Mental Health Analysis Profiles (MhAPs): Scotland

Alessia Forti

OECD

Organisation de Coopération et de Développement Économiques
Organisation for Economic Co-operation and Development

07-Jul-2014

_____

English text only

DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS
HEALTH COMMITTEE

Health Working Papers

OECD Working Paper No. 74

MENTAL HEALTH ANALYSIS PROFILES (MhAPs)
Scotland

Alessia Forti

JEL classification: I100; I120

Authorised for publication by Stefano Scarpetta, Director, Directorate for Employment, Labour and Social Affairs

All Health Working Papers are now available through the OECD's Internet Website at
http://www.oecd.org/health/workingpapers

JT03360243

DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS

www.oecd.org/els

OECD HEALTH WORKING PAPERS

http://www.oecd.org/health/workingpapers

This series is designed to make available to a wider readership selected health studies prepared for use within the OECD. Authorship is usually collective, but principal writers are named. The papers are generally available only in their original language – English or French – with a summary in the other.

OECD Working Papers should not be reported as representing the official views of the OECD or of its member countries. The opinions expressed and arguments employed are those of the author(s).

Working Papers describe preliminary results or research in progress by the author(s) and are published to stimulate discussion on a broad range of issues on which the OECD works. Comments on Working Papers are welcomed, and may be sent to the Directorate for Employment, Labour and Social Affairs OECD, 2 rue André-Pascal, 75775 Paris Cedex 16, France.

**Applications for permission to reproduce or translate
all or part of this material should be made to:**

**Head of Publications Service
OECD
2, rue André-Pascal
75775 Paris, CEDEX 16
France**

Copyright OECD 2014

ACKNOWLEDGEMENTS

ABSTRACT

As part of a wider project on mental health in OECD countries, a series of descriptive profiles have been prepared, intended to provide descriptive, easily comprehensible, highly informative accounts of the mental health systems of OECD countries. These profiles, entitled 'Mental Health Analysis Profiles' (MHAPs), will be able to inform discussion and reflection and provide an introduction to and a synthesised account of mental health in a given country. Each MHAP follows the same template, and whilst the MHAPs are stand-alone profiles, loose cross-country comparison using the MHAPs is possible and encouraged.

Mental health is a priority area within the Scottish health care agenda. In the Scottish mental health system significant focus is given to recovery, service user involvement, anti-stigma initiatives, and suicide reduction strategies. Amongst the peculiarities, and strengths, of the Scottish mental health system are its focus on data collection, monitoring and evaluation, with a strong focus on improvement and delivery, as data collection and mental health indicators are turned into a management tool for policy makers. However, better indicators could be developed to monitor specialist mental health services delivered in the community.

RÉSUMÉ

Lancée dans le cadre d'un projet plus vaste consacré à la santé mentale dans les pays de l'OCDE, la série de profils « Santé mentale : profils d'analyse » (*Mental Health Analysis Profiles* - MHAP) vise à décrire de manière simple et détaillée les systèmes de santé mentale des pays de l'OCDE. Ces profils, qui étayeront les examens et les réflexions qui seront menés, feront le point sur la situation d'un pays donné dans le domaine de la santé mentale. Les profils MHAP sont indépendants les uns des autres mais suivent le même modèle : il est donc possible, et recommandé, de les utiliser pour procéder à des comparaisons entre pays.

La santé mentale est un domaine prioritaire du programme de l'Écosse en matière de soins de santé. Le système de santé mentale écossais met l'accent sur la guérison, l'implication des patients, les initiatives de lutte contre la stigmatisation et les plans d'action contre le suicide. Le système de santé mentale de l'Écosse se distingue par certaines spécificités et plusieurs points forts, notamment la priorité accordée à la collecte de données, au suivi et à l'évaluation, avec un fort accent sur l'amélioration et la diffusion, la collecte de données et les indicateurs de la santé mentale étant convertis en outils de gestion à l'intention des décideurs. Toutefois, de meilleurs indicateurs pourraient être développés pour le suivi des services de santé mentale de proximité.

LIST OF ACRONYMS

BME: Black and Minority Ethnic
BSC: Balance Score Card
CAMHS: Child and Adolescent Mental Health Services
CHCP: Community Health and Care Partnerships
CHP: Community Health Partnership
CIS-R: Revised Clinical Interview Schedule
CMHT: Community Mental Health Teams
CPA: Care Programme Approach
CRER: Coalition for Racial Equality and Rights
CTO: Compulsory Treatment Order
DDD: Defined Daily Dose
DfMH: Delivering for Mental Health
EIM: Ethnicity in Mind
EU: European Union
GBP: Great British Pound
GHQ12: General Health Questionnaire 12
GIC: Gross Ingredient Cost
GMS: General Medical Services
GP: General Practitioner
HIMS: Highlands and Islands Medical Service
HMIP: Her Majesty's Chief Inspectorate of Prisons
IHTT: Intensive Home Treatment Teams
ISD: Information Service Division
LOT-R: Revised Life Orientation Test
MAPPA: Multi Agency Public Protection Arrangements
MHCT Act: The Mental Health (Care and Treatment) (Scotland) Act 2003
MHO: Mental Health Officer
NGO: Non-governmental Organisation
NHSS: NHS Scotland
NICE: National Institute for Health and Clinical Excellence
PMS: Personal Medical Services
QOF: Quality and Outcomes Framework
SAMH: Scottish Association for Mental Health
SHeS: Scottish Health Survey
SIGN: Scottish Intercollegiate Guidelines Network
SNAP: Scottish Needs and Assessment Programme
SPS: Scottish Prison Service
SRI: Scottish Recovery Indicator
UK: United Kingdom
WEMWBS: Warwick-Edinburgh Mental Well-Being Scale
WHO: World Health Organisation
WTE: Whole Time Equivalent

TABLE OF CONTENTS

Tables

Figures

Boxes

INTRODUCTION

1.   This report is part of a series of descriptive profiles – Mental Health Analysis Profiles (MHAPs), produced by the OECD to give key insights into the mental health systems of select OECD countries. Following a set framework, these profiles give a detailed introduction to the history, mental health needs, and organisation and payment of care in select mental health systems. Countries have been selected so as to give an overview of different ways of approaching mental health care system organisation across the OECD, as well as to highlight examples of particularly innovative practice.

2.   Mental health is a priority area within the Scottish health care agenda. In Scotland, as in many other OECD countries, mental health care has shifted from hospitals towards care in the community over the last decades. Amongst the peculiarities, and strengths, of the Scottish mental health system are its focus on data collection, monitoring and evaluation, with a strong focus on improvement and delivery, as data collection and mental health indicators are turned into a management tool for policy makers, although better indicators could be developed to monitor mental health care in the community.

3.   This report is designed to describe how mental health care is provided across the Scottish population, from service provision for children and young people to available mental health care for older people. Attention is also paid to any groups in the population who may have difficulties accessing appropriate mental health care, for example minority ethnic groups. The report begins with a short history of the evolution of the Scottish mental health system alongside a summary of the mental health characteristics of the population. The report goes on to describe the design of the Scottish mental health system, recent mental health policy and legislation and a detailed examination of the mental health services and financing in the country.

1. MENTAL HEALTH HISTORY, LEGISLATION AND HUMAN RIGHTS

1.1. History and development of the mental health system

4.	In 1707, the Act of Union created a single parliament, unifying the previously separated parliaments for Scotland and England. In 1885, the Scottish Office was created as a department of the UK Government, and the responsibility and the administration of many sectors, including health, was no longer headed by Whitehall Departments but rather by the Secretary of State of Scotland.

5.	Prior to 1948 and the establishment of the NHS Scotland, the health system was mainly composed of voluntary and municipal hospitals. With the purpose of treating the "seek poor", most voluntary hospitals did not charge patients any fee and consultants were unpaid. Municipal hospitals, resulting from the welfare system created by the historic Poor Law legislation (*e.g.* the 1845 Poor Law [Scottish] Act), were run by local authorities. However, staff and beds shortages, waiting lists and hospital infections were common. In 1913, the state-funded Highlands and Islands Medical Service (HIMS) was launched in the wake of a Treasury grant of GBP 42 000. The HIMS provided minimal-level-fees healthcare services to half of Scotland's landmass, and served most deprived areas in which previous to 1913 there were either poor or non-existent healthcare services.

6.	NHS Scotland (NHSS) was created as a separate legal entity by the National Health Service (Scotland) Act 1947 and came into effect on 5 July 1948. Some repeals were brought by the National Health Service (Scotland) Act 1972, and other remaining provisions were modified by the National Health Service (Scotland) Act 1978.

7.	NHS Scotland has, since 1948, maintained a distinct identity as a "service within a service" (Woods and Carter, 2003). Figures indicate that 383 000 patients were treated in 1948 by hospitals under the NHSS, and 1.2 million were seen as outpatients. In recent years, the NHSS has treated approximately 1.3 million inpatients per year and sees 4.4 million outpatients. As with all mental hospitals across the UK, mental hospitals in Scotland were nationalised in 1948 (Freeman, 1998), becoming part of the NHS.

8.	Despite the establishment of the NHS Scotland in 1948, policy divergence over health and mental health between Scotland and England occurred primarily after Scotland's devolution in 1998.

9.	Devolution occurred with the Scotland Act 1998, whilst the Scottish Executive and the Scottish Parliament were established in 1999. Power in devolved matters was transferred from the Secretary of State of Scotland and other UK Ministers to the Scottish Ministers. Policy autonomy in Scotland followed a "negative list" format, with Scotland granted authority over those powers not specifically retained by Westminster in the Scotland Act 1998. Almost all aspects of the health system are the responsibility of the Scottish Government.

10.	After devolution Scotland reversed several reforms in the governance and organisation of the NHSS that had been previously enacted in Westminster. For instance, from 1997 hospital trusts were reintegrated into a directly managed system, culminating in the abolition of NHS Trusts as legal entities through the National Health Service Reform (Scotland) Act 2004, and finally leading to the establishment of non-statutory Community Health Partnerships (CHPs). CHPs are semi-formal partnerships, of which there are 34 across Scotland, which are a mechanism for integrating health and social care in primary care

and community settings (see also http://www.chp.scot.nhs.uk/). Legislation is currently being taken forward which will supercede Community Health Partnerships by creating a legal framework for the formal integration of health and social care services.

11. Governance and planning is today geographically based, with 14 Health Boards responsible for resource allocation, local planning and service delivery (McDaid and Oliver, 2008) and 8 Special Health Boards that support Health Board activities by providing specialist services.

12. Following criticism in 1995 from the Grand Committee of Scottish Members of Parliaments (MPs) that mental health was fragmented and lacked "formal policy objectives" (Loudon and Coia, 2002: 84), Scotland has seen sustained attention to mental health. Concrete actions were taken after mental health was designated a national clinical priority in *Our National Health* (Scottish Executive, 2000). The National Programme for Improving Mental Health and Well-being Action Plan 2003-2006 (The National Programme) (Scottish Executive, 2003) was published in 2006, and was the first national programme devoted to public mental health that included commitments to promote the understanding of mental well-being and its determinants among the general population, in contrast to previous emphasis on service delivery.

