS/AC report—

> Increasing the availability of mental health and wellbeing services in primary care could help to prioritise prevention and early intervention and decrease pressure on specialist services. [12]

110. During oral evidence, the AGS told the Committee that "one of the key drivers

through which the Government intends to enact change in mental health service provision to a more upstream preventative approach is by investment in primary care services". [6]

111. The AGS/AC report stated that the Scottish Government has committed to ensuring that every GP practice has access to a mental health and wellbeing service by 2026. As at March 2022, 45% of GP practices across Scotland reported having full access to mental health workers while 66% reported having full access to community link workers.

112. The AGS highlighted in oral evidence that these commitments are at risk "unless there is a clear pathway, through spending and workforce performance information, to get to that point". [6] The AGS further stated—

> ...there is a long way to go for the Government to deliver on its ambition to have that preventative primary care-based mental health service that is expected to deliver the results. [6]

113. During the first roundtable evidence session, SAMH explained that it provides a link worker in every GP practice in Aberdeen City, and the benefits of this form of support—

> We are there as a support system for individuals when mental health is a component of why they are sat in their GP surgery, although there may be other reasons, so the GP can send them down the corridor to us, and we have the time to listen to them, work out what would be the best supports for that individual and help them to reach those community assets. [1]

114. The National Association of Link Workers also explained during oral evidence the value of the link worker role—

> Link workers are in a unique position, because we are a community of people who have managed to be embedded in the clinical teams in some GP practices. We find ourselves acting as a very strong link between the community and the clinical services. [2]

115. In written evidence, Change Mental Health highlighted the importance of community link workers in providing local support to those in rural communities. It explained that establishing strong links with community link workers can help to broaden engagement and foster trust in 'hard-to-reach' communities, where there is a perceived lack of trust and representation between themselves and key health support agencies. The organisation also stated that the third sector—

> can play a key role in facilitating this trust, using local knowledge and individual expertise that is difficult to replicate within government health support agencies. [14]

116. The AGS/AC report highlighted that the Scottish Government's Emergency Budget Review (EBR) delayed progress towards increasing the number of mental health workers and link workers in primary care. This included a £65 million funding cut for improving primary care services and mental health funding by £38 million in 2022/23.

117. In oral evidence, SAMH highlighted its concerns regarding the delay to expanding the community link worker programme, stating—

> It is a great programme, but we are very concerned about its future, because the emergency budget cut £38 million from the mental health budget. As a result of that, there was a delay to mental health and wellbeing primary care services progression, which is of deep concern. [1]

118. The RCPsych highlighted its disappointment with regard to the funding cuts to the expansion of primary care mental health services—

> In Scotland, the aspiration was that we would expand significantly the provision of mental health specialists and third sector mental health provision within the primary care setting, with the expansion of multidisciplinary teams. That would include input from not only psychiatrists and psychologists but link workers and third sector partners. All that has been on hold since the cut to the budget that was announced in the emergency review in December last year, and that is a challenge. What I have described is a much needed resource. It can be provided, and we have a very good idea of how that can be done, but it needs new investment. [2]

119. The Committee sought to understand the impact of these funding cuts on the delivery of mental health services in Scotland with IJBs and HSCPs. During the third roundtable evidence session, Argyll and Bute IJB explained that implementing primary care changes for mental health has been particularly challenging—

> We have not been able to get coverage for every general practice, which was the ambition in the primary care improvement plan. Our intention was to build on existing services with new funding. The absence of that funding meant that we had to curtail our planning on ensuring that we have appropriate access to early intervention services across every general practice in Argyll and Bute. We are still committed to that, but we will need to work through how we do it with the delay in funding. [3]

120. East Ayrshire HSCP responded—

> Each general practice has some time from a mental health practitioner, but there is no buffer in the system, so if a mental health practitioner is off sick, needs to attend training or is on maternity leave, there is no cover. That means that that service can suddenly no longer be available at the primary care surgery for a person in the community who has built up a relationship with the mental health practitioner. We had hoped to consolidate and expand the service, but we can now no longer do so. [3]

121. East Ayrshire HSCP further added that despite funding cuts, it is working closely with its “vibrant third sector” to build its capacity within primary care—

> We have community link workers who have been developed through the third sector and are available across our communities. The pathway from community groups, community link workers and mental health practitioners into secondary care services is really important, but it is also really challenging. The capacity that we have built in primary care has taken some pressure off primary care mental health teams—our specialist teams—and community mental health teams, but those teams are still extremely busy. [3]

122. Scottish Borders HSCP explained that in anticipation of additional funding for primary care, it had planned to use this money to bridge the gaps in primary care in relation to—

- Young people, particularly those with anxiety disorders and depression
- People with neurodevelopmental disorders who need an assessment but do not necessarily have complex needs requiring secondary care
- People with emotionally unstable personality disorders, particularly in primary care, outwith secondary care services.

123. Scottish Borders HSCP further explained—

> The impact of not having the funding has been that our plans to bridge that gap have had to be held in abeyance….the impact on general practices is obvious, notwithstanding the impact on individuals themselves. [3]

124. During oral evidence, the RCPsych highlighted the importance of primary care workers stating—

> the challenges in the interface between primary and secondary care include the capacity for communication and the need for mental health expertise to be available within the primary care setting. That is a real challenge, because our primary and secondary care services tend to work with distinct boundaries, so it can be challenging when someone does not neatly fit within those boundaries. [2]

125. The RCPsych added—

> ...expanding the provision of mental health and wellbeing services in primary care would have gone a long way in addressing some of those challenges. That includes the initial challenge that was described regarding how people get access to specialist services, and access to advice in order to determine what the best service for them would be and what the alternatives would be if they do not meet the threshold for special services. [2]

126. On 21 November 2023, the Deputy First Minister wrote to the Finance and Public Administration Committee to provide an update on in-year budget changes. The letter stated that there would be a £29.9 million cut to Mental Health programmes under the Health and Social Care portfolio.

127. During oral evidence, the Scottish Government confirmed that in-year budget changes for 2023/24 has meant that it has—

> ...had to step back and pause a little on our commitment to spend more money on mental health workers in primary care. [4]

128. The AGS/AC report highlighted that in January 2022, the Scottish Government issued planning guidance to IJBs on developing mental health and wellbeing in primary care services (MHWPCS). The AGS/AC report further highlighted that a key part of this guidance, intended to set out how to measure and evaluate outcomes from MHWPCS, was expected to be published in April 2022 but had still not been published. The AGS/AC report explained why this part of the guidance is so important—

> it will allow data to be collected on how these services are improving people's mental health and whether they are supporting the aims of the General Medical Services contract to refocus GPs' roles as expert medical generalists. [12]

129. During oral evidence, the Accounts Commission confirmed that they had no further information as to when this part of the guidance will be published.

A slow and complicated process

130. The AGS/AC report concluded that accessing mental health and wellbeing services is slow and complicated for many people. SAMH reinforced this conclusion during the first roundtable evidence session stating—

> The pathways are confusing and people have to constantly repeat details of a deeply distressing situation because they have to provide that account each time that they meet a new health professional. [1]

131. The AGS/AC report further highlighted that onward referral to specialist services can be a slow process, with many people who need mental health support not meeting the thresholds for specialist services. VOX Scotland agreed with this conclusion during the first roundtable evidence session stating—

> A lot of our members report being told that they do not qualify and they are not eligible to have any support or access the service that they want access to because they are "too well"—they are coping too well, they are too able, they are able to do this or they are able to do that, they are not crying or they are not too upset, and so on, so they are told that they do not need access to the service. [1]

132. The National Association of Link Workers stated—

> There are those who have mental illnesses... and those whose state of mental health is a result of other issues that need not a clinical treatment but a non-clinical approach such as link workers provide... When people do not fit into any box, they just bounce around the system and the referral comes back to the GP, whereas link workers who are based in the community or in primary care might be able to pick them up. [2]

133. During oral evidence, the Committee heard about the approach being taken by

Angus HSCP to "move toward a model of mental health and wellbeing care, support and treatment with no wrong door and no rejected referral"—

> We have focused on developing mental health-enhanced community services. We have primary care, community mental health and substance abuse teams supporting that... In addition, we have wellbeing services, psychology and peer support workers. Everybody can self-refer, or they can be referred by their GP or other partners. We have taken a no-wrong-door approach and we do not reject referrals—we will find the right person. [3]

134. In follow up written evidence to the Committee, Angus HSCP outlined the benefits to patients of this enhanced community support model—

- "Evidence of quicker access to support, care and treatment
- Patient fully informed at all times with letter and phone calls to patients after receiving referral
- Not telling their "story" multiple times to different professionals
- Choice and better access and flexible use of a range of service.
- A person-centred approach to provision of care". [15]

135. East Ayrshire HSCP reinforced the importance of the "no wrong door approach" during oral evidence stating—

> a no-wrong-door approach is the key. That is where we need to get to, so that a person can come in, contact their GP practice, hopefully have a conversation with a mental health practitioner or a peer worker and, from there, be directed to the service that will best meet their needs. That should happen once and go smoothly, so that the person gets help sooner and we do not create an unnecessary administrative burden that ties people up. [3]

136. In written evidence, SAMH calls for the introduction of multi-agency triage so that people can be quickly assessed and connected to the right support, without the threat of rejection. SAMH further explains the benefit of this recommended change to the way things are currently operating—

> This would broaden traditional referral and assessment routes beyond statutory assessment practices (from primary care to secondary mental health services) and ensure the full scope of community wellbeing assets are embedded and utilised when someone first tries to get support for their mental health. [16]

137. During oral evidence, the Committee sought to understand how the Scottish Government is responding to the AGS/AC report's conclusion that accessing support and services is "slow and complicated". The Chief Executive of NHS Scotland explained that the Scottish Government has been "investing in and supporting services in relation to avoiding mental health issues and in relation to early intervention." [4] Examples cited of investment in early intervention included—

- The distress brief interventions model, highlighted earlier in this report.

- Support to local authorities to ensure counselling services are provided in all secondary schools.
- NHS 24's mental health hub, which is takes around 2,500 calls a week. Digital services, for example computerised cognitive behavioural therapy.

138. The Chief Executive of NHS Scotland further highlighted that the Scottish Government has "invested a lot in trying to improve access while making sure that access is available in various ways, because it is not a one-type-suits all situation." [4]

139. While recognising the importance of early intervention during oral evidence, the RCPsych stated that this should not be at the expense of specialist services—

> There needs to be a focus on prevention but not at the cost of investing in specialist services as well. It is not an either/or model. It is a bit like saying, "We'll invest in smoking cessation, but we don't need to worry about cancer services."… Sometimes these conversations get simplified into an all-or-nothing position: that somehow, if we invest early, and invest in prevention, we will not have mental illness. That is not the case. [2]

The 24/7 person-centred model of mental healthcare

140. The Committee explored whether lessons could be learned from the person-centred model of healthcare used in Trieste, highlighted in the AGS/AC report. The main point of entry into mental health services in Trieste is through a network of community mental health centres, operating 24 hours a day where mental health support is available for anyone who asks for it, with no waiting lists or referral criteria.