13. One of the first consultations launched following devolution in 1998 was on reform of Scottish mental health legislation. The Millan Committee (2001), which conducted the review, set out new directions for mental health in Scotland, going beyond a simple review of the law. Broadly, the Millan Committee stressed the need to build more community based services, and the need to increase awareness of respect for human rights in mental health, including improving service-user and carers involvement decisions about treatment. The Committee also set out the principles that should guide mental health policy, mental health rights, and quality assurance for mental health services. This approach gained significant support across all interest groups and was the foundation for an ongoing consensus about mental health priorities and objectives.

14. Raising awareness and promoting mental health and well-being was also a theme, with recognition of a need to both address mental health problems, and promote prevention and population approaches (Tudor, 1996; WHO, 2001). To take this forward the National Programme was created, which produced the National Programme for Improving Mental Health and Well-being Action Plan 2003-2006 (The National Programme) (Scottish Executive, 2003). This was the first national programme devoted to public mental health and included commitments promoting understanding of mental well-being and its determinants among the general population, as an addition to the traditional emphasis on service delivery (Scottish Executive, 2003).

15. The Millan Committee also recommended a public education campaign to improve "public understanding [and] attitudes towards people with mental disorder" (Scottish Executive, 2001a:19), which was reinforced as a priority in policy documents to the role of individual attitudes and social structures in promoting positive mental health (Scottish Executive, 2001b). This became an aim of the National Programme and as with other objectives, work addressing stigma was led by a specific 'delivery vehicle', in this case the national "See me" campaign, established in October 2002. "See me" is currently run by the Royal College and four voluntary organisations (Smith, 2003, Myers et al., 2009) and is hosted by the Scottish Association for Mental Health (SAMH) (see section 4.5.).

16. Following Delivering for Mental Health (2006) and Towards a Mentally Flourishing Scotland (2009-2011), the Mental Health Strategy for Scotland 2012-2015 is the newly released strategy for mental health in Scotland (see section 3.3).

17. See Annex 1 for a comprehensive list of mental health strategies from 1997.

1.2. Mental health legislation

18.   *The Adults with Incapacity (Scotland) Act 2000* provides a legal framework for implementing tailored welfare, financial and medical measures for people who are unable to make decisions themselves because of mental impairment. The Act provides general principles of good practice, which allow people to take decisions legally on behalf of inpatients. Even though the Adults with Incapacity Act does not directly deal with restraint, it may give consent to concerned individuals to apply restraint in compliance with the law.

19.   *The Mental Health (Care and Treatment) (Scotland) Act 2003*[1] (hereafter MHCT Act), a flagship piece of legislation in the Scottish Parliament, largely replaced the Mental Health Act 1984. The Bill for this Act was passed by the Parliament on March 2003, received Royal Assent on April 2003 and came into force in October 2005.

20.   The MHCT Act sets out a series of general principles to deal with people with a mental disorder. The Act allows the use of compulsory measures in particular circumstances. Under the MHCT Act, there are three main kinds of compulsory powers: emergency detention, under which the patient can be kept in hospital and given treatment for no more than three days; short-term detention, under which the patient is treated for up to 28 days; and a Compulsory Treatment Order (CTO), which could be either hospital- or community-based. A CTO lasts for six months, extendable, but may only be imposed by an independent Tribunal. The legitimate use of these powers is limited to specific situations: the person must have a mental disorder; the ability of the person to make decision should be severely impaired; without administering medical treatment there should be a significant risk to the person or to others, so that the treatment serves to protect the public and the person from serious arm, rather than being a form of punishment. Moreover, the 2003 MHCT Act gave inpatients detained in high security hospitals the possibility to appeal against the level of security under which they are detained.

21.   In case the patient does not consent to treatment, treatment is given in accordance with the rules set out in part 16 of the Act, or under the Adult with Incapacity (Scotland) Act 2000, which provides a legal framework for treating adults with incapacity.

22.   As indicated above, the 2003 Act resulted from a report of the Millan Committee in 2001 (Scottish Executive, 2001a)*, which was produced by* an appointed committee following a two-year consultation. The Scottish Executive accepted the Millan Committee's ten principles shaping recommendations[2] as the basis for legislation, including a stated focus on improving the health of the individual.

23.   For children below the age of sixteen, the Adults with Incapacity Act does not apply. Instead, the child's parents have the right and the duty to take the necessary measures to protect him or her. This right must be exercised in good faith (Principles and good practice guidance, the Mental Welfare Commission for Scotland, 2006).

---

[1]   The MHCT Act is currently being reformed. The Public Services Reform (Scotland) Act 2010 aims, among other things, to amend the MHCT Act to make provision in relation to the Mental Welfare Commission for Scotland. For further information see http://www.legislation.gov.uk/asp/2010/8/part/6

[2]   Non-discrimination, equality, respect for diversity, reciprocity, informal care, participation, respect for carers, least restrictive alternative, benefit, child welfare.

Tribunals and commissions

24.   The 2003 MHCT Act relies on the decisions of a Tribunal system, which represents a key component in delivering mental health services.

25.   The Mental Health Tribunal for Scotland, created on 5 October 2005 by virtue of section 21 of the MHCT Act, decides on compulsory treatment orders (CTOs), monitors and considers regular periodic reviews of orders and appeals against orders made under the MHCT Act.

26.   The Mental Welfare Commission for Scotland, initially established in 1960 under the Mental Health Act, is publicly funded but independent body. The MHCT Act gave the Commission new powers which extended its role in the protection of the rights of service users. These include:

*   to monitor how the Act is working;
*   to publish information and guidance;
*   to carry out surveys, investigations and medical examinations; and
*   to inspect patient records.

Moreover, the Commission ensures that restraint is applied in accordance with good practice.

27.   The Scottish Human Rights Commission has established a framework for embedding rights within mental health care, treatment settings and services.

Detainment, restraint and seclusion rates

Detention Rates

28.   A formal admission refers to a patient admitted under the Mental Health (Scotland) Acts 1960 & 1984 and the Mental Health (Care and Treatment) (Scotland) Act 2003. There was a small increase in the number of people on compulsory treatment orders in Scotland from 2 066 in 2010-11 to 2 181 in 2011-12. Of these, 38% were community based compulsory treatment orders, a slight increase from 2010-11 (ISD, 2013a). Overall, the number of people detained in hospital has fallen since the introduction of community based compulsory treatment orders.

29.   Data gathered from acute and psychiatric hospitals show that the proportion of all admissions that were formal is similar to the previous year, at around 16%. Total admission rates between men and women do not differ: for both men and women, approximately 11.8% of first admissions were formal in the year ending 31 March 2012. Concerning re-admission rates, 16.2% of re-admissions for men were formal compared with 12.9% for women in the year ending 31 March 2012 (ISD, 2013a).

Seclusion and restraint

30.   In general, as settled in the ''Principles and good practice guidance'' prepared by the Mental Welfare Commission for Scotland, restraint should not be used as a punishment. On the contrary, it should be applied for a specific purpose, and the patient should be clearly informed about what this purpose is. Moreover, according to the principle of minimum necessary intervention, restraint should be applied for the minimum possible time and the type of measures taken should be the minimum reasonably necessary (Mental Welfare Commission, 2006).

31.   Monitoring of the use seclusion and restraint also falls to the Mental Welfare Commission, though they do not collect or publish data presently.

2. POPULATION CHARACTERISTICS

2.1. Prevalence of mental ill health across the population

32.   At any given time, one out of six Scots report some kind of mental ill health, one out of 200 suffer from a psychotic disorder, and one out of 25 have a personality disorder (Scottish Government, 2009b).

33.   According to the latest release of the Scottish Health Survey (SHeS) (Scottish Government, 2012a) (see section 3.5. for further information on the SHeS), in 2010-2011, about 7% of people experienced two or more symptoms of depression, a slight decrease from 2008-2009 (8%). However, the percentage of people reporting one symptom of depression significantly increased from 5% in 2008-2009 to 12% in 2010-2011, with similar rates reported for men and women. About 9% of people in Scotland experienced two or more symptoms of anxiety in 2010-2011, with no significant change from 2008-2009. Unlike depression, anxiety was associated with gender, with women being more likely than men to suffer from one or more anxiety symptoms (in 2010-2011, 9% of women and 5% of men had one symptom, and 10% and 8% had two or more, respectively) (Scottish Government, 2012a) (see Figures 1 and 2).

Figure 1. Percentage of people experiencing one or more symptoms of depression, 2010-2011
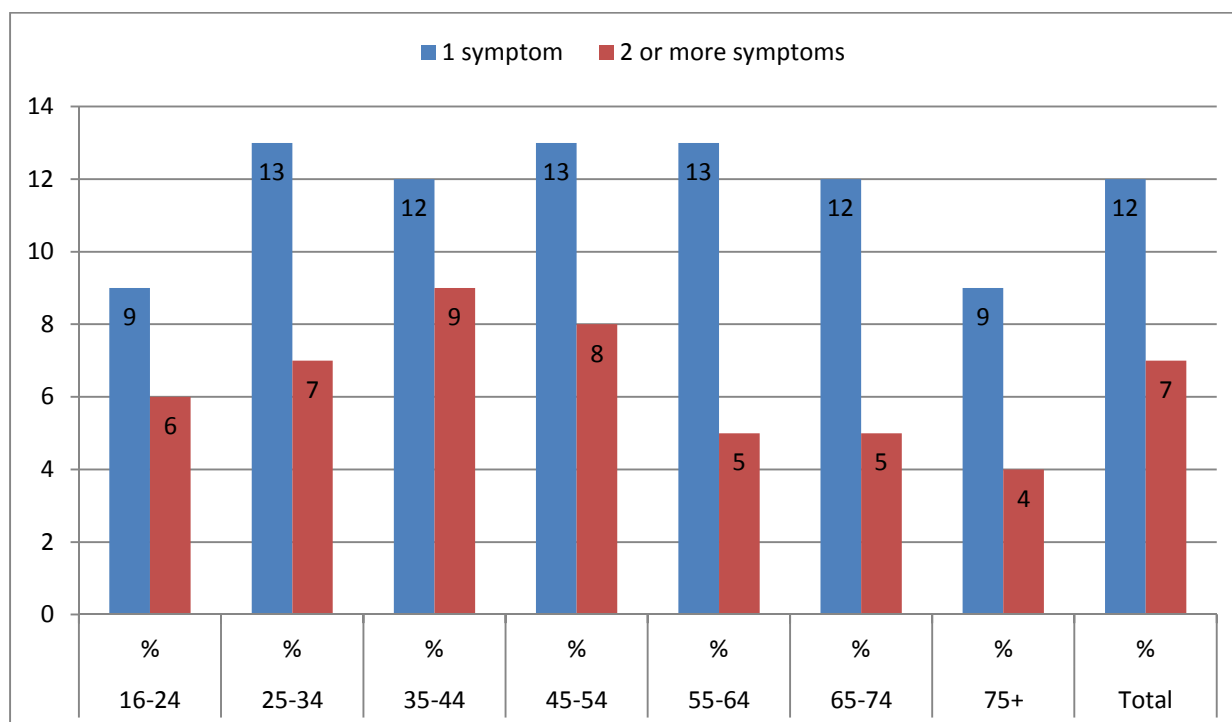
Source: Scottish Government (2012a), The Scottish health survey 2011: Vol. 1: Main report.