141. During oral evidence, the Committee heard about the importance of having access to support at different times of the day. During oral evidence, VOX Scotland stated—

> People say that although crisis support is something that is really needed at the weekends and during the night, they cannot access it when they need it. [1]

142. Young Scot also highlighted the importance of out of hours support—

> In the survey work that we have done, young people have flagged up to us that such services are sometimes available only during business hours, when they are at school or in employment. [1]

143. During oral evidence, Chris's House outlined their support for the Trieste model stating—

> I have based Chris's House on the principle that anyone in crisis can access mental health services at any time, 24 hours a day, seven days a week, 365 days a year.[2]

144. Penumbra Mental Health further highlighted the benefits of the Trieste model, stating that "earlier intervention in crisis will always be more cost effective."[2] The RCPsych further recognised the merits of the Trieste model, stating that it is what guided the shift to community mental health in Scotland. However, it highlights—

> Unfortunately, it is a job half done. We made the shift, we shut the asylums and we have moved into the community—but then we kind of lost interest.[2]

145. The Committee also heard about the challenges of implementing the Trieste model in Scotland. During oral evidence, COSLA stated—

> My first question would be about how it would work if you were to try to scale it up. It might work very well in a city centre where there might be a lot of drop-ins and it was sustainable. However, it might be more difficult to manage in a rural setting, where fewer people might come in.[3]

146. The Scottish Borders HSCP agreed with the concerns raised about how the model could be replicated in rural settings, stating during oral evidence—

> We looked at that a few years ago, and it is really interesting. I agree with the previous witness that you would not be able to replicate that across a rural area. We have five localities, and most people—60 per cent of the population—live in the central belt, where there are two big communities. That is a limiting factor, but the principle is around a walk-in service without stigma, if you can avoid it.[3]

147. Reflecting on the "walk-in" approach to seeking help for your mental health, the Scottish Borders HSCP also recognised the potential for change in how health centres currently operate—

> Generally, everyone goes to their GP. Perhaps we need to develop some of those into wellbeing centres rather than health centres. Is it more about health and social care and those centres becoming more of a community hub? That is certainly a route to go down, particularly in rural areas; indeed, I do not see why it could not be looked at in all areas.[3]

148. During oral evidence, Penumbra Mental Health highlighted two physical walk-in mental health crisis services where it provides support; NHS Lothian (Edinburgh crisis centre) and NHS Tayside (Hope Point community wellbeing support centre in Dundee). In terms of this form of support, they further highlighted that while there are "some areas of good work out there…they are few and far between."[2]

149. The Committee sought the Scottish Government's views on whether the Trieste model is an appropriate model for Scotland. The Principal Medical Officer, Mental Health Division responded—

> Yes, although there is a "but", as you might expect. We have to see it in context. Trieste is a city with 200,000 people. It had a mental health hospital that had 2,500 beds. The changes were made at a time when there was a radical political leadership together with a visionary clinical leadership, and they were able to do something that other places have simply not been able to do. They closed 95 per cent of their beds at a swipe.[4]

150. The Principal Medical Officer further highlighted that the Trieste model could not work without it being place based, where people can go to a community hub. Through the expansion of digital mental health services, the Principal Medical Officer recognised that there is scope to consider "virtual hubs", complemented by people accessing face-to-face help."[4]

151. During oral evidence, Police Scotland stated that until mental health services are available 24/7, the police "will continue to fill that gap."[2] When asked about the provision of services that the police can refer people to at any time of day, the Principal Medical Officer stated—

> We already have that with the mental health hub, whereby there is an opportunity to refer someone on to local services that function 24/7. However, it is about taking that further so that it is not just a phone line. In many places, community psychiatric nurses are involved in working directly with the police on triage. We are looking to develop all those models where we can.[4]

152. Chris's House stressed the importance of universal access to support whenever people need it during oral evidence—

> Everyone needs to have access to a service when they are in crisis. People are not in crisis in three weeks' time or in two days' time. We do not organise crisis; it happens when it happens, and people have to be attended to.[2]

Remote and in-person appointments

153. The AGS/AC report highlighted that during the Covid-19 pandemic, face-to-face support was offered "only where clinically necessary". It referred to surveys undertaken by SAMH which concluded that there had been a widespread loss of face-to-face support during the pandemic and that most mental health support was still being provided remotely.

154. The AGS/AC report also stated that remote options have increased access to mental health services and self-help resources. However, not all NHS boards routinely offer face-to-face appointments as a choice. During the first roundtable evidence session, VOX Scotland confirmed this position—

> some members might prefer virtual appointments as that might help them, but a lot would prefer face-to-face, and they might not be getting that choice. People do not feel that they have agency and choice in the treatment that they are receiving.[1]

155. During oral evidence, Young Scot highlighted a preference for in-person appointments with a trusted adult amongst young people, stating that—

> face-to-face appointments continue to be young people's preference in terms of access and support….there is a big misconception that, because young people spend a bit more of their time online, they are able to use these digital spaces to access appropriate support. However, going on TikTok is not the same as knowing where to find and how to use a mental health support too.[1]

156. SAMH further added during oral evidence that there is "a clear preference for face-to-face support"[1] for people who already have some experience of mental health care and support.

157. During oral evidence, the Committee also heard about the benefits of remote services. For example, the MHF stated—

> I have seen evidence that such a choice has led to people who have never asked for mental health support coming forward for it. I have heard that, for parents of young children, the ability to get support at home instead of having to organise their infant in order to get out the door for it might be the difference between their getting help and not getting help. Moreover, for communities and people who still have a high sense of stigma around seeking help—indeed, men and older people still feel some stigma around seeking help for mental health—we think that the digital option could be important in enabling those people to access support that they might otherwise not go near.[1]

158. The RCGPS also highlighted the benefits of remote services—

> Videoconferencing works really well for some people because they can interact with services without missing large amounts of their time in employment or giving up some of their caring responsibilities.[2]

159. NHS Borders HSCP highlighted the positive impact of its talking therapies service, which is predominantly provided online—

> The feedback and the outcomes that we get are very good, both from the commissioners—the GPs—and the people who access the service. We are a rural service in an area with no major cities, so it is a geographical challenge for people to travel and access services. Moreover, as a small board, we tend to get a small amount of funding for various initiatives, so it is about the practicality of being able to provide a service that allows access for the majority.[3]

160. NHS Lothian also outlined how it was using remote services to provide support to people for their mental health—

> For psychological therapies, we also have a number of online platforms that people can use for cognitive behavioural therapy and so on, so we are embracing the online option where possible. The feedback is positive, especially from children.[3]

161. NHS Highland explained the benefits of providing remote services, including how it has co-produced services with people who use them—

> 58 per cent of NHS Highland appointments for psychological therapies take place online. That has been a really positive experience. We measured people's experience in that regard, but we also engaged with them on the services that we are able to deliver within our financial envelope and how to make them sustainable…One of the ways to engage them was to talk about waiting times and how we could modify and redesign our service to get them to be seen more quickly.[3]

162. The AGS/AC report showed a significant variation among health boards in the number of face-to-face appointments versus telephone or video appointments for psychological therapy. For example, the Committee noted that in NHS Ayrshire and Arran, 86% of psychological therapy appointments are face to face compared to just 32% in NHS Lanarkshire despite having similar population demographics.

163. The RCGPS provided its insight into this variation, stating—

> Many primary care practices are in very limited premises that cannot house all the members of staff, especially where we have been trying to transform primary care and bring in an expanded multidisciplinary team. There are also differences in preference. It would be interesting to map that activity to patient preference and experience, as well as to clinician preference. Even with our current information technologies, we are not doing a good job in mapping who has a preference for taking an appointment as a phone call or video call.[2]

164. The Scottish Borders HSCP also offered its perspective on the variability of face-to-face appointments stating—

> Resources being committed to that area of activity must be one of the big reasons for that, because it is more resource intensive to offer predominantly face-to-face appointments…That is my assumption, without seeing the investment figures for those areas.[3]

165. During oral evidence, the Committee asked Public Health Scotland whether it investigated the reasons for the variability. They responded—

> We have staff who interact quite a lot with the boards, and they tend to understand the reasons why those variations exist. However, I do not think that there is anything in particular that you can latch on to. It is a combination of, for example, resources, people's deprivation and the availability of public transport or parking.[3]

166. Angus HSCP highlighted during oral evidence that while data is available for remote consultations, it does not—

> take into account the levels that are offered. It might be that a high number of remote consultations have been offered and that it is purely about uptake rather than the availability of a face-to-face appointment as an option. We could, perhaps, consider looking into the information behind that, as well.[3]

167. The Scottish Government and COSLA's Digital Health and Care Strategy states that people will not be forced to use a digital service if it is not right for them. The AGS/AC report recommended that the Scottish Government, NHS boards and others who provide services must ensure that people are routinely given a choice about whether they access services remotely or in-person.

168. In response to a question on the extent to which people have a choice in the type of support that they receive, a VOX Scotland member, who also represents the Royal Edinburgh Hospital Patients Council, told the Committee—

> In response to your question whether people have a choice, no, they do not—there is coercion. Our end of the mental health system relies on coercion, which is a human rights violation. By definition, many people in the psychiatric hospitals have not chosen to be there and do not have a choice about the treatment that they receive. Their voice is basically irrelevant. What they want does not really matter at all. There is no choice in the system for many of its most disabled users.[1]

169. During oral evidence, the Committee asked the Chief Executive of NHS Scotland whether the Scottish Government was committed to giving people a choice in how they access services so that no one is forced to use a digital service. They responded—

> Digital services have huge benefits and many people find that they are very comfortable with them. Our satisfaction rates with computerised cognitive behavioural therapy, for example, are very high, at about 83 per cent. It works really well for some people by allowing them to quickly access help and support, but it will never be something that everybody wants.[4]

170. The Chief Executive of NHS Scotland also recognised during oral evidence that some people are digitally excluded, and that some demographics are not as comfortable with using digital as others, meaning that the provision of face-to-face services always needs to be available. They further added—

> …if people are comfortable with digital services and find them helpful, that takes pressure off face-to-face services, so it is a really valuable resource for us and for people. [4]

171. Seeking further reassurance that people will always have a choice in the type of support that they receive, the Chief Executive of NHS Scotland reinforced the Scottish Government's commitment in this regard.

Awareness of services

172. The AGS/AC report highlighted that the awareness of support, such as primary care mental health services, in addition to third sector services and peer support, varies across Scotland.

173. During oral evidence, the National Association of Link Workers confirmed that people "are not very aware" [2] of the community link worker role. It also highlighted

the need for a national campaign to raise awareness of the support that can be provided by community link workers.

Peer support

174. The Committee heard specifically about the value of peer support as a way people can get help for their mental health through its scrutiny of the AGS/AC report. A VOX Scotland member stated—

> We might be empowering professional groups very well—psychiatry and psychology are very well empowered—but I do not know whether we are empowering people to get into mutual aid and to support their own mental health. A paradigm shift towards much more social funding might be what our members would like to see.[1]

175. During this same roundtable evidence session, MHF agreed that peer support is often what can help people in their mental health journey stating—

> That means spending time with others and being given opportunities to connect with other people who are in a similar situation…Peer support is not meant to be a replacement for important clinical services that people need. However, a vast quantity of mental distress cases involve people with mild to moderate mental health difficulties, and, for situations of that kind, it is possible that peer support can play an important role.[1]

176. In its written submission, Angus HSCP highlighted that using Action 15 and Primary Care Improvement funding, mental health and wellbeing peer workers have been available in every GP practice in Angus since 2020. The submission provided further details about how this form of support operates—

> The peer model provides access to appointments within 2 weeks in a person's local area, and most initial appointments are within 3 days. The peer worker role is vital in Angus, offering a unique and empowering perspective, and their early intervention is often based on only a few words in a self-referral. During appointments, peers share a range of coping strategies they have used personally or which they have been trained to deliver. The peers offer up to three support sessions, and support access to a range of online and local community resources, to meet ongoing need.[15]

177. The Committee notes that the Mental Health and Wellbeing Delivery Plan, published in November 2023, includes the following strategic action—

> **Strategic Action 2.3:** Recognising the important role that people with lived experience can play as part of the mental health workforce, to improve mental health, we will champion the value of peer support across a range of settings.[17]

178. The Delivery Plan includes a specific action to—

> Work with partners to further understand the enablers and barriers to developing peer support in mental health and identify how it can be appropriately integrated into supports and services. As part of this, we will explore how peer support can be further developed as an approach to supporting people with their mental health from prevention to recovery. [17]

179. While recognising the Scottish Government's commitments to enhancing learning and capacity around peer support in both the Mental Health and Wellbeing Strategy and the accompanying delivery plan, in its written submission to the Committee, SAMH highlights that "there are no clear resource commitments." [16] It therefore calls for "a national peer workforce target and clearer commitments to expand peer support infrastructure".

Signposting to local support

180. The Poverty Alliance highlighted the benefits of community-based responses in supporting people with lower levels of mental distress—

> We have seen members of ours—for example, the Scottish Professional Football League Trust—working with grass-roots community football clubs and trusts that are associated with football clubs. They have been a real driving force in tackling social isolation, particularly—but not only—for men, and in addressing mental ill health through that means. [1]

181. During evidence, the Committee sought to explore the extent to which GPs are aware of more local forms of community-based activities and peer support groups. SAMH responded—

> I suspect that the answer is no. Many years ago, there was an attempt to gather up all that intelligence. I cannot remember the name of the system, but it was populated with lots of those programmes, supports and interventions and made available to GPs so that they would be more knowledgeable about what was going on in their area. However, sadly, the system got very tired very quickly because funding cycles mean that things go as quickly as they are set up, so that is a real challenge. [1]

182. COSLA further stated that GPs need more knowledge of and confidence in the services that are available and the stability of the funding for these services—

> Funds for third sector organisations and local authority services are unstable. It is not just mental health provision that link workers need to refer people to; we are talking again about the wider determinants around employability and poverty. Funding in that area is being constantly cut back. Those services are very important. GPs need to be able to refer confidently to services that exist. [3]

183. East Ayrshire HSCP highlighted that while there are many forms of supports available to people—

> There is a challenge in making sure that people are aware of that in keeping service directories up to date and promoting those services. We find that our community link workers and mental health practitioners are key to that. If they are informed and know what is available, they are the link person who moves that information and the people towards those new services.[3]

184. During oral evidence, the Scottish Government's Deputy Director, Improving Mental Health Services highlighted work it has undertaken to raise awareness of available services—

> Guidance on available support was issued to primary care last year, and we will continue to look at that. If it needs to be updated or we need to recirculate it to make sure that GPs are aware of it, we will try to do that.[4]

Fragmented adult mental health services

185. The AGS/AC report concluded that adult mental health services are fragmented, making it more difficult to develop person-centred services. It highlighted that there are multiple organisations involved in planning, funding and providing adult mental health services, including IJBs, HSCPs, NHS boards, councils and third sector organisations. The report therefore highlighted challenges that can arise from this fragmented structure, making it more difficult to develop and provide person-centred services.

186. During oral evidence, the Committee explored how the structure of adult mental health services is currently operating. The RCPsych responded—

> The move to integration has, more than anything else, meant nothing but fragmentation for the area of mental health. There has been duplication of governance structures, and a lack of co-ordination and planning as result of a lack of clarity about responsibility between integration joint boards, HSCPs and boards. In most cases, it is felt that mental health has come as an afterthought.[2]

187. In response to these concerns, the Chief Executive of NHS Scotland stated—

> I assure the committee that mental health is absolutely not an afterthought…we include the mental health priority objectives in our annual delivery plan guidance for NHS boards, and, when we meet NHS boards to complete their performance reviews, which we do regularly, we include folk from the mental health team so that we look not just at performance in urgent and unscheduled care, planned care and cancer but at how boards are doing in mental health.[4]

188. The Scottish Government's Principal Medical Officer, Mental Health Division acknowledged some of the RCPysch's concerns stating–

> In the past while, there has been a huge focus in the interaction between Government and local systems around the psychological therapies and CAMHS waiting times initiatives. That might have led to a perception that adult services were getting less focus and attention. As we have moved into the current process with the mental health and wellbeing strategy that has been published, the delivery plan and the publication of the core mental health standards, we are very much trying to rebalance the thinking in the system.[4]

Role and accountability of IJBs

189. The AGS/AC report highlighted that the Scottish Government lacks oversight of most adult mental health services, meaning that there is limited transparency and accountability for how they are performing. It further stated that the Scottish Government holds NHS boards accountable for psychological therapies waiting times performance, despite IJBs being responsible for planning, funding and overseeing the provision of these services, and managed operationally by HSCPs.

190. During oral evidence, the AGS provided further detail on the accountability arrangements for IJB as regards the funding for adult mental health services—

> Although the funding is commissioned through to the IJBs, accountability with regard to the Scottish Government's funding direction still seems to rest with the health boards. That needs to be resolved if IJBs are to be an effective pillar in relation to how public spending can be delivered more effectively.[6]

191. The Accounts Commission explained how IJBs are funded, and the particular challenges associated with this approach—

> IJBs are not funded directly; their funding comes from the local authorities and the NHS boards, and it has to trickle through into their commissioned services. Therein lies another difficult problem, because IJBs, in working to commission services on an annual budget, need to look ahead three to five years. When we audit councils and IJBs, we ask them for medium and long-term financial planning, but they have to do that with an annual dollop of money.[6]

192. The Committee asked how IJB accountability and transparency could be improved during oral evidence. Argyll and Bute IJB, representing the IJB chief officer network responded—

> I suggest that, rather than IJBs being deficient, we should perhaps challenge the structure that set them up. IJBs work to the parliamentary act that legislated on the arrangements that you describe, so it might be slightly unfair to say that they are deficient in operating to the legislation as it was written.[3]

193. Scottish Borders HSCP agreed that there have been challenges associated with the structure, as set out in the relevant legislation. However, it also highlighted that progress has been made as regards the accountability of IJBs—

> When the IJB first came into being, it was basically made accountable for everything that was going wrong locally. The health board would say, "It is the IJB", and the council would say, "It is the IJB", or they would say that it was each other… We are, collectively, taking more responsibility for the problems and the solutions, irrespective of whether it is predominantly a social care problem or a healthcare problem.[3]

194. East Ayrshire HSCP also provided an example of how integration is working in practice—

> we are piloting an approach that we call "the Tuesday morning". The police, mental health services, addictions services, housing and the third sector get together on a Tuesday morning, and we talk about our 15 most vulnerable people who, across those agencies, we are all worried about and watching very intently. We decide who is best placed to try to engage with each of those 15 people that week, given the scenario that they are in that particular week. Because we do that together, we have greater flexibility in those various departments.[3]

195. In response to the question of what needs to change to improve IJB accountability, Scottish Borders HSCP stated—

> We are up against it with the whole design, where we have the health board, the council and the IJB…Where there is more than one budget, there will be a problem. It comes down to that fundamental structural problem that we have around budgets and the two organisations. That is a personal view. As an integrated manager, those are the sorts of problems that I have had to deal with all the time over the years. I have to go to the council, the health board and the IJB to explain something. It is almost as if a third party has come in that I have to negotiate with. That has moved on quite a bit locally, but it is a challenge that is inherently there all the time.[3]

196. The Committee asked the Scottish Government during oral evidence whether it had any plans to review the governance arrangements for IJBs. The Chief Executive of NHS Scotland responded—

> the committee will be aware that we have been working with COSLA on the development of the national care service, which is intended to create far more consistency and to address some of the governance barriers to delivering primary care services in communities, primary care and the acute sector.[4]

197. **The Committee recognises the key role that GPs play in supporting people with their mental health. We are concerned however that having to first explain their medical symptoms to a receptionist may deter some people from approaching their GP for help. We suggest that the Scottish Government works with NHS Health Boards to develop guidance for GP practices setting out options that can be used to support people wishing to make a GP appointment for their mental health.**

198. **While there are many forms of local support available to people seeking help for their mental health, we heard that those working in primary care services, including GPs, are not always aware of them. The Committee encourages the Scottish Government to review its guidance on available support, issued to primary care last year, and update it as necessary to ensure that it remains a reliable and up to date source of information.**

199. **We welcome the Scottish Government's ambition to achieve a more preventative primary care-based adult mental health service and its commitment to ensure that every GP practice has access to a mental health and wellbeing service by 2026. The Committee seeks the Scottish Government's assurances that it will provide sufficient funding to ensure greater progress is made against these commitments.**

200. **The Committee welcomes the Scottish Government's stated commitment to ensuring that people have a choice in the way in which they access services, whether that be digitally or in-person. We are concerned however, that not everyone who prefers face-to-face support is receiving it. The Committee also notes the significant variation among health boards in the number of face-to-face appointments versus remote appointments for psychological therapy. We recommend that the Scottish Government explores in more detail what is driving this variability and to report its findings to the Committee as soon as possible.**

201. **The Committee heard mixed views about the merits of the Trieste model of mental healthcare. We invite the Scottish Government to further consider the lessons that can be learned from this 24/7 person-centred form of support, particularly in relation to the development of 24-hour walk-in services, including how this approach could work in rural areas. The Committee recommends the Scottish Government makes its findings public.**

202. **The Committee recognises the benefits of peer-support and notes that there is scope to expand this form of support. The Committee echoes SAMH's call for the Scottish Government to set a national peer workforce target and set out clearer commitments to expand peer support infrastructure.**

203. **The Committee also recognises the vital role that community link workers play in supporting people with their mental health. The Committee notes the suggestion made by the National Association of Link Workers for a national campaign to raise awareness of the support that can be provided**

by community link workers. The Committee recommends that the Scottish Government takes this forward.

204. **The Committee is concerned at the evidence heard regarding the limited oversight, transparency and accountability in relation to the performance of adult mental health services. We note the Scottish Government's plans for reform of governance structures through the National Care Service (Scotland) Bill and asks for information on how it will ensure greater accountability in relation to adult mental health care through this process.**

Mental health inequalities

205. The AGS/AC report highlighted that mental health inequality is a long-standing problem, and that progress to address this issue has been slow. It further stated that inequalities in mental health often arise because of inequalities in society.

206. The report also explained that accessing mental health services is more difficult for some groups than others, for example people living in rural communities, people from ethnic minorities, and people living in poverty. Indeed, those living in the most deprived areas are three times more likely to end up in hospital due to mental health issues than those living in the least deprived areas.