Figure 2. Percentage of people experiencing one or more symptoms of anxiety, 2010-2011
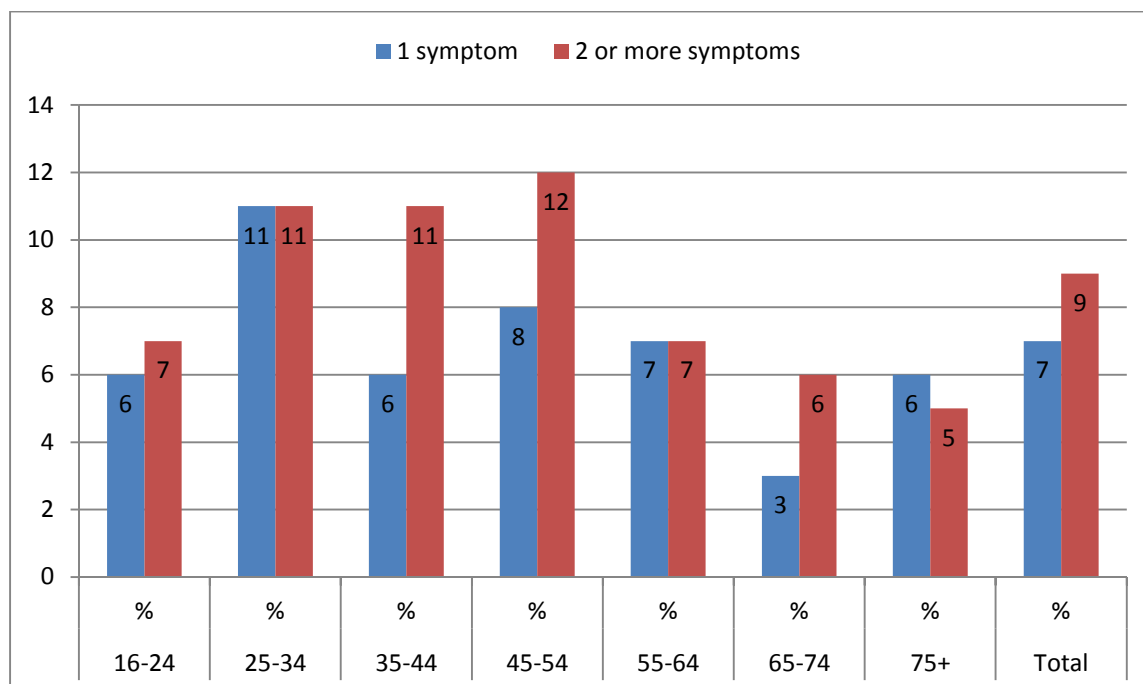
Source: Scottish Government (2012a), The Scottish health survey 2011: Vol. 1: Main report.

2.2. Suicide

34.   The standardised suicide rate over the period 2008 to 2012 was 18.4 per 100 000 population[3]. The data has been standardised by age, sex and deprivation. Approximately 4.4% of these suicides occurred within 30 days of a psychiatric discharge (ISD, 2013a). Different definitions of suicide translates to different way to gather data and different outcomes as a result. OECD data takes into account only confirmed suicide – and as a result comparisons between Scotland and other OECD countries might be difficult.

35.   Looking at the last 30 years, there was a general increase in the 1990s and a general decrease more recently (see Figure 3).

---

[3]   This figure includes (1) suicides (2) underdetermined deaths and (3) some drug related deaths

Figure 3. Suicide rates per 100 000, by gender, 1982-2011*
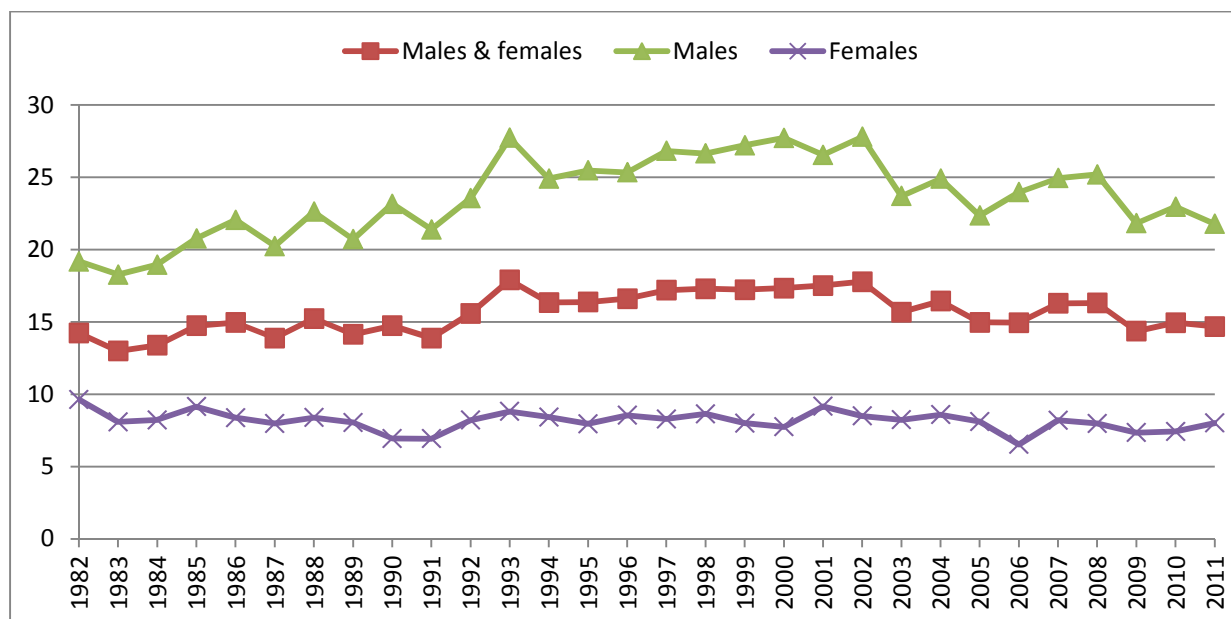
*2011 data based on the new coding rules is not directly comparable to data from previous years.

Source: SCOTPHO (2012a), Suicide: national trends [Online]. Available: http://www.scotpho.org.uk/health-well-being-and-disease/suicide/data/national-trends [Accessed 14/08/2012].

36.   The SHeS (Scottish Government, 2012a) also measured suicide attempts and deliberate self-harm across the population. In order to measure suicide attempts, the survey asked participants the following question: *Have you ever made an attempt to take your own life, by taking an overdose of tablets or in some other way?* SHeS revealed that during the period 2010-2011, 5% of the people interviewed reported having attempted suicide at least once at some point in their lives (6% women and 4% men), with a slight increase from 4% in 2008-2009. 2% of people reported having deliberately harmed themselves without suicidal purpose (Scottish Government, 2012a).

37.   Some specific groups in Scotland are known to have a rate of suicide that is above average. For instance, in the most economically deprived deciles suicide rates are double the Scottish average (ScotPHO, 2012b).

2.3 Other indicators

38.   The number of people receiving incapacity benefit/severe disablement allowance with a mental health diagnosis decreased from 1 908 claimants per 100 000 population in 2010-11 to 1 552 claimants per 100 000 population in 2011-12. The largest group of claimants (36%) had a diagnosis of 'depressive episode' (ISD, 2013a).

39.   The mortality rate for persons in contact with the mental health service in Scotland is 2.8 times higher than the mortality rate for the general population when standardised by age and sex (ISD, 2013a).

3. POLICY AND GOVERNANCE

3.1 Governance and organisation of the health system

40.   NHS Scotland was created as a separate legal entity by the National Health Service (Scotland) Act 1947 and came into effect on 5 July 1948. Figures illustrate that in recent years the NHS Scotland treats approximately 1.3 million inpatients per year and sees 4.4 million outpatients.

41.   Governance and planning are geographically organised, with 14 regional Health Boards responsible for resource allocation, local planning and service delivery (McDaid and Oliver, 2008). Since the abolition of NHS Trusts in Scotland in 2004, the management of hospitals has been under the control of the Boards. At present, following the Health Board (Membership and Elections) Scotland Act 2009, democratic elections have been introduced for the selection of members of the pilot Health Board. As a result, since the first elections, in 2010, members of each pilot board are democratically elected rather being appointed by Ministers. Alongside the Health Boards, there are seven non-geographical Special Health Boards[4] that support Health Board activities by providing specialist and national services.

42.   Healthcare Improvement Scotland was created on 1 April 2011, following the endorsement of the Public Services Reform (Scotland) Act 2010, which was meant to improve the quality of public service provision within Scotland. This public health body has been established in order to sustain the activities emerging from the Quality Strategy for NHS Scotland, a flagship priority strategy of the Scottish Government.

43.   Each of these Boards report to Scottish Ministers, supported by the Scottish Government Health and Social Care Directorates, which include the Health Finance and Information Directorate, the Health Workforce and Performance Directorates, the Health and Healthcare Improvement Directorate, the Chief Nursing Officer, Patients, Public and Health Professions, the Chief Medical Officer, the Health and Social Care Integration, and the Children and Families Directorate.

44.   Health services are often dispensed by community-based organisations. Community Health Partnerships (CHPs) and Community Health and Care Partnerships (CHCPs) are responsible for managing a wide range of local health services that are delivered in schools, health centres, clinics and homes. Some CHPs and CHCPs are also responsible for delivering local social work services (Audit Scotland, 2009).

3.2. Governance and organisation of the mental health system

45.   Mental health services in Scotland are provided by a wide range of organisations at the national and local level. At the national level, the NHS Scotland, through the Health Boards, provides hospitals and community settings. At the local level, councils provide social care and support services as well as a range of other complementary services for promoting well-being, including leisure and recreation services. Voluntary and private organisations also play an important role in providing and managing mental health facilities as well as some security services (*e.g.* prisons).

46.   Access to the majority of mental health services, including primary and secondary care, is controlled by general practitioners (GPs). The primary Medical Services (Scotland) Act 2004 requires that NHS Boards provide or secure "primary medical services" for their populations. As a consequence, at

---

[4]   NHS Health Scotland; Scottish Ambulance Service; NHS National Waiting Times Center; NHS24; The State Hospital Board for Scotland; NHS National Services Scotland.

present GP services are commissioned either locally by Health Boards or nationally by the NHS Scotland through Personal Medical Services (PMS) or "General Medical Services" (GMS) contracts (for further information see section 5.2).

47.   Consultation with a GP is the main contact point for those suffering from mood disorders, such as anxiety and depression, and often is a key contact point for those with severe and enduring mental health problems, such as schizophrenia and bipolar disorders. Data show that mild to moderate mental health problems account for over 30% of GPs' time (Situation Report, 2005). Specialist mental health services are generally provided by hospital psychiatry services and Community Mental Health Teams (CMHTs).

48.   With regards to hospital psychiatry services, the number of psychiatric beds in hospitals as well as the number of admissions to hospitals for psychiatric reasons has significantly decreased over the last ten years in Scotland (for further data about admission rates and beds availability see section 4).

49.   Community Mental Health Teams (CMHTs) usually include community psychiatric nurses, but could also include psychiatrists, clinical psychologists, pharmacists and social workers, depending on arrangements with local agencies and the NHS Scotland. The role of social workers is to ensure that people suffering from some kind of mental illness are supported by social and employment advice services. For instance, Mental Health Officer (MHO) workers are social workers with a specialist training in mental health.

50.   For mentally disordered offenders, there are some forensic mental health services provided in hospitals and prisons or by the community. For instance, The State Hospital is a high-security forensic mental health facility that is administered by a special Health Board – The State Hospitals Board for Scotland, accountable to Scottish Ministers through the Scottish Government – whilst there are other medium and low-security hospitals locally managed by Health Boards. Prisons are managed by the Scottish Prison Service (SPS), and primary healthcare treatments in a prison setting are today directly provided by the NHS Scotland. Prior to November 2011, primary healthcare was provided by the SPS, whilst mental health services have always been provided by the NHS (for further information, see section 4.3).

3.3. Current mental health strategy and recent mental health policy

51.   Over the last ten years, both the World Health Organisation (WHO) and the European Union (EU) have considered mental health to be a particularly important issue that needs increasing resources. The World Health Report of 2001, "Mental Health: New Understanding, New Hope", endorsed by the WHO and the World Health Assembly in 2002, established mental health as a priority in the Global Agenda. In 2008, the European Commission launched its European Pact on Mental Health and Well-being. The Scottish Government collaborates with both the European Commission and WHO in developing mental health policy, including in the development of the European Mental Health Action Plan and in support of the EU Joint Action on Mental Health.

52.   Following Delivering for Mental Health (2006) and Towards a Mentally Flourishing Scotland (2009/2011), the Mental Health Strategy for Scotland 2012-2015 is the most recent mental health strategy. The Mental Health Strategy is consistent with the purpose of the Scottish Government to "focus Government and public services on creating a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth" (Scottish Government, 2012b). The strategy is also in line with the 2020 Vision, whose scope is to assure that, by 2020, "everyone is able to live longer healthier lives at home, or in a homely setting", and fully supports the 3 Quality Ambitions, which set out that health care in Scotland should be person-centered, safe and effective.

53.   The main focus of the 2015 strategy is the improvement of "prevention, anticipation and supported self-management''. The strategy addresses 7 key themes, deployed across 36 government commitments. The main themes tackled by the strategy are:

- *Working more effectively with families and carers*: the strategy aims at involving families and carers in the process of policy development and implementation with regards to mental health. In particular, the Carers Strategy for Scotland 2010-2015, whose scope is to improve support for and provide advice to carers, was set in 2010 and will be pushed forward.

- *Embedding more peer-to-peer work and support*: the work established by the Delivering for Mental Health strategy with regards to peer support will be continued and consolidated. In addition to the peer support worker role within care teams, formal and informal peer support approaches will be integrated.

- *Increasing support for self-management and self-help approaches*: the development and delivery of current self-help programmes, such as Living Life Guided Self-Help Service (NHS 24, 2013), Step for Stress (Scottish Government, 2010b) and the Well Scotland website (NHS Health Scotland, n.d.), will be further supported. Dignity and humanity in treatment has been a priority in Scottish mental health policy (see section 1), and this theme continutes to figure strongly in the 2015 strategy.

- *Extending the anti-stigma agenda to include further work on discrimination*: the strategic direction for the national campaign of *See me* will be further developed for the period 2013 onwards and will focus attention more directly on stigma and discrimination in health and social care services.

- *Focusing on the rights of those with mental illness*: the Government will further work together with the Scottish Human Rights Commission and the Mental Welfare Commission to ensure that the rights of mentally ill individuals are safeguarded.

- *Developing the outcomes approach to include personal, social and clinical outcomes*: the Scottish Recovery Network (Scottish Government, 2013a) was established in Scotland in 2004 to take forward the recovery model. According to the model, the evaluation of a person's well-being should also take into account social and personal outcomes rather than their clinical status alone. Among the existing indicators developed are the Scottish Recovery Indicator, the adult mental health benchmarking indicators and the toolkit. Outcomes-focused planning for mental health will be further promoted.

- *Ensuring that we use new technology effectively as a mechanism for providing information and delivering evidence-based services*: the strategy aims at providing innovative approaches to tackling mental illness. Existing examples of these approaches in Scotland include Cognitive Behavioural Therapy and Guided Self-Help (NHS 24, 2013), provided by NH24 to tackle depression, and Living Life to the Full Online, Beating the Blues and Moodgym services provided by Heath Boards. The NHS Inform service (NHS 24, 2012) provides information on mental health and well-being.

54.   The link to the 2015 mental health strategy is available at: http://www.scotland.gov.uk/Resource/0039/00398762.pdf

55.   A full list of National strategies undergone by the Scottish Governments since devolution is available in Annex 1.

3.4. Mental health strategic initiatives

Suicide

56.   Suicide prevention has been a particular focus of mental health policy in Scotland. After *Choose Life* (see Box 1), in December 2013 the Suicide Prevention Strategy 2013-2016 was launched (Scottish Government, 2013b). The Scottish Government's strategy to reduce suicide focuses on 5 key themes of work in communities and in services with 11 commitments to continue the downward trend in suicides. The key themes are: responding to people in distress; talking about suicide; improving the NHS response to suicide; developing the evidence base; and supporting change and improvements (Scottish Government, 2013b).

Box 1. *Choose Life* strategy

Following a Ministerial commitment to tackle suicide in 2000, the *Choose Life* suicide prevention strategy and action plan was launched in December 2002 (Scottish Executive, 2002a). At the moment of its endorsement, *Choose Life* had seven main objectives with regards to suicide rates: responding to immediate crises; improving support for hope and recovery; providing support to those who are affected by suicidal behavior; awareness-raising and encouraging people to seek help early; supporting the media in the reporting of suicide, knowing what works; early prevention; and intervention. Following recommendations raised by the evaluation of phase one of the strategy, further statutory objectives were introduced within the *Choose Life* strategy, specifically: improve national and local co-ordination; make better connections with key services; develop a more strategic approach to training; and allocate more resources on high-risk groups. Setting a HEAT target of a 20% reduction in suicides in Scotland between 2003 and 2013 also was a concrete engagement made by the *Choose Life* strategy (see section 3.5.).

Funding of GBP 4 million per year for 2003-04 to 2005-06 was earmarked in April 2003 for the *Choose life* programme. A designated National Implementation Support Team (NIST) was established within the Scottish Executive to develop and support implementation of the *Choose life* strategy at the national level. GBP 3 million was allocated to Community Planning Partnerships for local activities. For the period 2006-07 and 2007-08, GBP 1 million continued to be available each year for the national activities taken forward by the NIST, and GBP 3.2 million was allocated to local authorities.

Two independent evaluations examined how far the strategy was embedded in local health boards' work with the National Implementation Support Team, and estimated the cost-effectiveness of the strategy (Platt *et al.*, 2006, Russell *et al.*, 2010), with a third report from the National Suicide Prevention Working Group recommending targeting high-risk groups for the final years of the strategy (Scottish Government, 2010b). Evaluations of *Choose Life* revealed mixed views on the value of such an ambitious high-level target, including questioning whether it was suitable for measuring the broader impact of the strategy.

Given the nature of suicide behaviours, one of the critical challenges in preventing suicide is providing cross-sector initiatives that are not directly related to mental health, but could have positive externalities on the reduction of the number of suicides. Together with a national commitment to reduce suicide rate and a national suicide strategy – *Choose Life* – Scotland provides a range of related mental health services, including work on alcohol abuse and access to psychological therapies, which are likely to reduce suicide rates (Russell *et al.,* 2010).

Source: Scottish Executive (2002a), Choose Life National Strategy and Action Plan, Edinburgh; Scottish Government (2010b), Step for stress: a simple guide to stressing less and enjoying life more, [Online] Available: http://www.stepsforstress.org/. Accessed 13 May 2013; Platt, S., J. McLean, A. McCollam, A. Blamey, M. MacKenzie, D. McDaid, M. Maxwell, E. Halliday & A. Woodhouse (2006), Evaluation of Phase 1 of Choose Life, Edinburgh: Scottish Executive; Russell, P., C. Lardner, L. Johnston & D. Griesbach (2010), Evaluation of Phase 2 of Choose Life, Edinburgh Scottish Government.

Stigma

57.   The inception and the development of *See me* in Scotland stems from a range of specific political, policy and legislative circumstances. The UK-wide Human Rights Act (1998) and Disability Discrimination Acts (1995 and 2005); the European Commission Green Paper on Mental Health in 2005

(European Commission, 2005); the Mental Health Declaration for Europe in 2005 (WHO, 2005); and the international Convention on the Rights of Persons with Disabilities (UN, 2006), all provided the legislative and political framework for addressing discrimination and, in Scotland, gave political legitimacy to proposals aimed at tackling stigma related to mental health. In Scotland, the development of a new legal framework, culminating in the establishment of the 2003 Mental Health (Care and Treatment) Act, fostered the development of an anti-stigma campaign within the Scottish priority agenda.

58.   In addition to these legal dimensions, a two-year Committee – the Millan Committee – was appointed by the Scottish Government in 1998 to review the Mental Health (Scotland) Act 1984 and design a set of recommendations on which the 2003 Act should be based on (see section 1; section 3). Most of the 10 principles drawn by the Committee were directly or indirectly related to the reduction of stigma, addressing non-discrimination, equality, respect for diversity, reciprocity and participation. More importantly, the Committee explicitly recommended that "There should be a campaign of public education designed to improve public understanding of mental disorder, and attitudes towards people with mental disorders, and to reduce the stigma of mental disorder." Running in parallel to legislative changes was the development of a national mental health strategy within the context of a broader health improvement agenda. In 2000, *Our National Health* (Scottish Executive, 2000) identified mental health as one of three National Clinical Priorities. Along with the *Our National Health*, an informal alliance of four, then five, mental health organisations[5] identified stigma as a common concern and subsequently agreed to commit funding to preliminary work. Scotland's first national mental health strategy – *The National Programme for Improving Mental Health and Well-being* (Scottish Executive, 2003) – classified stigma as one of the four key commitments of the strategy. Once the commitment was made and monies identified, in October 2002 *See me* became the vehicle to deliver on the commitment.

59.   Managed by a small core of voluntary and professional organisations, *See me* is the Scottish Government's key anti-stigma campaign for mental health. This model – government oversight and funding for a campaign managed by non-government organisations – allowed the development of a comprehensive and multilateral decision-making process: a bottom-up approach through contacts with the field; a top-down approach from the Scottish Government as a funder; and expertise and knowledge from the management group. Operationally, the activities are run by a small staff of eight people, whilst a Scottish Executive delegate sits as ''observer'' on the management group. A communications agency, IAS Smarts, manages *See me* public relations activity, carries out evaluations, and undertakes the creative design work.

60.   With a principal target of eliminating stigma and discrimination with regards to mental health illness, *See me* refers to five statutory objectives: 1. To tackle stigma and discrimination by raising public awareness of how both affect individuals with mental health problems, and by improving public understanding of mental health. 2. To challenge individual incidents of stigma and discrimination. 3. To involve people in anti-stigma activities across Scotland at the national and local levels and across sectors and communities of interest. 4. To ensure that the voices and experiences of people with mental health problems and their carers are heard. 5. To promote a culture of learning and evaluation through all its work, so that effectiveness can be demonstrated and lessons shared.

61.   Since its establishment, *See me* has undertaken a number of initiatives in order to achieve the above mentioned objectives:

- *General public campaign*: since its establishment, *See me* has used cinema and TV advertisements, press releases and outdoor posters to reach the general public. A *See me* website

---

[5]   SAMH, Penumbra, NSF and the Royal College of Psychiatrists (the Highland Users Group joined the alliance in early 2002).