207. The AGS/AC report stated that mental health inequalities have been made worse by the Covid-19 pandemic and the cost-of-living crisis. The MHF agreed with this conclusion, reporting that the cost-of-living crisis could have a negative effect on mental health on a similar scale to the Covid-19 pandemic.

208. In oral evidence, the MHF also highlighted the challenges and experiences of those from minority ethnic communities—

> There are significant problems with people from minority ethnic communities knowing where to go for help and how to navigate the system. However, we also heard that, when those people come into contact with the system, they are often met with a very white ethnocentric service that does not properly recognise the way that their community talks about and understands mental health and the appropriate way to respond within that community.[1]

209. This view was shared by the International Women's Group and BEMIS, who told the Committee that while the Scottish Government acknowledges the existence of mental health inequality among ethnic minorities, there is a lack of culturally appropriate services available. It was also highlighted that people from ethnic minorities often experience a language barrier when attempting to access mental health services.

210. The MHF further highlighted during oral evidence that lone parents are an "at risk group" stating—

> Not only do they experience isolation just from the process of being a lone parent but they are much more likely to live in poverty—they are at higher risk of having low income.[1]

211. The MHF stated that while a perinatal mental health service exists for lone parents who have severe mental health problems, there is no such provision for new lone parents with mild and moderate mental health problems.

212. The Committee also heard about the challenges that people living in rural communities face when seeking help for their mental health. For example, VOX Scotland told the Committee that—

> …a lot of our members in rural areas report that it is extremely difficult to get an appointment with psychiatry, a community psychiatric nurse or a psychologist, because there are no staff in their area to give them one. People are willing to travel, but it is difficult for them to afford that, and transport arrangements are not in place for them to attend appointments that they would like to attend elsewhere.[1]

213. The Poverty Alliance further highlighted that a lack of transport in rural areas can prevent people accessing the support they need—

> For a number of organisations that are based in rural parts of Scotland, there are real problems with people finding accessible transport to allow them to engage with services. That acts as a barrier to people receiving the help that they need.[1]

214. In written evidence, Change Mental Health noted that there are "key structural issues facing those in rural communities when accessing mental health services", including poor public transport infrastructure which is both a cause of social isolation, contributing to poor mental health, and also a specific barrier to accessing mental health services.[14]

215. The AGS/AC report also highlighted that younger people are more likely to experience anxiety, with around 22% of people aged between 25-34 reporting at least two symptoms of anxiety. In oral evidence, Young Scot provided further information about the mental health and emotional wellbeing of young people—

> We did survey insight with the older demographic of 12 to 25-year-olds, of which around 35 per cent were over 18, and almost half of those reported that they did not feel good about their mental health and wellbeing. As you said, it is an issue that young people deal with.[1]

216. In terms of accessing services, Young Scot highlighted the importance of privacy, trust and confidentiality to young people in addition to "physically being able to access services, transport, affordability and timing of when services are available for young people to access."[1]

217. Referring to its "Thriving Learners" study, the MHF highlighted that there was a clear link between lower levels of mental wellbeing among the students who participated in the study and food insecurity—

> Lots of things in young people's lives might negatively affect their mental health, but we often forget the reality that many young people today struggle to have enough money in order to eat and have adequate shelter. That financial stress further exacerbates young people's mental health issues.[1]

Scottish Government action

218. The AGS/AC report highlighted that the Scottish Government recognises the importance of addressing mental health inequalities, "but the impact of its commitments is not always clear". To illustrate this point, Audit Scotland cited during

oral evidence the example of the Scottish Government's Mental Health Transition and Recovery plan, published in October 2020, which recognised inequalities as a significant issue. However, the plan did not provide timescales for the actions relating to tackling inequalities, and no review of the plan's progress has been carried out.

219. Audit Scotland also highlighted in oral evidence that while the Mental Health and Wellbeing Strategy has a significant focus on addressing inequalities, there is very little detail about how it will tackle inequalities. Audit Scotland said that it hopes the Mental Health and Wellbeing Delivery Plan would include this information.

220. The Mental Health and Wellbeing Delivery Plan was published in November 2023. In oral evidence to the Committee, the MHF told the Committee that—

> …we cannot see any specific action in the delivery plan to deliver culturally sensitive mental health services. That is a significant concern. [1]

221. In oral evidence, the Committee asked the Scottish Government why the delivery plan did not include this specific action. The Chief Executive of NHS Scotland responded that the Scottish Government worked with equalities groups to develop the delivery plan. The Scottish Government's Deputy Director, Improving Mental Health Services, added—

> Through our engagement with the boards and through the annual delivery planning process, we ask what boards are doing on equalities to meet the needs of different groups. We do that not only on mental health, but across the board. We are setting the policy intent, but the boards that are delivering the services need to get into that level of detail. [4]

222. The Chief Executive of NHS Scotland went on to reinforce the point that it is the responsibility of local systems to assess the needs of their populations, and "take into account the clear inequalities across the system to determine how they best take forward the actions that are in the plan." [4]

223. It was noted that the Scottish Government is working with Public Health Scotland to gather data to help address inequalities. It was further explained during oral evidence that this information is being used to engage with health boards and councils to ensure that "they are delivering for the groups they need to deliver for." [4]

224. In oral evidence, the MHF raised further concerns about the Mental Health and Wellbeing Delivery Plan, stating it is—

> still relatively vague on how Government departments beyond the Mental Health Directorate and beyond NHS mental health services will be involved in taking action on mental health. [1]

225. The MHF suggested a particular action the Scottish Government could take during oral evidence to improve mental health inequalities—

> One of the best ways of reducing mental health inequalities would be to require every Government decision to be assessed on its impact on mental health. In other words, any decision on, say, social security, transport, housing, investment in community spaces and so on that was taken by the Government would be assessed on its mental health impact.[1]

226. SAMH agreed with this suggestion during oral evidence stating—

> I whole-heartedly agree with everything that Shari McDaid just said about the cross-Government opportunity. The delivery plan that was published earlier this week is vague on that. Something like 80 national policies are listed at the back of that delivery plan, but there is no sense of how we are going to make that a reality.[1]

227. The Committee asked the Chief Executive of NHS Scotland whether an assessment of the impact on mental health of all Government decision making is a measure the Scottish Government would be willing to explore. They responded—

> We could explore that proposal, absolutely. As I said in an earlier answer, mental health and mental distress are not just for the health and social care portfolio. The factors that impact on mental health run across all sectors of society, including the areas where Government has an opportunity to intervene, so we would need to consider the issue in relation to decision making across Government.[4]

Funding to address mental health inequalities

228. The AGS/AC report highlighted that the Scottish Government's Mental Health Transition and Recovery Plan (MHTRP), published in October 2020, aims to tackle inequalities through actions targeting employment, socio-economic inequalities and women and girls' mental health. In 2021/22, the Scottish Government allocated £21 million, through the Communities Mental Health and Wellbeing Fund (CMHWF), to support some of the aims of the MHTRP. A further £15 million was allocated in 2022/23 and £15 million for 2023/24.

229. In response to the question of whether funding has been appropriately targeted to address mental health inequalities, SAMH referred to the CMHWF, stating that while it is welcome, it is funded on an annual basis which limits its effectiveness.

230. During oral evidence, the International Women's Group and BEMIS highlighted that they have received high levels of demand following the creation of bilingual services such as a counsellor who speaks both Arabic and English. However, due to funding challenges, they have been unable to offer services in other languages. They further explained that as they have only received two years of funding for this service, they will be unable to continue the project.

231. The Committee sought to establish what should be done to more effectively target spend to reduce mental health inequalities. Young Scot expressed support for a whole-system approach to tackling mental health inequalities, describing the current

focus as a "sticking plaster approach", [1] and suggesting that the focus should instead be on asking what could be done further upstream on early and effective intervention.

232. In noting that the Scottish Government's Emergency Budget Review cut mental health funding by £38 million in 2022/23, while in-year budget revisions decreased the 2023/24 Mental Health Directorate's budget by almost £30 million, the Committee asked the Scottish Government what impact this will have on marginalised communities. The Principal Medical Officer responded—

> work on which we have been able to make new investment—particularly through the community mental health and wellbeing fund for adults, which is mostly landing in the third sector— has been specifically targeted towards inequalities and the relevant groups, which have been asked to look specifically at additional services and additional supports as a priority. Inequalities have been at the forefront of work on making changes around earlier intervention and prevention. [4]

233. A VOX Scotland member also suggested to the Committee that more investment in the NHS would not necessarily lead to more people from black and minority ethnic communities having access to mental health services.

A whole system approach

234. The AGS/AC report concluded that mental health services cannot address mental health inequalities alone. It also acknowledged that Scottish Government and COSLA's Mental Health and Wellbeing strategy recognises the importance of a whole-system approach and provides a foundation for better joint working.

235. During oral evidence, The Poverty Alliance highlighted that reducing mental health inequalities "largely lie outside the mental health system" [1] and provided several examples of areas which could be prioritised to reduce mental health inequalities including—

- Ensuring Scottish Government policies and strategies are aligned to efforts to reduce mental health inequalities.
- Fostering a wellbeing economy, where issues relating to how the labour market operates, the security of contracts, the stability of work and the number of hours people work all contribute to reducing mental health inequalities
- Prioritising housing to address mental health inequalities resulting from homelessness and insecure accommodation.

236. When asked to provide examples of what the Scottish Government is doing to take a whole-system approach to tackling poor mental health, the Chief Executive of NHS Scotland cited the community wealth building model, whereby health boards act as "anchor institutions", which involves—

> considering how they can support employment in their local communities, use the money that they use to buy goods and services—their procurement—to grow wealth in local communities, and use their estate in their contribution to the green agenda. Although there are things for which we do not have the levers, there are also ways in which we can ensure that we make best use of the money that we already spend to help to drive wealth building in local communities.[4]

237. They also explained that many policies set out in the policy prospectus and in mandate letters to the Cabinet Secretary are focused on tackling inequalities and poverty, and that—

> All those policies contribute to alleviating some of the economic conditions that influence not just poor mental health but poor physical health. Although they are levers for the broader Scottish Government, the health and social care system can make a huge contribution.[4]

238. **The Committee welcomes the Scottish Government's commitment to addressing mental health inequalities. However, the evidence we heard highlights that the Mental Health Transition and Recovery plan (MHTRP) lacked timescales and its progress has not been reviewed. We also heard that detail on specific actions is missing from the Mental Health and Wellbeing Strategy and associated delivery plan. We recommend that a review is carried out of progress being made against the MHTRP. This review should also consider where best to set out further detail on the specific actions the Scottish Government will take to address mental health inequalities and the timetable for delivering these actions.**

239. **One area of particular concern for the Committee is a reported lack of culturally appropriate services for minority ethnic communities seeking help for their mental health. We ask the Scottish Government to set out the steps it is taking to address this reported omission.**

240. **The Committee further shares the concerns raised by the Mental Health Foundation that there is currently a lack of provision for new lone parents with mild and moderate mental health problems. We recommend that the Scottish Government urgently undertakes an audit of the support currently available for this at-risk group and identify how any gaps in provision will be addressed.**

241. **The Committee considers that a whole-of-government approach is essential to ensure progress in addressing mental health inequalities. We heard that one way of doing this could be to require every Government decision to be assessed on its impact on mental health. The Committee invites the**

Scottish Government to consider how it can best support a whole-of-government approach to tackling this important issue.