(www.seemescotland.org) was developed to share information on the campaign and related activities. *Partnership with external institutions and "The Pledge":* education and sport institutions, such as the Bell College and the Motherwell Football Club, agreed to publicly *s*ign the *See me* anti-stigma pledge. "The Pledge" provides a visible commitment by organisations to work with *See me*. For instance, the football players of the Motherwell Football Club wore <u>See me</u> t-shirts during their football matches.

- *Stigma Stop Watch:* this programme is meant to give people the opportunity to complain about offensive representations of people suffering from mental health illness in the media and advertising. Notification of such content enables *See me* to take prompt and integrated public responses. For instance, in 2003 *The Sun* newspaper ran the headline, "Bonkers Bruno Locked Up", referring to the boxer Frank Bruno's detention under mental health legislation. In response to this, *See me* sent an email alert to those who had signed up to Stigma Stop Watch and provided a public integrated reaction.

- *Media guidelines "Mind Your Language":* the guidelines aim at supporting the use of non-stigmatising language by preventing the use of denigratory terms around mentally illness in the media.

- *Media volunteer programme*: through this programme, people who are suffering from some kind of mental illness can have access to a programme offering training for communications with the media.

- *Local activities*: *See me* undertook a variety of initiatives with the aim of supporting local initiatives and extending the campaign's outreach in rural areas. Among others, the event "*See me* By The Sea" in 2003 and the Highland Comedy Tour held across 17 Scottish rural communities was a valuable means of promoting the anti-stigma message in remote areas across Scotland.

- *Young people campaign*: launched in 2005 to prevent stigma among the youngest population, the campaign used the slogan "see me… I'm a person just like you", along with two cartoon images, "Cloud Boy", a young boy who self-harmed, and "Cloud Girl", a young girl who had an eating disorder. The campaign was advertised through some Scottish TV channels.

62.   The evaluation and measurement of *See me's* achievements was judged essential to improving past policies and promoting new initiatives. To date, two evaluations of the work of the *See me* campaign have been commissioned. "*See me* so far" (See me, 2005) is the first review published covering the first four years of the campaign, and a second evaluation was published in 2009 (Myers *et al.,* 2009).

63.   The national survey, "*Well, what do you think?",* collects indicators on levels of stigma and discrimination towards mental health within the Scottish population (Scottish Executive 2002b; Scottish Executive 2005a; Scottish Government 2007a; Scottish Government 2009b). However, as discussed in the 2009 report (Myers *et al.,* 2009), the many parallel activities occurring during this time period make it difficult to measure outcomes and to attribute positive trends in mental health awareness and attitudes to any single initiative. Besides the difficulty of measuring outcomes, the *See me* campaign was a valuable means of raising awareness about mental health issues, by giving a voice to users and carers, promoting a series of "knocking on open doors" local activities, preventing the use of denigratory terms about mentally ill individuals within the context of media reporting, and creating an overall background "noise" around these issues. The 2009 evaluation of *See me* did note a lack of systematic evaluation of the effectiveness of activities in the campaign addressing stigma and discrimination, with only 10 of 28 recorded activities having been evaluated (Myers *et al.*, 2009).

64.   In the coming years, it is planned that the *See me* campaign should adapt to the significant changes in the mental health agenda, and a new strategy will be conceived to meet the scopes and objectives of the Mental Health Strategy for Scotland 2012-2015 (Scottish Government, 2012b). The revised strategy was published at the end of 2013, with a revised narrative meant to be based on the following key aspects: outcomes rather than outputs; alignment with other agencies across the mental health spectrum; communicating the message that people are at the heart of treatment; and a focus on where people experience discrimination.

3.5. Monitoring in the mental health services

Monitoring Surveys

The Scottish Health Survey (SHeS)

65.   The Scottish Health Survey (SHeS) is national survey that aims to gauge the state of physical and mental health across the population, and includes information on the health and lifestyles of Scottish families. The SHeS is an essential tool for monitoring health in Scotland, and consequently identifying gaps within services provisions and assisting the Scottish Government's forward planning (Scottish Government, 2012a).

66.   The SHeS is divided into two main components. The first part covers self-assessed general health and long-term conditions in adults. The second part covers adult mental health and well-being, with a focus on depression, anxiety, self-harm and suicide attempts.

67.   The instrument used for measuring mental health prevalence across the population was the well-established Revised Clinical Interview Schedule (CIS-R). The CIS-R comprises 14 sections, each of which covers a type of neurotic symptom and asks about the presence of symptoms in the week preceding the interview. The two mental health indicators are: *Percentage of adults who have a symptom score of 2 or more on the depression section of the CIS-R. Percentage of adults who have a symptom score of 2 or more on the anxiety section of the CIS-R.*

68.   The first SHeS was conducted in 1995, and then again in 1998 and 2003, whilst the continuous Scottish Health Survey started in 2008 and aims at covering the period 2008-2015. The latest annual release dates back to September 2012. In the section devoted to mental health, the survey was conducted through face-to-face interviews between nurses and participants, and covered depression, anxiety, suicide attempts and deliberate self-harm (see section 2.1. for further information).

"Well? What Do You Think?"

69.   Progress against the priority areas of the National Programme was partially measured between 2002 and 2008 with biennial national cross-sectional surveys in the series, "*Well? What Do You Think?*", collecting data on participants with regard to their: self-assessed health and lifestyle; understanding of concepts of mental health and well-being and of factors affecting their own mental health and well-being; experiences of mental health problems and recovery; sources of information on issues relating to mental health; awareness and understanding of work from the National Programme; general attitudes to mental health problems; and attitudes to vignettes describing individuals with symptoms of mental illnesses (Myers *et al.*, 2009; Scottish Executive, 2002b; Scottish Government, 2007; Scottish Government, 2009b).

70.   The survey was repeated in 2004, 2006 and 2008, with few changes. The final version of the survey was conducted using a random sample of 1 177 Scottish adults (aged 16 to 96, with an average age of 47) between November 2008 and March 2009, through face-to-face interviews (Scottish Government

2009b) (see Section 3.4 for further information). Elements of the survey have now been incorporated into the Scottish Health Survey.

71.   The survey included the WEMWBS, the GHQ12 and the Revised Life Orientation Test (LOT-R) to assess the state of the population's mental health, along with a self-assessed mental health test, and an additional wealth indicator-life satisfaction test.

72.   The Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) is used to measure mental well-being. Researchers at Warwick and Edinburgh Universities were commissioned by NHS Scotland to design this scale for assessing a population's mental well-being. The WEMWBS is a set of 14 questions, which are scored on a range from 14 (lowest level of well-being) to 70 (highest level), for individuals aged 16 and above. As reported in the Scottish Health Survey (Scottish Government, 2012a), in 2010 the mean WEMWBS score was 50.2 for men and 49.6 for women. The vast majority of respondents (75%) fell into the "average mental well-being" category (including those having obtained a WEMWBS score of within one standard deviation of the mean), 12% were classified as having "above average mental well-being" and 13% as having "below average mental well-being". These scores are in line with those reported in *Well?* 2006 (Scottish Executive 2007a).

73.   The General Health Questionnaire 12 (GHQ12) is a survey which aims at gauging levels of possible psychiatric disorders within the population. The test is composed of a set of questions asking whether the patient has experienced symptoms such as happiness, anxiety, depression, etc., on a four-point scale ranging from "less than usual" to "more than usual". These scores were summed up, giving an overall score running from 0 to 12, with 0-3 classified as few symptoms of a psychiatric disorder and 4 and above indicating the possible presence of a psychiatric disorder. *Well?* 2008 shouwed that about 21% of adult respondents were classified as having a low score and 79% a high score.

74.   The Revised Life Orientation Test (LOT-R) has the aim of measuring the level of population optimism. Respondents were asked to choose among six sentences, three of which were phrased in an optimistic manner, with the remaining three expressed in a pessimistic manner. A 5 point scale ("I disagree a lot and I agree a lot") was used to determine whether the respondents agreed with the sentence. Around 50% achieved pessimism scores between 3 and 8, while around 40% achieved scores between 9 and 15 (Scottish Government, 2009b).

75.   The results of the three tests, the WEMWBS, GHQ12 and the (LOT-R) test appear to be consistent (Scottish Government, 2009b).

76.   An additional mental well-being test – the life satisfaction test – was included in the Scottish Health Survey in 2008. In 2010, the average life satisfaction score was 7.5, on a scale ranging from 0 to 10. This figure has not changed significantly since 2002 (Scottish Government, 2012a). In the self-assessed general mental health ratings, respondents were asked to self-assess their general health on a 5-point scale ranging from ''very good'' to ''very bad''. Approximately 74% of respondents rated their health as very good (32%) or good (42%), while 18% said their health was fair and 8% said it was bad (6%) or very bad (2%). These results did not register major changes compared with the results of the 2006 survey, in which 76% rated their general health as good or very good, 18% as fair and 6% as bad or very bad (Scottish Government, 2012a).

77.   The process of selecting and developing indicators offers lessons on the use of information to benchmark mental health. For instance, information for population health indicators to produce *Scotland's Mental Health and its Context 2009* came mostly from routine surveys with large sample sizes. However, survey data presents problems, including representativeness (as household surveys may omit particularly vulnerable populations), difficulty in ensuring the questions remain comparable between years, and recall

bias due to reliance on self-reporting (Parkinson, 2006; Garcia-Armesto *et al.*, 2008). As a consequence, some of the available data should be interpreted with caution.

Outcomes and quality indicators

Adult Mental Health Benchmarking Toolkit

78.   The main instrument developed specifically to monitor service activity is the *Adult Mental Health Benchmarking Toolkit* (ISD, 2013). In line with other elements of the National Benchmarking Project in NHS Scotland, the toolkit presents performance indicators in a balanced scorecard (BSC) format, combining structural, process and outcome indicators (ISD, 2012c).

79.   In the pilot scorecard first developed, indicators were grouped under four domains: efficiency, patient quality, cost and future (sustainability and preparation for future needs, such as staff training). When the Toolkit was implemented, a similar, though not identical, set of indicators was instead categorised under domains used in the NHS Quality Strategy: "Efficient, Effective, Person-centred, Safe, Equitable and Timely" (Donnelly, 2008; ISD, 2013a; Scottish Government, 2010a; Institute of Medicine, 2001), as shown in Table 1.

80.   Benchmarking is conceived as both a measurement and a management tool, with the intention that a coordinated and reliable system for recording data should help engage clinicians with their own practices and outcomes compared to those nationally. A consistent and standardised tool such as this is designed to identify both best practice and failings, nationally but more importantly for individual clinicians. GPs are encouraged to learn from colleagues, and services are motivated to draw on best practice examples in areas where they may be performing less well (Coia and Glassborow, 2009). As well as the efficiency arguments detailed in the initial Benchmarking Project reports, consistent data collection in certain areas is a requirement of the MHCT Act and equalities legislation (Donnelly, 2008).

Table 1. Indicators used in the Adult Mental Health Benchmarking Toolkit

Balanced scorecard in use from 2009 onwards:

Efficiency	Effectiveness
Total spend for mental health Total mental health spend in the community **Percentage community spend** **Drugs Cost - Gross Ingredient Costs** Drugs Cost - Defined Daily Doses Total occupied care home beds per 100 000 population **Total mental health staff numbers** Applied Psychologists **Total psychiatric beds per 100 000 population**	**Average length of stay** Average length of stay: 80/20 split **Information quality and capture** Percentage readmissions within 28 days Percentage readmissions within 133 days
Person Centeredness	**Safety**
Percentage delayed discharges Percentage of community CTO of Total CTO	**Percentage of voluntary inpatients and compulsory inpatients by Board** Number of practising mental health officers **Suicide rates per 100 000 (crude and standardised rates)** **Training and supervision index**
Equity	**Timeliness**
Persons on incapacity benefit/severe disablement allowance **Relative risk of death for persons with severe and enduring mental illness**	*[no indicators yet included]*

Source: ISD (2013a), *Adult Mental Health Benchmarking Toolkit*, ISD Scotland 2013.