Data and outcomes

Lack of oversight

242. The AGS/AC report concluded that while funding for adult mental health services has increased significantly since 2017, a lack of data makes it difficult to identify the impact of this increase in spending. It further concluded that the Scottish Government "does not have sufficient oversight of most mental health services because of a lack of information". [12]

243. Incomplete and poor-quality data is a long-running concern for the Public Audit Committee. The Session 5 Public Audit and Post-Legislative (PAPLS) Committee concluded in its Key audit themes report, published in September 2019, that—

- A number of audit reports it had scrutinised revealed that key policy developments were not underpinned by basic data. This meant that it was not possible for the Committee to know with any accuracy how much was being spent on these key areas of public service provision which the Committee considered unacceptable.
- The collection of data has become ever more important given its potential to assist public bodies to identify where productivity and efficiency savings can be identified and subsequently implemented.

244. The PAPLS Committee also raised concerns in its key audit themes report that a number of audit reports it had scrutinised revealed that—

> Data on outcomes in relation to key service provision was incomplete or absent…This lack of data meant that the Committee could not be reassured that public funds were being spent wisely or whether such policies were making a difference to service users and their families. [18]

245. In this current Session of Parliament, the Public Audit Committee has considered a number of reports raising similar significant concerns with regard to the issue of data gaps including Planning for skills , Community Justice: Sustainable alternatives to custody , Tacking child poverty and Early learning and childcare Progress on delivery of the 1,140 hours expansion.

246. The AGS/AC report highlighted that the only national performance measure of adult mental health services is waiting times for psychological therapies. It therefore concluded that "insufficient focus is given to the wide range of mental health support and services that people with mental health problems rely on". [12]

247. During oral evidence, SAMH highlighted that it has been calling for a long time for the need to understand the effective use of the mental health budget, stating—

> The fact that we only measure things by waiting time targets on a quarterly basis is just not good enough. [1]

248. During oral evidence, the RCPsych also raised concerns about the focus on

measuring psychological therapies, particularly as "it accounts for less than 10 per cent of total mental health service activity"—

> What we do not know is how long someone might need to wait when they are in crisis; how long they might need to wait if they need admission to a hospital bed; or how many people have died while waiting for admission to a hospital bed. We have no idea about any of those metrics, and there is an overwhelming focus on psychological therapy targets to the exclusion of all other clinical priorities.[2]

249. The RCPsych further explained—

> To really understand what is happening in our services, we need a suite of measures. We need a broad-based approach to measuring how services are performing, not to focus on one thing and get stuck on that.[2]

250. The AGS/AC report stated that the Scottish Government recognises that psychological therapies waiting times do not provide sufficient information to assess how well adult mental health services are performing. To improve the way performance is measured and to improve the experiences of and outcomes for people accessing psychological therapies and secondary mental health services, the Scottish Government has published—

- **A National specification** for psychological therapies and interventions (psychological therapies specification) – which aims to ensure that people who use these services receive the right information, care and support, at the right time. Measuring the quality of services is a key aim of the specification.

- **Quality standards for adult secondary mental health services** – these aim to ensure that secondary mental health services meet the needs of everyone. The standards are focused on key themes including access to services; assessment, care planning, treatment, and support; moving between and out of services; workforce; and governance and accountability, that is, the way services are managed and who is accountable for this.

251. The Chief Executive of NHS in Scotland referred to these publications during oral evidence, stating that they will improve the quality of information that is gathered—

> We are asking boards to self-assess their delivery against those standards. We are also working with Public Health Scotland so that we have the data to measure delivery and…identify the systems that are doing well and the systems that have room for improvement.[4]

252. In response to these recent developments, SAMH highlighted in written evidence that while they have "welcome elements, they do not represent the step change needed to ensure people can easily access timely support at the first time of asking."[16]

253. During oral evidence, the Committee explored how the Scottish Government is addressing the range of data gaps identified in the AGS/AC report. The Scottish Government's Deputy Director, Improving Mental Health Services, highlighted that investment had been made in UK benchmarking and provided further details of this

information and how it is used—

> we get data that allows boards to look at various things such as how bed numbers and staffing numbers compare not just across Scotland but with comparable services in the rest of the UK. That is very much driving improvement at the moment.[4]

254. The Deputy Director further explained that the focus of this work is on adult services, child and adolescent mental health services and that three events are planned for the beginning of 2024. They went on to state—

> We are sharing that intelligence and planning with mental health leads, so that boards can consider what works, what different models look like and how they can learn and use that intelligence to develop and improve their own services.[4]

255. Asked whether the benchmarking information is publicly available, the Deputy Director responded—

> The benchmarking information that we disseminate is not published at the moment, because boards use it primarily as an improvement tool. We talk to the boards about that, and, through the process next year, we will look at whether we can publish anything from it.[4]

Improving primary care

256. During oral evidence, the AGS highlighted the lack of data that is available on primary care—

> …despite the successive reports that we have produced on the NHS in Scotland and despite our having a comprehensive statistical recording arrangement through NHS National Services Scotland and the Information Services Division, we lack information on primary care.[6]

257. Audit Scotland further added that–

> Public Heath Scotland is working on that and trying to improve the situation, but the data that is available right now is experimental. Public Health Scotland is trying to develop it so that it becomes more robust and reliable, but whether that will include how many appointments are to do with mental health remains to be seen. We have commented on several occasions on the lack of insight into and data on what is going on in general practice.[6]

258. During oral evidence, PHS highlighted that there has been robust data on in-patient mental healthcare since 1963, stating—

> If you are admitted to hospital with a mental health problem, we will know about you and will produce statistics that describe what happened and what happened next.[3]

259. PHS went on to explain that this information does not exist for primary care and community settings. To illustrate this point, it highlighted that information is not collected at a national level on interactions between a district nurse and an elderly person with mental health problems or a health visitor visiting a new mother with mental health problems. PHS further stated that "we need the sort of established infrastructure that hospital services have for doing that." [3]

260. PHS further highlighted the reason for the absence of this data—

> There is a gap in the data…because those services are provided by a whole suite of different organisations, professionals, social care, community-linked workers and third sector bodies. The amount of services that are provided is vast and they are provided in different ways. How they assess what "good" looks like for them differs from place to place. There needs to be some standardisation of what "good" looks like and how it is reported. [3]

261. During oral evidence, Scottish Borders HSCP stressed the need for consistency in data collection. They further stated that—

> Ironically, only a tiny element of the number of people whom we support are in hospital. In general psychiatry in the Borders, we have 19 beds, of which 14 or 15 are used generally. The vast majority of people are in the community, and we do little measuring of that. It is completely the wrong way round. [3]

262. PHS explained during oral evidence the work it has undertaken to improve the consistency of data collection—

> We produce things such as definitions to make sure that data is collected consistently and that we are measuring the same thing. We are doing all those things with a view to improving the quality of the data that we receive month on month. That is the journey that we are on. We have not got there yet. [3]

263. PHS also cited particular issues with the data it receives on psychological therapies and child and adolescent mental health services. PHS explained that while it receives aggregate figures on the number of people who have been referred or are waiting for treatment, or who have been discharged, "there is only so much that you can do with numbers when you do not have the whole information about each individual who attended". [3]

264. To address this issue, PHS has developed a child, adolescent and psychological therapies national dataset, which is referred to as being in the experimental phase. PHS provided details about what the dataset will include during oral evidence—

> It will include the patient's details—the referral, appointment, diagnosis, treatment and intervention details—and the clinical outcomes for that individual. It will detail what measures were used to determine what the outcomes were for those individuals. It will also include discharge details about what happened next to the individual, where they went and whether they died. [3]

265. PHS went on to highlight that it considers this approach to be "the way to go" particularly as the equivalent information exists for in-patient experiences of people

who are admitted to hospital, “not just for mental health problems but for surgical procedures”. They also highlighted the opportunity to “transfer that experience, which has been in existence for many decades, into a new area and to focus on children and adolescents."[3]

266. The Committee asked the Scottish Government during oral evidence whether lessons could be learned from the way in which data is currently gathered for secondary care to improve the availability and quality of adult mental health data in primary care settings. The Chief Executive of NHS Scotland responded by agreeing that lessons could be learned, while recognising the complexity of how these services are delivered—

> one of our challenges is that, although we have good data in the acute sector, otherwise the situation is more complex, because many more organisations are involved in that activity in primary care—including more than 900 general practices—and, more broadly, in the third sector in the community.[4]

267. The Chief Executive of NHS Scotland went on to state that the Scottish Government has been working with Public Health Scotland on primary care data, and that it was “committed to ensuring that we get that picture of activity on adult mental health no matter where that takes place. That is important to us."[4]

268. During oral evidence, PHS confirmed that it is developing a primary care intelligence system in anticipation of new primary care data becoming available. Asked whether PHS was experiencing any resistance to this work, PHS responded—

> It is not resistance; it is about making sure that the governance framework involves GPs. They need to be involved because, in data protection terms, they are data controllers, and they need to be satisfied that good use is being made of the data that is collected. NHS National Services Scotland will set up the structures for all that, and Public Health Scotland will have the intelligence required to better understand what is happening in primary care.[3]

269. Argyll and Bute IJB explained to the Committee some of the challenges it is facing at a local level, and how this relates to the work of PHS, including the importance of appropriate governance arrangements—

> We are trying to implement an integrated system, but we have to design it as we go, because there is no off-the-shelf product ready for us to buy. That is a huge amount of work for my staff and the leadership across all the professions, who have to be assured that what goes into that data is appropriate, that when [PHS] is ready for us, we can provide what [it] is looking for to feed [its] national framework, and that that is appropriately governed.[3]

Quality of mental health services and patient outcomes

270. The AGS/AC report concluded that the Scottish Government does not measure the quality of mental healthcare or the outcomes for people receiving it. It further stated that as a result, it does not track whether services or interventions improve people's mental health and wellbeing.

271. In written evidence, SAMH highlighted that "reform of the mental health system must be accompanied by a shift to not only measuring inputs (such as referral numbers and waiting times) but also measuring people's outcomes." VOX Scotland also raised concerns during oral evidence about the lack of information available in this regard—

> It seems ridiculous that we do not collect that information and data or have that evidence about how things are working and where they are working for people. It would be welcome if we were able to do that.[1]

272. During oral evidence, SAMH cited particular concerns about the lack of information available about the impact of the Communities Mental Health and Wellbeing Fund—

> We…know very little about the outcomes for the recipients of that—in fact, we know nothing. I am not saying that there was no benefit to those individuals, but we do not know what it was. We might know how many people have received support in some way, but we do not know what the outcomes were for those people. That is the kind of transparent data that we need in order to assess mental health spending.[1]

273. The AGS/AC report explained that while there are examples of local services measuring mental health outcomes, this is not happening routinely across Scotland. During oral evidence, the National Association of Link Workers referred to Aberdeenshire's Mental Health Improvement and Wellbeing service, mentioned in the AGS/AC report, where a tool is used to assess progress in outcome measures following targeted work with a community link worker, stating—

> We need to have minimum data sets to capture link workers' information, but we also need a suite of tools that we can use. I think that a Scottish Government team was exploring evaluation and measurement tools. I would like that work to be restarted, and we would very much like to engage with it.[2]

274. In response to the question of how improved reporting on outcomes can be achieved, the RCGPS explained its preference for tracking clinical outcomes and patient experience. However, they raised concerns about the capacity to undertake this work, stating—

> …as yet, and for the foreseeable future, our workforce does not have the capacity to do that….General practice clinical systems are able to capture data on outcomes, but our teams need the time to work together so that, for example, the primary care and mental health workers know how to use those clinical systems to their best effect, so that further generations of clinical systems can be harnessed.[2]

275. During oral evidence, the RCPsych highlighted that “having an appropriate and adequate IT system and the infrastructure to support the recording of information and data and having the workforce capacity” are the two biggest issues to be able to capture outcomes.