Scottish Recovery Indicator (SRI)

81.   The concept of "recovery" gained prominence in Scotland in the late 1990s, with Scottish service-user groups and NGOs drawing on existing policy in New Zealand to articulate the concept of recovery (Smith-Merry *et al.*, 2010a). As a policy goal, "recovery" differs from clinical remission in that it looks beyond clinical symptoms and includes dimensions such as social inclusion and fulfilment, following the principle that "regardless of symptoms people with serious mental health problems should be given every opportunity to lead a fulfilling and satisfying life" (Bradstreet and Brown, 2004:5).

82.   At the time of the Mental Health (Care and Treatment) (Scotland) Act 2003, recovery was not included as a key principle. That same year, however, recovery was codified as one of the four aims in the National Programme and was further established in the policy document for mental health services, *Delivering for Mental Health* (2006a), the review of the mental health nursing profession *Rights, Relationships and Recovery* (2006b), and the population mental health improvement plan *Towards a Mentally Flourishing Scotland* (2009a). "Recovery" as a policy goal represented a broadening of the approach to mental health in Scotland, widening treatment objectives for mental disorders. This policy target was followed by further redefinitions of the approach to mental health, as mental health was introduced to the Scottish "HEAT targets"[6] from the early 2000s.

83.   The review *Rights, Relationships and Recovery* (Scottish Executive, 2006a) recognised that as well as affirming the values of recovery, examples of good practice included initiatives that formally

---

[6]   **H**ealth Improvement for the people of Scotland – improving life expectancy and healthy life expectancy; **E**fficiency and Governance Improvements – continually improve the efficiency and effectiveness of the NHS; **A**ccess to Services – recognising patients' need for quicker and easier use of NHS services; and **T**reatment Appropriate to Individuals – ensure patients receive high-quality services that meet their needs.

embed recovery-based approaches in practice. In addition to networks linking service with user organisations, environmental audit tools were recommended as useful mechanisms for practitioner self-assessment. Subsequent to this, the *Delivering for Mental Health* strategy (Scottish Executive, 2006b) included a commitment to developing a tool to measure how far mental health services met expectations in promoting "equality, social inclusion, recovery and rights". Recovery is here defined as "the degree to which services are structured to deliver better outcomes across a range of domains, including employment, housing, education and training opportunities, family and social life" (Scottish Executive, 2006b:1).

84.   The Scottish Recovery Network developed a self-assessment instrument for local services named the Scottish Recovery Indicator (SRI), piloted in 2007[7]. *Towards a Mentally Flourishing Scotland* (Scottish Government, 2009a) proposed that the SRI was to be used in a majority of services by 2012, although only the extent of uptake is directly monitored by the government, not the actual results, on the basis that the focus of the SRI is local improvement in services. The SRI consists of online forms with guidelines directing staff to assess different aspects of their services against ten indicators, such as promoting social inclusion (Scottish Recovery Network, 2011). As Smith-Merry *et al.* (2011) point out, the depth of the guidelines provided and the preparation required by the self-assessment team is designed to reinforce the specified recovery values through a lengthy self-reflective process. The SRI2 was launched in 2013 to be more user friendly and is seeing greater uptake.

The HEAT Targets

85.   A number of health policy commitments are translated into HEAT targets, representing Ministerial priority areas agreed with NHS Scotland for which NHS Boards are directly accountable (Scottish Government, 2011a). Introducing mental health targets within the overall HEAT targets was challenging as it represented a cultural change requiring the creation of quality mental health data that was relevant and also subjecting mental health services to expectations of measurable improvement. There were concerns from some stakeholders across all sectors about how this would work in practice and if it could be done in a way that understood how of mental health was 'different' from other health challenges, and in a way that reflected what was really important and not just what was measureable. However, whilst this was quite radical it is regarded as being a success and the trend in Scotland has continued with considerable success, and is a direction increasingly followed in other OECD countries.

86.   The first HEAT target set for mental health was a commitment in the *Choose Life* strategy to reduce the suicide rate by 20% between 2002 and 2013. Due to the breadth of factors affecting suicide rates, the target was criticised as a weak indicator for the success of any individual intervention or of the Health Boards as a whole. On the other hand, the symbolic power of the outcome target was recognised as facilitating financial investment and public engagement with the strategy (Russell *et al.*, 2010; Smith-Merry *et al.*, 2010b).

87.   In 2008, another HEAT target was established to "[ensure] 50 per cent of key frontline staff in mental health and substance misuse services, primary care, and accident and emergency [are] educated and trained in using suicide assessment tools/suicide prevention training programmes" (NHS Scotland, 2006) by 2010. In 2010, the target was considered to be met, since all NHS Boards had trained between 50-56% frontline staff, with a national average of 52% (NHS Scotland, 2012).

88.   The Delivering for Mental Health (DfMH) strategy (Scottish Government, 2006a) introduced a further target to reduce the annual rate of increase in defined daily dose (DDD) per capita of antidepressants to zero by December 2009. This was primarily linked to concern about low "availability of

---

7   For further information on the SRI see http://www.sri2.net/27-introduction-to-the-new-scottish-recovery-indicator-sri-2.

and access to psychological therapies and support for self-care" (Scottish Government, 2006a: 4). In addition, approximately 40% more antidepressants per capita were prescribed in Scotland than in England and Wales (ISD, 2002), though this gap has been closing in recent years. When this target was set, however, there was insufficient data about availability, staffing and outcomes of services in operation to directly measure this (NHS Quality Improvement Scotland, 2007), and by 2009, it was clear that the target would not be met.

89.   Some evaluations of the prescribing habits for antidepressants suggest that the rising DDDs were not driven by inappropriate prescribing, but that the chief driver was a small increase in long-term patients (Moore *et al.*, 2009; Cameron *et al.*, 2009; Burton and Simpson, 2010). Increased access to psychological therapies also did not appear to reduce antidepressant prescriptions, rendering the target even less effective as a proxy (Mental Health Collaborative, 2011). A report by NHS Greater Glasgow & Clyde (2007) raised plausible explanations for the year-on-year increase in DDDs that were not incorporated at the time the target was set, such as effective anti-stigma campaigns and the perceived greater safety of new generation drugs (as well as pharmaceutical marketing), which make people more willing to approach their GPs for antidepressants. Furthermore the Scottish government stated that it was well aware of the various issues at play around antidepressant prescribing, suggesting that the main determinants of the target not being met were changed clinical guidance on volume of prescribing; better adherence to prescribing guidelines by GPs; an absence of evidence for a direct short term link between increased access to therapies and reduced prescribing. Overall this missed target is not in and of itself a cause for major concern.

90.   In addition, the Health Boards stated that they would strive to meet the HEAT target, which was useful, but that their *"immediate priority is to work towards ensuring that our prescribing practice is appropriate only when we have achieved such self-assurance will we be in a position to assess our [DDD] prescription levels"* (NHS Greater Glasgow & Clyde, 2007:5). For the Health Boards the primary objective was good clinical care, and considered that if clinical care was appropriate missing the target was less of an issue that it might have been otherwise. Additionally, the above research was conducted due to having a HEAT target, with a meagre initial evidence base on drivers of antidepressant prescribing (ISD, 2002). While the antidepressant target was "[always] acknowledged as a proxy measure for improved access to psychological therapies" (Scottish Government, 2009:8), this acknowledgement was not explicit in the DfMH; the target could not be officially abandoned before its delivery date, but was reframed as a driver for research.

91.   DfMH set a target of a 10% reduction in readmissions within one year of individual psychiatric inpatient admissions of over 7 days; this was intended to capture how local crisis services, inpatient units and discharge processes were of high quality and were functioning together, as reducing readmissions would require improvements on all three fronts (2006a). The target was met and exceeded, with a national reduction of 27%, which has largely been maintained.

92.   In 2009, the Government set a HEAT target of reducing to "26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013; reducing to 18 weeks by December 2014". To date**,** around 94% of people were seen within 26 weeks and 85% of people were seen within 18 weeks, and the current median wait is about 9 weeks (ISD, 2013b).

93.   The most recent HEAT target, set in March 2010, was to reduce waiting times for psychological therapy to a maximum of 18 weeks from referral, to be met by December 2014. A Psychological Therapies Implementation and Monitoring Group (PTIMG) was established in order to deal with the implementation and governance of the target. The current median wait is about 8 weeks for accessing psychological therapies in Scotland. It was estimated that the number of therapies has increased from around 20 000 per year in 2008 to around 35 000 in 2013.

(See Annex 2.1 for a comprehensive list of HEAT targets related to mental health).

Children and adolescent mental health indicators

94.   The CAMHS Balanced Scorecard BSC is a strategic performance measurement framework, still under development, that comprises the 16 key performance indicators summarised below.

Delivering best practice

Key Performance Area	KPI
(1) Deliver good clinical outcomes	To be developed
(4) Provide effective and evidence based treatments	**4.1 Numbers of 3-4 year olds whose parent(s) have received a targeted evidence-based parenting programme in the last 6 months (supported or delivered by specialist CAMH workforce)**
(8) Comply with best practice guidance (assessments and treatments)	**8.1 Admission bed days of all 0-18s/100k** **8.2 Admission bed days (adult wards)/100k pop**
(10) Provide a comprehensive range of effective CAMH specialist services	**10.1 Community tier 4 direct patient work as proportion of all activity**

Client/patient focus

Key Performance Area	KPI
(2) Provide person centred services	To be developed
(5) Achieve fast access to services	**5.1 Waiting (RTT) more than 26 weeks** **5.2 waiting ≥ 26 weeks as a % of referral volume**
(6) Achieve wide access to services	**6.1 Number of patients referred for mental health assessment in the last 3 months who are categorised as having a learning disability** **6.2 % of 16 and 17 year olds with access to specialist CAMHS**
(7) Provide quality clinical services	To be developed
(17) Effective user and carer	To be developed

Internal processes

Key Performance Area	KPI
(3) Conduct effective and integrated assessments	To be developed (from CAMH ICP standards)
(9) Ensure fully comprehensive integrated care pathways	To be developed (from CAMH ICP standards)
(11) Promote and publicise services	**11.1 No of referrals/100k pop**
(12) The gathering and use of evidence	**12.1 no of peer reviewed publications with a CAMHS theme in last 24 months**
(15) Ensure the engagement of multi-agency partners in the CAMH capacity development agenda	**15.1 Number of consultations**

Best use of resources

Key Performance Area	KPI
(13) Conduct effective planning and management	To be developed (from CAMH ICP standards)
(14) Ensure we have the right people with the right skills	**14.1 Specialist clinicians/100k pop** **14.2 Staff sickness absence (as %)**
(16) Ensure adequate resourcing	**16.1 Community CAMHS wages budget /100k pop**
(18) Deliver value for money services	**18.1 % of all appointments which are DNAs** **18.2 Total number of appointments/100k/month**

Indicators commissioned by the National Programme

95.　　NHS Health Scotland was commissioned in 2004 by the Scottish Government's National Programme for Improving Mental Health and Well-being (the National Programme) to design a set of indicators to be used in developing a wide-ranging population mental health monitoring system. A set of some 54 adult mental health indicators was finalised in December 2007 (Parkinson, 2007). The 54 indicators are divided into high-level constructs of mental health status (positive and negative mental health) and contextual constructs, covering protective factors (determinants) and the consequences of mental health, which may be at an individual, community or structural level (see Table 2).