276. The Committee notes Action 38 of the Mental Health Strategy 2017-2027 which was to “develop a quality indicator profile in mental health which will include measures across six quality dimensions - person-centred, safe, effective, efficient, equitable and timely." [19]

277. The AGS/AC report explained that in relation to the latest release in April 2023 “just 19 indicators were published, and just 12 of those included updated data. The publication is marked as experimental and there are several data quality problems. It is not clear when these indicators will be sufficiently robust and regularly reported”. During oral evidence, the RCPsych confirmed its involvement in the development of these indicators but that “there has been no investment in the infrastructure that is needed to measure them." [2]

278. The RCPsych further highlighted—

> The underlying administrative and IT infrastructure to record the information just does not exist. It is left to individual areas to find different systems, and they need to prioritise where they spend their money. [2]

279. NHS Lothian cited a local example of how it was capturing the quality of the service people have experienced—

> We use the patients council, which is a collective advocacy service. On an annual basis, it provides a report to us that tells us what patients think of the care that they are receiving. We use that to plan improvements in our service. We are working with the patient-experience team in NHS Lothian to develop a survey for inpatients who are leaving the hospital and their families to complete so that we can use the feedback from it to try to improve the quality of service. It is not scaled up to cover all services at the moment, but it is a start towards doing what you suggested. [3]

280. During oral evidence, the Scottish Government explained that it was working to gather information on satisfaction levels. The Scottish Government’s Deputy Director, Improving Mental Health Services stated—

> …information is collected for certain schemes—but we have not done that systematically at a national level, so one of the commitments that we will look at this year in our delivery plan is a patient satisfaction survey, which would tie in with that and give us national as well as local oversight. [4]

281. The Deputy Director recognised that while the Scottish Government seeks the views of those with lived experience as it develops its policy, “there has been a gap” [4] in understanding people’s experiences at the end of their treatment. The Deputy Director confirmed that there is a commitment in the delivery plan to deliver on the patient satisfaction survey in 2024.

282. COSLA also highlighted during oral evidence that there is continued engagement with those with lived experience in relation to the mental health and wellbeing strategy and its accompanying actions.

283. Referencing the publication of the Outcomes Framework in November 2023, intended to monitor and evaluate the progress of the Mental Health and Wellbeing Strategy and accompanying delivery plan, PHS also highlighted the involvement of those with lived experience in its development—

> People and organisations representing those with lived and living experience were heavily involved in all those processes. The intelligence from all that exists, and that is the basis that influenced the approach to the outcomes framework.[3]

284. PHS provided further information about the next stage of the outcomes framework that is being progressed during 2024 through an evaluability assessment—

> The evaluability assessment uses evidence to see how we demonstrate what exists in the outcomes framework and how we measure, using proper evidence, whether we are moving in that direction….There is a plan for deliverables up until March 2024. We are on the journey to make the framework clearer to those who have been exposed to it so that they can see how it is operationalised and then report on it.[3]

Learning from NHS England

285. The AGS/AC report stated that NHS England now routinely publishes detailed information on mental health service activity and performance, spending and inequalities. While there are known data quality and completeness issues with some of this data, the report highlighted the opportunity for the Scottish Government and its partners to learn lessons from NHS England.

286. The report referred specifically to performance measures used by NHS England, which uses a 'recovery rate' to assess a person's experience of anxiety or depression after a talking therapy service. SAMH highlighted its support for the approach taken by NHS England during oral evidence, stating—

> We have studied that and written quite a lot about it. Individual outcomes data is routinely published and readily available. That includes data on recovery and lots of other things. That is a good example of what can be done. I am not saying that it is the only example, but it demonstrates that it is possible to do that.[1]

287. In written evidence, SAMH provided more detail about the approach adopted by NHS England, while also highlighting that it could be adapted to a Scottish context—

> A key component of the programme is the use of standardised outcome monitoring on a session-by-session basis. This includes recording and measuring of 'recovery', 'reliable improvement' and outcomes related to employment/employability. The outcomes for the service as a whole are published on a monthly basis to ensure public transparency and identification of service variations to improve shared learning and increased quality. [16]

288. During oral evidence, the Committee asked the Scottish Government if it planned to learn from NHS England. The Chief Executive of NHS Scotland stated—

> We are absolutely committed to improving the data that we have and to being able to publish more of it….we are also undertaking benchmarking work to ensure that we are able to compare ourselves with NHS England. We are keen to learn from all systems— not just in NHS England but in NHS Wales and outwith the UK—what works well for people. [4]

289. The Scottish Government's Deputy Director, Improving Mental Health Services explained that the NHS England system differs from that used in Scotland. The Principal Medical Officer, Medical Health Division explained why the two systems differ—

> the big difference is commissioning, to be frank. In order for mental health trusts to justify to their clinical commissioning groups certain activities that they are doing, it is necessary for them to get that data. It adds a lot of bureaucracy to NHS England that we do not have in NHS Scotland, but it means that there is more data produced, collected and monitored. We can learn from that system, but I hope that we can do it without having to introduce such a bureaucratic commissioning layer in order to make it happen. [4]

290. Recognising the clear benefits of the "dashboard" approach used by NHS England to demonstrate its performance against a suite of mental health indicators, the Committee asked the Scottish Government whether it intended to develop a Scottish mental health dashboard. The Chief Executive of NHS Scotland responded—

> Yes. As we have described, we are working really hard with Public Health Scotland to try to ensure that we can get all the data on a consistent basis across Scotland. I do not know whether every trust in England is able to make data available for the dashboard, but we would certainly want to ensure that we are being consistent across Scotland so that we can compare like with like and make fair comparisons. It is really important that we make that data available so that local systems can see how they compare with other systems and, therefore, identify their opportunities for improvement. [4]

291. The Scottish Government explained that it was hoping to develop the dashboard during 2024 which would then be "available as management information so that they are seen by local systems, which have an opportunity almost to quality assure them locally." [4] Asked when this information would then be made publicly available, they stated—

> Public Health Scotland, as the statistics regulator, has some processes that it needs to go through, and I would need to ensure that it is happy before I start giving timescales.[4]

Workforce data

292. The AGS/AC report highlighted that data on the mental health workforce in Scotland is fragmented and only includes some roles providing mental healthcare. Data on the mental health workforce in primary care, community mental health teams and the third sector is not routinely collected.

293. The report also highlighted that the Scottish Government has asked NHS Education for Scotland (NES) to develop a dedicated NHS mental health workforce statistical publication covering all staff involved in providing mental healthcare across the NHS, including primary care staff. The NHS statistical publication was originally expected to be completed in 2023. However, reductions in funding following the EBR has delayed progress in this area.

294. During oral evidence, it was confirmed by the Scottish Government that no funding has been provided for NES to develop the mental health workforce statistical publication and that this would be considered as part of the 2024/25 budget. Asked what the implications may be if this funding is not provided, the Chief Executive of NHS Scotland further responded—

> We need to be careful not to automatically assume that every extra bit of work needs extra money. There might be things that we would want NHS Education for Scotland to prioritise over other things in order to ensure that we are able to get access to the data that we want. We are very keen to improve that statistical report, but we need to have a conversation about what that means in the context of the overall resource budget that is made available to NHS Education for Scotland and how that is deployed.[4]

295. **Incomplete and poor-quality data in the public sector is a long-running concern for the Public Audit Committee. In the context of adult mental health services, we are concerned that this lack of data means there is no effective means of measuring outcomes or the impact that the substantial investment in these services is having on the ground. Significant gaps in data will have an impact on the ability to make well-informed decisions about the delivery of mental health services.**

296. **The Committee therefore welcomes the work the Scottish Government is progressing to address deficiencies in the quality and availability of adult mental health data. We note in particular Public Health Scotland's work to address a lack of information on primary care. The Committee asks the Scottish Government for an update and timetable for completion of this work.**

297. **To support transparency and scrutiny, we would like to see data relating to the performance of adult mental health services made publicly available. While the Committee welcomes the Scottish Government's involvement in the UK Benchmarking exercise, we urge it to publish as much information from this exercise as soon as possible.**

298. **The Committee also welcomes the Scottish Government's commitment to develop a Scottish mental health dashboard during 2024. This information should be made publicly available as soon as practicably possible following quality assurance.**

299. **We ask the Scottish Government to learn any lessons from NHS England and its health and social care partners in its development of such a 'dashboard' approach to demonstrate its performance against a series of mental health indicators.**

300. **The Committee notes the development of a child, adolescent and psychological therapies national dataset. We encourage the Scottish Government to work with Public Health Scotland to explore how this work can be replicated for adult mental health services.**

301. **The Committee supports the development of a NHS mental health workforce statistical publication covering all staff involved in providing mental healthcare. We agree with the AGS/AC report's finding that this would significantly improve the information available on, and understanding of, the mental health workforce in Scotland, enabling more effective planning and monitoring. We therefore seek assurance from the Scottish Government that this statistical publication will be progressed and made publicly available without further delay.**

Resources for adult mental health services

Spending on adult mental health

302. The AGS/AC report stated that adult mental health spending has increased between 2017/18 and 2021/22—

- NHS boards reported that they spent £1.2 billion on adult mental health services, a 16 per cent increase in real terms since 2017/18
- Councils reported that they spent £224.7 million on adult mental health services, a 14 per cent increase in real terms since 2017/18.

303. The report further stated that these figures do not include spending by NHS 24 of £10.8 million in 2022/23 and the Scottish Ambulance Service (SAS), which spent £570,877 in 2021/22. The AGS/AC report recommended that Public Health Scotland—

> Should include spending by all services that provide adult mental healthcare in its reporting of NHS spending on adult mental health. This should include spending on clinical psychology and spending by NHS 24 and SAS. This will enable the Scottish Government to report more accurately on progress towards meeting its commitment to increase spending on mental health.[12]

304. The AGS/AC report also highlighted that the Scottish Government's Mental Health Directorate Budget increased from £63.6 million to £290.2 million between 2017/18 and 2023/24, representing a 356% increase in real terms. It further stated that the Scottish Government is committed to increasing the Mental Health Directorate budget by 25% and ensuring that 10% of the front-line NHS budget is spent on mental health by the end of the current parliament, in 2026. In November 2022, the Scottish Government announced a £38 million reduction in its Mental Health Directorate's budget for 2022/23 as part of the Emergency Budget Review.

305. The AGS/AC report stated that "the Scottish Government is facing considerable financial constraints, and it is not currently on track to meet these commitments".[12]

306. In written evidence, SAMH highlighted the importance of the commitment to ensure that 10% of front-line health spending by NHS boards is on mental health services—

> Progress against this target has been poor, with Audit Scotland highlighting that the proportion of spend on mental health has actually decreased over recent years. It is essential that the Government reverse this trend through the upcoming 2024-25 budget.[16]

307. During oral evidence, the Committee asked the Chief Executive of NHS Scotland whether NHS boards are on track to meet the 10% commitment. She responded—

> In the context of a very challenging financial position, it is difficult for me to say absolutely that we will be on track. The commitment was for around 10 per cent of NHS spending, but it is important to recognise, as Audit Scotland did, that this is not only about the spending that goes through the NHS. Work on prevention and early intervention is very important in improving mental health, so a lot of our investment has been in communities and in the third sector. We must look at the whole spend, rather than focusing on the NHS part of that.[4]

308. In November 2023, the Deputy First Minister wrote to the Finance and Public Administration Committee to provide an update on in-year budget changes for 2023-24. It stated that there would be a £29.9 million reduction to Mental Health programmes under the NHS Recovery, Health and Social Care portfolio.

309. During oral evidence, the Committee sought to establish the impact of these in-year reductions in funding for adult mental health services in 2022-23 and 2023-24. The Chief Executive of NHS Scotland responded—

> Despite the cuts and reductions in budget that you alluded to, we are spending more than twice the amount on mental health than we were spending back in 2021, so there has been a substantial increase in the investment in mental health services.[4]

310. The Scottish Budget 2024-25 was published on 19 December 2023 and is currently subject to parliamentary scrutiny. The Committee notes that the Mental Health Directorate Budget is set to remain flat in cash terms in 2024-25 at £290.2 million. This represents a real terms decrease of 1.6 per cent.

Spending on medicines used for mental health

311. The AGS/AC report stated that spending on mental health medicines within the community fell in real terms from £117.7 million in 2017/18 to £90.4 million in 2021/22. It also stated that "more items were dispensed in 2021/22, meaning that the fall in spending was caused by a decrease in the cost of these medicines".[12]

312. The Committee sought further information from the AGS during oral evidence on the increasing use of anti-depressants to support people with their mental health, as reported by the media. He responded by re-stating that spend on mental health medicines in a community setting has fallen, while noting—

> At the same time, we are seeing an increase in the number of items that are being prescribed. That is consistent with the point that you make, and it leads us to an interim conclusion—we have not done any audit work or have any evidence on this—that the cost of medicines for some conditions has fallen, but the scale of access is still high and increasing.[6]

313. VOX Scotland added—

> I know that, with regard to a lot of the increase in the use of medication, you hear reports about the increase in the prescription of antidepressants. I assume that that is to do with the lack of resource or workforce to be able to give other therapies, treatments or help, and GPs having to resort to medication because there is not that other help. [1]

314. The Committee sought to establish views on the use of medication to support people with their mental health. A VOX Scotland member responded—

> Yes, there definitely is too much emphasis on medication. There is an unchallenged assumption that just keeping taking the tablets works. It is as simple as that. It is assumed that people should either get professional help or just keep taking the tablets. Those are very old-fashioned ideas, but we still hold to them. [1]

315. VOX Scotland also stressed the importance of access to medication for some of its members, while highlighting that other forms of support are also needed, “and where the money is spent is important." [1]

Funding for the third sector

316. The AGS/AC report stated that the third sector plays an important role in providing mental health services, but short-term funding and contracts affects their ability to recruit and retain staff. During the oral evidence, the AGS stated—

> The third sector plays an enormously important role in the provision of adult mental health services, including prevention measures and support, across a range of factors and geographies. It is not unique to such services that their funding cycle is almost always annual. They tell us that is challenging for them to recruit and retain people who can provide those skilled services when such uncertainty exists. [6]

317. In its written submission to the Committee, SAMH stated—

> Short-term funding represents a clear barrier to long-term planning and innovative service design and delivery. It also does not provide stability for the workforce, care providers and most importantly does not provide stability and continuity for people supported by community and social care services. [16]

318. Young Scot also noted that third sector organisations’ ability to engage in long-term planning in hindered by the annual budget cycle, and that this represents a “huge problem”. [1]

319. During oral evidence, the AGS highlighted the importance of providing the third sector with more certainty around its funding—

> If we are to make a step change in the provision of adult mental health services, accountability for them, and their funding and outcomes, which I hope we will do, careful thought must be given to providing third sector practitioners with certainty on how they can apply their work over a longer period.[6]

320. Asked whether this may be difficult to achieve given the Scottish Government is funded on an annual basis the AGS responded—

> That is fair, to a point. The Scottish Government and local authorities will generally know from year to year what their baseline is, and they have certainty that they will get a sum of money that is generally around the amount that they had last year. However, it takes much longer for such certainty to be given to the third sector, so work needs to be done in that arena, too.[6]

321. During oral evidence, the RCPsych highlighted the need for improved multi-agency long term decision making—

> We have not seen that joined-up process of making long-term investment decisions—not year-by-year decisions but long-term investment decisions—especially with regard to third sector support and commissioned services.[2]

322. More broadly, the Committee heard concerns from a VOX Scotland member about the perception of the third sector—

> The advocacy view is that there is a power dynamic between the NHS, integration joint boards and local authorities. Sitting on the sidelines, we see a pecking order when it comes to partnership working between the third sector and the public sector. There is an assumption that the NHS is professional and does the serious stuff—the good stuff—whereas the people in social care are keen amateurs. In other words, we are well intentioned, but we do not really know what we are doing.[1]

Recruitment and retention

323. The AGS/AC report highlighted that recruitment difficulties and high vacancy and turnover rates are putting pressure on the mental health workforce. Such challenges include—

- The estimated shortfall in whole time equivalent mental health officers doubled between 2017 and 2021.
- A national shortage of psychologists
- Vacancies for mental health nurses have more than doubled between March 2017 and March 2023, and the turnover rate has reached a record high.

Psychiatry services

324. The AGS/AC report highlighted that the number of WTE general psychiatrists decreased between 2017 and 2023 and vacancies for general psychiatry consultants are the highest of all medical and dental consultant roles in Scotland. Noting that the number of appointments has not returned to pre-pandemic levels for general psychiatry, unlike most other mental health services, the Committee sought to explore the particular challenges facing psychiatry services in Scotland.

325. During evidence, the Committee asked why psychiatry appointments appear to have declined. The RCPsych responded—

> The simplest explanation is that that is a reflection of the workforce crisis that we face. We just do not have the staff to provide the basic services that we need to provide, let alone the high-quality services that we want to provide. There is a finite number of consultations and appointments and a finite amount of work that each individual clinician can undertake. There has been a reduction in the number of psychiatrists in the past five to 10 years, rather than an increase to match the increase in demand.[2]

326. The RCPsych also referred to its "State of the nation report: The psychiatric workforce in Scotland", published in October 2023. The report provides an insight into the shape of the psychiatric workforce including why doctors join, why they leave, and solutions for reversing a declining trend. The RCPsych highlighted during oral evidence that one issue in the report related to consultant psychiatrists, with vacancy rates in general adult psychiatry at almost 30 per cent which he explained—

> …is more than three times the official figure of 9 per cent, which is an underrepresentation because a lot of posts are being filled by locums who will not necessarily have the relevant qualifications. If there is a vacancy rate of 30 per cent, with one in three posts empty, you can get a sense of how that translates to the capacity of services.[2]

327. The RCGPS described how referrals to psychiatry services are often managed, in light of the capacity issues described by the RCPsych—

> Our psychiatry specialist services are under so much strain that the people who are asked to triage and look at those referrals sometimes find reasons to try to hold the dam and knock things back to general practice. A lot of referrals are not progressed. That is a reflection of the limited workforce capacity in that specialist service.[2]

328. The RCPsych also provided an insight into the recruitment and retention challenges facing the profession—

> We are seeing high turnover rates, with staff leaving due to burnout. I do not use the word "crisis" lightly, but it feels as though we are in a death spiral. The more staff who leave, the greater the burden on the staff who remain, and that has a huge impact on the burnout rate of that workforce.[2]

329. The use of locum psychiatrists was also cited by the RCPsych as a concern for the

profession—

> Twenty per cent of our consultant workforce is made up of locums, and there are real challenges with that, not least the fact that a large proportion of locums do not have the appropriate or necessary qualifications. For example, they do not have the certificate of completion of training required to be a specialist in that post.[2]

330. The RCPsych further explained that in addition to seeing patients, consultants also provide training and supervise other staff within the team, which is integral to expanding the profession. However, they highlight that locums do not receive this same level of support, meaning—

> …we have a critical loss to the system's capacity not just to improve but to change, which is what is needed. That is partly what I mean when I say that we are in a death spiral. The numbers have become so low that it has become virtually impossible to provide a safe service, let alone a good-quality service in large parts of the country.[2]

331. VOX Scotland also provided a view on the use of locum psychiatrists—

> From what we hear, a lot of money—and I mean a lot of money—is being spent on, for example, locum psychiatrists that could otherwise be spent a lot more wisely. I hope that the workforce plan will do something to help with that, so that psychiatrists or community psychiatric nurses can be recruited in the areas in which they are needed rather than locums being used, and that the money that is left can be used elsewhere to help.[1]

332. During oral evidence, the Scottish Government accepted that there is an overreliance on locum psychiatrists. It further explained that it is working to improve recruitment and retention issues by increasing the number of psychiatry training places.