Table 2. Framework of adult mental health indicators (number of indicators in brackets)

Mental Health		
Mental Well-being (2)	Mental health problems (7)	
CONTEXTUAL CONSTRUCTS		
Individual (10)	Community (12)	Structural (23)
Learning and development (1)	Participation (3)	Equality (2)
Healthy living (4)	Social networks (1)	Social inclusion (2)
General health (3)	Social support (2)	Discrimination (3)
Spirituality (1)	Trust (2)	Financial security/debt (2)
Emotional intelligence (1)	Safety (4)	Physical environment (6)
		Working life (6)
		Violence (3)

Source: SCOTPHO (2012c), Scotland's mental health. Full Report, October 2012. NHS Health Scotland 2012 At:http://www.healthscotland.com/uploads/documents/19848Scotland'sMentalHealthAdults%202012%20-%20full%20report.pdf

96.　　It is largely recognised in Scotland that mental health is composed of mental well-being and mental health problems (Parkinson, 2007). Mental well-being characteristics include life satisfaction, having a purpose in life and enjoying positive relationships with others. In Scotland, mental well-being has been calculated lately through the WEMWBS measure (see section 3.5.). Mental health problems range from common mental disorders such as anxiety and depression to severe and enduring mental illnesses such as schizophrenia. The presence of mental health problems within the population has been assessed through the GHQ12 test (see section 3.5.).

97.　　The first data published available to populate these indicators was in the population health report *Scotland's Mental Health and its Context* (Taulbut *et al.*, 2009), whilst the latest publication, reporting data for 45 of the indicators and the equalities analysis, was released in October 2012 (ScotPHO, 2012c). The indicator set should be used to facilitate monitoring over time and comparisons between population and geographical sub-groups (Parkinson, 2007; Scottish Government, 2009a). It is also intended to assist in developing the understanding of the interplay between contextual factors and mental health outcomes. The indicators are explicitly not designed to inform provider performance management or as an assessment of service delivery.

3.6. User involvement: consumer associations, family associations and other NGOs

98.   A large number of non-governmental organisations (NGOs), such as The Mental Health Foundation (http://www.mentalhealth.org.uk/), Scottish Association for Mental Health (SAMH) (http://www.samh.org.uk/), Vox (http://www.voxscotland.org.uk/) and others have an important role in raising awareness across the Scottish population, providing support to users, conducting surveys of services access and needs, and providing mental health services or advice about available mental health services. These NGOs also enhance the active involvement of mental health users in the decision-making process, giving a voice to people with mental health problems and their families.

99.   NHS Scotland's engagement with community services is apparent today. Local participation in the decision-making process with regards to mental health policies is largely encouraged by the Scottish legal framework and currently implemented by national strategies. Most recently, the Mental Health Strategy for Scotland 2012-2015 stresses that service users should participate in the decision-making and governance process. Two out of the seven key themes of the 2015 Strategy comply with community participation in the development of mental health services. The first key point entails, "Working more effectively with families and carers". This includes involving families and carers in the development of policies and their implementation. The second key point outlined by the 2015 Strategy is the importance of "Embedding more peer-to-peer work and support", continuing the work started by Delivery for Mental Health.

4. ORGANISATION AND DELIVERY OF SERVICES (INCLUDING HUMAN RESOURCES)

4.1. Adult mental health

Primary care

100.   Primary mental health care is primarily provided by general practices, as, since the amendment of the National Health Service (Scotland) Act 1978 with the introduction of the Primary Medical Services (Scotland) Act 2004, patients must register with the practice as a whole rather than with the GP. Patients should therefore have access to a wider range of services, including consultation with other health professionals and nurses.

101.   Data are available on the number of consultations between patients and members of the practice team, defined as all GPs and practice-employed nurses. It is estimated that in 2012-2013 there were just below 500 000 consultations for anxiety within general practices. This figure has fallen slightly since 2003-2004. Also, most of the people seeking a consultation for anxiety and stress-related symptoms are more likely to contact a GP rather than a nurse or a health visitor (ISD, 2013c) (see Figure 4). This is in part a consequence of the focus on depression established under the QOF (see section 5.2.) and under the Delivering for Mental Health (2006) which has led to greater care in recording data and a greater bias towards treatment.

Figure 4. Anxiety and related conditions – estimated number of consultations, 2003-04 to 2012-13, by staff discipline

102.   The number of females estimated to consult their GP for anxiety is more than double the number of males, for almost all age groups (see Figure 5).

Figure 5. Anxiety and related conditions – per capita patient visits, 2012-13, by gender and age
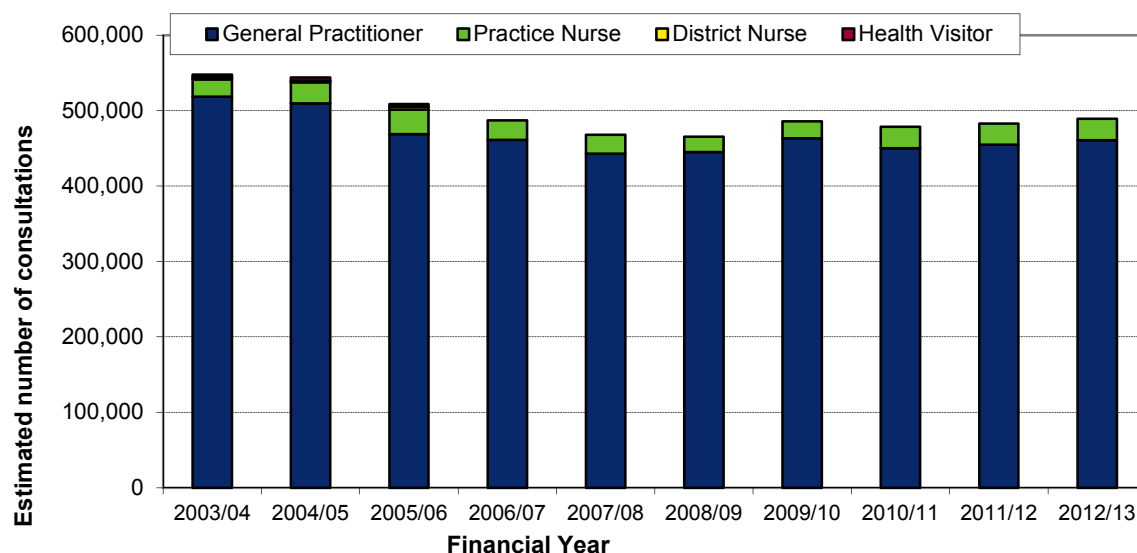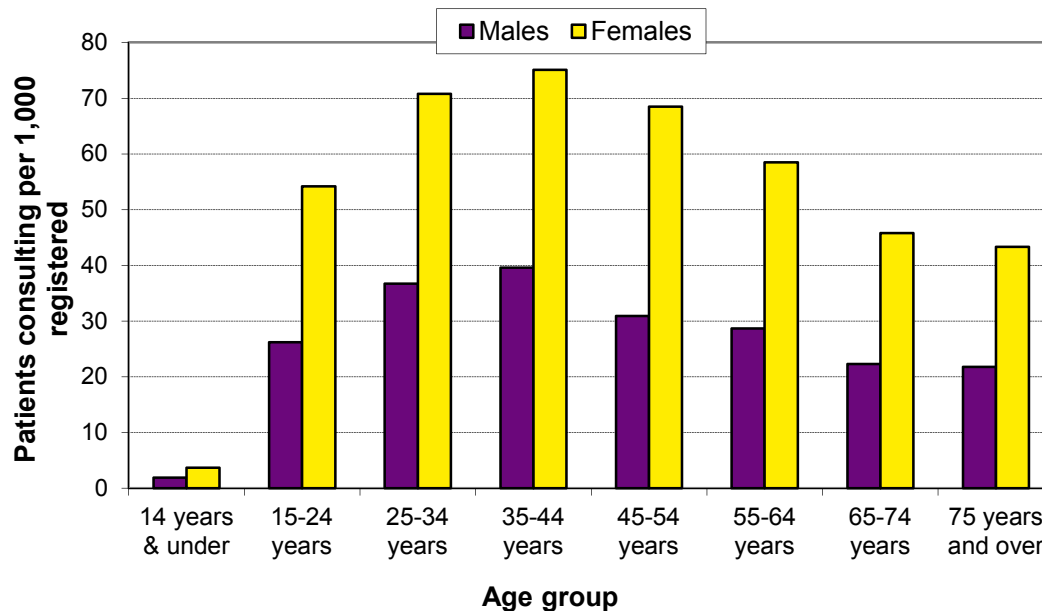
Source: ISD (2013c), *Practice Team Information (PTI)*. Available: http://www.isdscotland.org/Health-Topics/General-Practice/Publications/2013-10-29/2013-10-29-PTI-Report.pdf?97323244811

103.   It has been estimated that in 2012-2013 just above 400 000 consultations for depression took place in general practices in Scotland. Even though the total number of consultations for depression has decreased significantly from 2003-04 to 2012-13, this decrease should be taken with caution, as it is more likely to reflect changes in diagnostic coding practice than an actual decrease in the number of consultations. The vast majority of consultations for depression were with a GP, whilst the involvement of other specialists was reasonably small (see Figure 6) (ISD, 2013c).

Figure 6. Depression – consultations, 2003-04 to 2012-13, by staff discipline

104.   Like the number of consultations for anxiety, the number of females consulting a GP for depression is higher than for men for all age groups (ISD 2012f) (see Figure 7).

Figure 7. Depression – consultations, 2012-2013, by gender and age

105.   Since October 2010, the United Kingdom Government has introduced welfare reforms and austerity measures, namely a reduction of GBP 81bn in public spending over four years. "GPs at the Deep End" is a group of 100 general practices serving the most deprived areas of Scotland. A report was drawn

on the experience of Deep End practices with regards to the direct and indirect consequences of deprivation on patients' health (Blane and Watt, 2012). In particular, it was found that poverty had deteriorating effects on the mental health status of people living in the most deprived areas. People suffering from chronic mental health problems have a greater number of contacts with their GPs and psychiatrists and higher use of psychotropic drugs and higher alcohol consumption. As a result of the increasing pressure on appointments, "[primary care] practices report sadness and frustration among staff members at their inability to alleviate the suffering they see, and increased stress due to extra workload. […] [T]his has potentially significant detrimental impacts on patient care" (Blane and Watt, 2012:4). There are indications that the recession has put pressure on both services through increased demand with flat budgets and through the more challenging welfare environment established by the UK Government.