333. The Principal Medical Officer stated—

> Psychiatry has historically been one of the more difficult medical specialties to attract doctors into and we went through a spell of struggling to fill core training places. For the past three or four years, we have had a 100 per cent fill rate for core training, but that training takes a minimum of six years and most people take eight or nine years to complete it because of various different options or because of part-time working, so that will take time to filter through.[4]

334. The Principal Medical Officer highlighted the positive outcomes resulting from this strategy to tackle the overreliance on locum psychiatrists, including the Scottish Government's next steps—

> Increasing the number of core training places in the past few years has been successful, in that we have filled those places, but the next phase, as those core trainees come through into higher training places, will be to ensure that we keep them in Scotland and bring them into the Scottish workforce. Our working group, which includes the Royal College of Psychiatrists, NHS Education for Scotland and others, is working to achieve that.[4]

335. In its written submission, Angus Health and Social Care Partnership identified how it was responding to the national shortage of Consultant Psychiatrists—

> …we have developed a Community Mental Health senior multi-disciplinary team and are developing new pathways to meet patient need and reduce Consultant demand.[15]

336. In response to the particular challenges facing psychiatry services, the AGS suggested during oral evidence—

> Perhaps, as part of workforce considerations, a longer-term review is required of how people come into the specialism and how they are retained, and, as part of that, a costed workforce financial plan is needed across the piece to ensure consistency of service provision across specialisms.[6]

Community link workers

337. The AGS/AC report highlighted that short term funding and contracts for third sector providers affects their ability to recruit and retain staff recruitment. The National Association of Link Workers explained during oral evidence how these challenges relate specifically to community link workers and in particular, the "Glasgow link worker crisis."[2]

> …community link worker posts are not sustainable, despite their delivering fantastic services. That also concerns GPs and the community sector. Patients have actually said, "This saved my life." Despite that, in Glasgow, the number of link workers is about to be slashed by a third.[2]

338. During that oral evidence session, the Scottish Government announced an additional £3.6 million of funding over three years to preserve the existing community link worker programme within Glasgow City Health and Social Care Partnership. The National Association of Link Workers responded—

> We have just had the announcement that the Glasgow link worker crisis is about to be resolved, but our members cannot get a mortgage, because they are all on temporary contracts. If you see a vacancy for something that is not even stable, you do not want to apply, and that is not very good.[2]

339. The National Association of Link Workers also highlighted its concerns about the extent to which link workers feel valued—

> …we are not fully valued. I looked at the consultation on the statutory guidance for the Health and Care (Staffing) (Scotland) Act 2019 and saw that it is due to come in in April 2024—but can you imagine it? We are not even listed there, so what am I doing on this panel? We need to be listed, because we are part of the health and social care workforce. This is about making people feel valued and making the profession attractive as well as providing support.[2]

340. Responding to the concerns raised by the National Association of Link Workers, the Chief Executive of NHS Scotland stated—

> The community link worker role is enormously valuable, especially in our more deprived communities. The Scottish Government has recently intervened to provide additional financial support, in the context of a very challenging financial climate, to support on-going provision of community link workers in Glasgow. Community link workers are really important, particularly when we think about some of the underlying causes of mental distress in relation to the cost of living and so on. They are absolutely a valued part of the whole workforce family across health and social care in Scotland.[4]

341. During oral evidence, the National Association of Link Workers stressed the importance of universal access to community link workers, stating—

> We need the Scottish Government to commit to the number of community link workers that it will recruit and to demonstrate that we truly want to demedicalise life issues in Scotland.[2]

342. The Committee notes that the AGS/AC report included a recommendation for the Scottish Government to publish a costed delivery plan setting out the funding and workforce that will be needed to achieve its aim of establishing sustainable and effective MHWPCS across Scotland by 2026.

343. The Committee asked the Scottish Government whether it would fulfil this recommendation. The Chief Executive of NHS Scotland responded—

> We have published part of the delivery plan against the mental health and wellbeing strategy. The data work that we are doing is about gaining a better understanding of where the money that we are spending is having the best impact. That work will feed into our developing a delivery plan that looks at services and how they interface with each other across Scotland.[4]

344. When asked what the timetable for this work will be, the Scottish Government responded, “the commitment in the delivery plan is for us to produce a report on progress around November next year."[4]

345. During oral evidence, the AGS recognised the plans the Scottish Government has put in place to address the scale of the challenge it faces in improving adult mental health services. He further stated—

> My caution is that successive Governments have had plans, but those have not been followed through with a detailed and costed plan for how to get from a strategy to implementation that can be evaluated.[6]

346. **It is vital that this Parliament is able to track the Scottish Government's commitment to increase spending on mental health. The Committee therefore agrees with the AGS/AC report's finding that Public Health Scotland should include spending by all services that provide adult mental healthcare when reporting NHS spending on adult mental health.**

347. **We note the Scottish Government's commitment to ensure that 10% of the front-line NHS budget is spent on mental health by 2026. We are disappointed at the evidence we heard that progress against this commitment is poor. We ask the Scottish Government to set out how it plans to make greater progress against this commitment, particularly against a backdrop of financial constraint.**

348. **The third sector plays a significant role in supporting people with their mental health. It is therefore of considerable concern to the Committee that the nature of this funding is fragile and unpredictable. While recognising that the Scottish Government itself does not receive multi-year funding settlements, we ask it to consider how more certainty can be provided to the third sector for the funding that it receives, such as providing outline multi-year spending plans. Not only will this enable organisations to plan their services more effectively, but crucially, it will provide reassurance to those using these services.**

349. **The Committee recognises that community link workers are a critical part of the primary care services workforce. Indeed, they will play an integral role in supporting the Scottish Government's commitment to ensure that every GP practice has access to a mental health and wellbeing service by 2026. We therefore welcome the additional funds secured to protect the Glasgow Link Workers service and seek assurances regarding the funding of community link workers across all areas of Scotland, urban and rural.**

350. **It is crucial that the Scottish Government publishes a costed delivery plan setting out the wider funding and workforce that will be needed to achieve its aim of establishing sustainable and effective MHWPCS across Scotland by 2026. This should include the number of community link workers that it will recruit. We ask whether the Scottish Government is on course to produce a costed delivery plan by November this year as planned.**

351. **The Committee is deeply concerned by the workforce crisis facing psychiatrists in Scotland. It is also troubling to hear that there is an over-reliance on locum psychiatrists. This approach represents poor value for money and poses a risk to the quality of the services provided. We note that the Scottish Government told us that it is actively working to increase the number of psychiatry training places, which is welcome. As part of its wider workforce considerations, the Committee recommends that the Scottish Government undertakes a longer-term review and costed workforce financial plan of the recruitment and retention of psychiatrists in Scotland, as suggested by the AGS during oral evidence.**

Annexe: Extracts of minutes

Extracts from the meeting minutes of the Public Audit Committee

24th Meeting, Thursday 28 September 2023

2. Adult mental health:

The Committee took evidence from—

Stephen Boyle, Auditor General for Scotland; Leigh Johnston, Senior Manager and Eva Thomas-Tudo, Audit Manager, Audit Scotland; Christine Lester, Member, Accounts Commission.

3. Adult mental health (In Private):

The Committee considered the evidence heard at agenda item 2 and took further evidence from—

Stephen Boyle, Auditor General for Scotland; Leigh Johnston, Senior Manager and Eva Thomas-Tudo, Audit Manager, Audit Scotland; Christine Lester, Member, Accounts Commission.

The Committee considered the evidence heard at agenda items 2 and 3 and agreed its approach to future scrutiny of the report.

28th Meeting, Thursday 9 November 2023

2. Adult mental health:

The Committee took evidence in a roundtable format from—

Jo Anderson, Director of Influence and Change, Scottish Association for Mental Health; Paula Fraser, Acting Manager, Voices of Experience Scotland; Peter Kelly, Director, The Poverty Alliance; Dr Shari McDaid, Head of Policy and Public Affairs (Scotland, Wales and Northern Ireland), Mental Health Foundation; Meriem Timizar, Project Co-ordinator, International Women's Group (representing BEMIS); Kirsten Urquhart, Chief Executive, Young Scot; Simon Porter, Project Director, Royal Edinburgh Hospital Patients Council (Representing Voices of Experience Scotland).

3. Adult mental health (In Private):

The Committee considered the evidence heard at agenda item 2.

29th Meeting, Thursday 16 November 2023

2. Adult mental health:

The Committee took evidence in a roundtable format from—

Mike Burns, Chief Executive, Penumbra Mental Health; Derek Frew, Temporary Chief Superintendent, Head of Partnerships, Prevention and Community Wellbeing, Police Scotland; Stephen Low, Policy Officer, UNISON; Christiana Melam, Chief Executive

Officer, National Association of Link Workers; Anne Rowan, Founder, Chris's House; Dr Pavan Srireddy, Vice Chair, Royal College of Psychiatrists in Scotland; Dr Chris Williams, Deputy Chair, Royal College of General Practitioners Scotland.

3. Adult mental health (In Private):

The Committee considered the evidence heard at agenda item 2.

30th Meeting, Thursday 23 November 2023

2. Adult mental health:

The Committee took evidence in a roundtable format from—

Hannah Axon, Policy Manager, Convention of Scottish Local Authorities

(COSLA); Simon Burt, General Manager, Mental Health and Learning Disability Services, Scottish Borders Health and Social Care Partnership; Pamela Cremin, Chief Officer, Highland Health and Social Care; Fiona Davies, Chief Officer , Argyll and Bute Integration Joint Board (also representing the Health and Social Care Scotland Chief Officer network); Richmond Davies, Head of Public Health Analytics and Intelligence, Public Health Scotland; Jillian Galloway, Acting Chief Officer, Angus Health and Social Care Partnership; Jo Gibson, Head of Wellbeing and Recovery, East Ayrshire Health and Social Care Partnership; Tracey McKigen, Services Director, Royal Edinburgh and Associated Services, NHS Lothian.

3. Adult mental health (In Private):

The Committee considered the evidence heard at agenda item 2 and took further evidence from—

Stephen Boyle, Auditor General for Scotland; Mark MacPherson, Audit Director and Eva Thomas-Tudo, Audit Manager, Audit Scotland.

4. Adult mental health (In Private):

The Committee considered the evidence heard at agenda items 2 and 3.

33rd Meeting, Thursday 14 December 2023

2. Adult mental health:

The Committee took evidence from—

Caroline Lamb, Chief Executive of NHS Scotland and Director-General for Health and Social Care, Gavin Gray, Deputy Director Improving Mental Health Services and Dr Alastair Cook, Principal Medical Officer, Mental Health Division, Scottish Government.

3. Adult mental health (In Private):

The Committee considered the evidence heard at agenda item 2 and took further evidence from—

Stephen Boyle, Auditor General for Scotland;

Leigh Johnston, Senior Manager and Eva Thomas-Tudo, Audit Manager, Audit Scotland.

4. Adult mental health (In Private):

The Committee considered the evidence heard at agenda items 2 and 3 and agreed to draft a report on the joint Auditor General for Scotland and Accounts Commission report on Adult mental health.

5th Meeting, Thursday 8 February 2024

6. Adult mental health (In Private):

The Committee considered a draft report on Adult mental health and agreed to continue consideration at a future meeting.

6th Meeting, Thursday 22 February 2024

7. Adult mental health (In Private):

The Committee agreed a draft report on Adult mental health.

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[3] Official Report. (2023, November 23). Retrieved from https://www.parliament.scot/api/sitecore/CustomMedia/OfficialReport?meetingId=15575

[4] Official Report. (2023, December 14). Retrieved from https://www.parliament.scot/api/sitecore/CustomMedia/OfficialReport?meetingId=15620

[5] HM Inspectorate of Constabulary in Scotland. (2023, October). HMICS Thematic review of policing mental health in Scotland. Retrieved from https://www.hmics.scot/sites/default/files/publications/HMICS20231018PUB.pdf

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[7] Written submission from NHS Lothian. (2023, December 7). Retrieved from https://www.parliament.scot/-/media/files/committees/public-audit-committee/correspondence/2023/adult-mental-health-written-submission-nhs-lothian-7-december-2023.pdf

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[13] Scottish Government. (2023, November 7). Police officer quarterly strength statistics: 30 September 2023. Retrieved from https://www.gov.scot/publications/police-officer-quarterly-strength-statistics-30-september-2023/#:~:text=The%20key%20findings%20of%20the,quarter%20from%2030%20June%202023

[14] Written submission to the Public Audit Committee from Change Mental Health. (2023, November 10). Retrieved from https://www.parliament.scot/-/media/files/committees/public-audit-committee/correspondence/2023/adult-mental-health-change-mh-to-pac-13-nov-2023.pdf

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