Secondary care

106.   Following consultation with GPs, specialist mental health services are the point of entry into the mental health system for those suffering from a mental disorder, especially for individuals suffering from severe and enduring mental health problems, such as schizophrenia and bipolar disorders. Specialist mental health services are generally provided by hospital psychiatry services and Community Mental Health Teams (CMHTs). Psychological therapy and similar therapeutic interventions for mild-to-moderate disorders have been significantly developed in recent years. Investment in such therapies can be seen somewhere between primary care services (GP services, primary care clinics) and specialist services, historically concentrated on severe and enduring disorders, as they are generally offered as secondary service, but not by CMHTs. Community services have developed over the last ten years; however, there is a lack of data about how they work (Audit Scotland, 2009). Psychiatric wards of general hospitals generally provide mental health treatments and care on a voluntary or formal (involuntary) basis.

Inpatient care

107.   There were approximately 20 919 inpatient admissions (10 516 male and 10 016 female) with a primary diagnosis of a mental disorder in the year ending 31 March 2011 (ISD, 2012). This figure, which includes formal (involuntary) and voluntary admissions, is 17% lower than that recorded in 2006-2007. About 55% of those 20 929 inpatients were re-admissions to a mental health facility, and 45% of the admissions were recorded as a first admission to hospital (ISD, 2012).

108.   General (adult) staffed psychiatric beds have decreased from approximately over 3 000 beds in 2004 to over 2 000 in 2013, and occupancy rates decreased as well, passing from 84.5% to 81% in the same period (ISD, 2013d) (see Figure 8). In Scotland, the overall average length of stay for general mental health specialties increased from 46 days in 2004 to over 36 days in 2013 (ISD, 2013d).

Figure 8. General staffed psychiatric beds and occupancy rate, 2004-2013
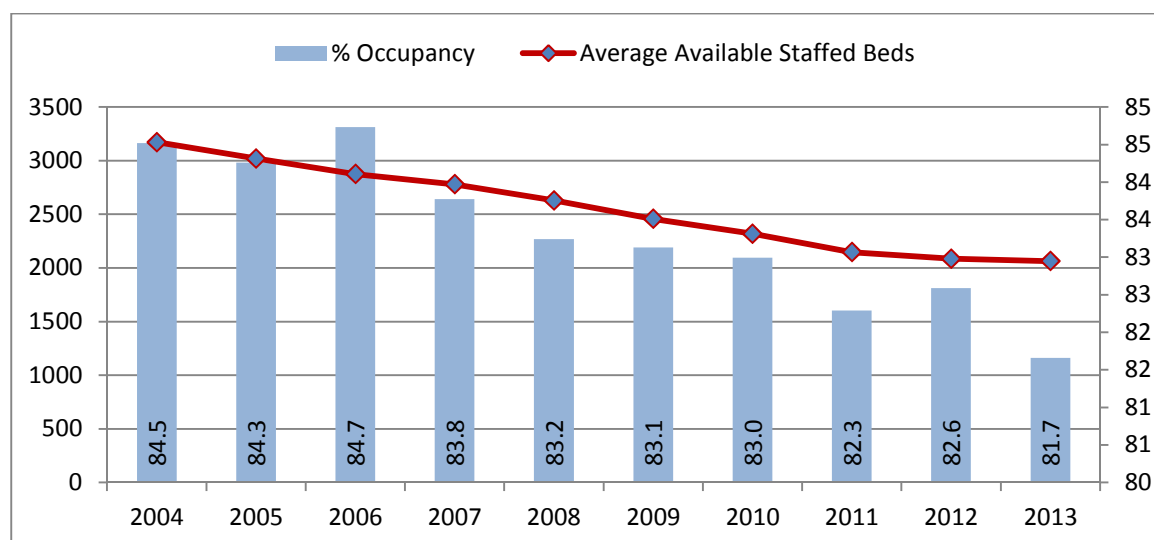
Source: ISD (2013d), Available Beds by Specialty & NHS Board of Treatment [Online]. Available http://www.isdscotland.org/Health-Topics/Hospital-Care/Beds/

109.   During the year ending March 2012, patients with a diagnosis of mood (affective) disorders accounted for 27% of all admissions, followed by schizophrenia (14%), depressive episode (13%), alcohol misuse (12%), dementia (11%) (ISD, 2012) (the results are summarised in Figure 9).

Figure 9. Mental illness discharges by main diagnosis on discharge: year ending 31 March 2012
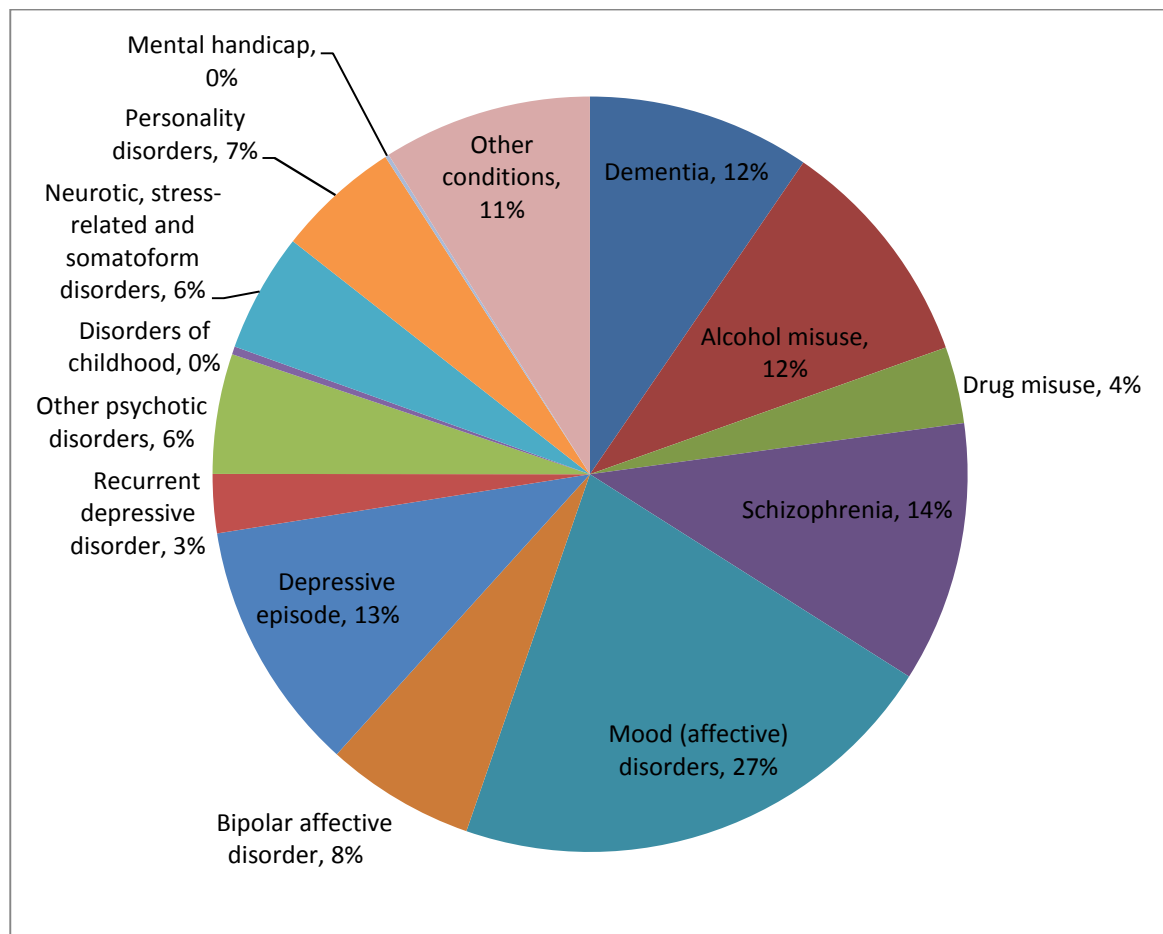
110.   With regards to the average length of stay in acute and psychiatric hospitals (all stays), more than 75% of discharges occurred within 4 weeks of admission in the 15-44 age group, progressively declining to around 28% of discharges in people aged 75 and over. Longer lengths of stay by elderly patients are likely explained in part by the use of compulsory treatment orders for dementia sufferers (ISD, 2012).

111.   With regard to the readmission rate in acute and psychiatric hospitals alone, the number of readmissions within one year of the discharge date decreased steadily from 4 576 for the year ending 31 December 2004 to 3 426 for the year ending 31 December 2009, *i.e.* a 25.1% reduction in readmission rates over five years (ISD, 2012).This was in the context of a HEAT target and a structured improvement process. The target was to reduce readmission rates by 10%, and for the period covered (years 2008, 2009 and 2010) the reduction delivered was much higher.

Outpatient care

Psychological therapies

112.   NHS Scotland has seen an increase in demand for applied psychologists and psychological therapies in recent years. Recent mental health strategies, such as *Delivering for Mental Health* (Scottish

Executive, 2006b) and *Towards a Mentally Flourishing Scotland* (Scottish Government, 2009a), have promoted psychologically-based approaches as treatments to tackle mental health disorders. In addition to the engagement of national strategies, the Scottish Intercollegiate Guidelines Network (SIGN), the Scottish Association for Mental Health (SAMH) and the National Institute for Health and Clinical Excellence (NICE) recognise the effectiveness of psychological therapies in delivering positive change for a wide range of mental health clinical conditions.

113.   Timely access to healthcare is a key measure of quality. The HEAT target "Deliver faster access to mental health services by delivering 18 weeks referral to treatment for psychological therapies from December 2014" was approved by the Scottish Government in November 2010 and is currently being implemented in Health Boards. The objective is to deliver on-time[8] evidence-based psychological therapies to efficiently and effectively treat mental disorders.

114.   A range of improvement programmes have been put in place to support the achievement of the HEAT Target and guarantee on-time evidence-based psychological treatments. For instance, the Psychological Therapies "Matrix" has been developed as a guide to help Health Boards to deliver efficient and effective psychological therapies. In order to achieve this objective, the Matrix summarises the most up-to-date advice on evidence-based interventions, provides the necessary training for delivering safe and effective therapies, and identifies the key gaps in mental health services. The Driver Diagram has been developed to support the implementation of the target across the Health Board activities. It is a method conceived to identify the parts of the mental health delivery system that need to be improved, and then to make recommendations for specific changes.

Intensive home treatment services

115.   Intensive Home Treatment Teams (IHTT) services have been developed in a number of Health Board areas (Mental Welfare Commission, 2012) as an alternative to hospital admission. The IHTT service is designed to provide community-based intervention during periods of crisis and acute illness, to monitor medication and to solve problems by adopting a person-centered approach. The service allows individuals to stay in their own home or care-setting and to receive hospital-equivalent care without being admitted as an inpatient. The IHTT service is provided within both adult and children mental health facilities (see section 4.2.).

116.   The adult IHTT service is active in 19 health facilities across the 14 NHS Boards. Generally, teams working within IHTT receive referrals from mental health inpatient wards, GPs, A&E departments, Community Mental Health Teams (CMHTs), psychiatrists, psychologists, social work, self-referral, carers/relatives, voluntary agencies, drug & alcohol services and the police, although differences exist across NHS Boards. Practitioner numbers in adult services varied from 2.5 whole-time equivalent staff in a rural service to 26 staff in an urban setting (Mental Welfare Commission, 2012).

4.2. Child (and adolescent) mental health

Inpatient care for children and adolescents

117.   The overall number of psychiatric beds for children and adolescents (under 18), and occupancy rate, have increased slightly over the last ten years (see Figure 10) (ISD, 2013d).

---

[8]   The waiting time is defined as the interval between the date referral was received and the date psychological therapy begins as planned.

Figure 10. Child and adolescent psychiatry: average available staffed beds and occupancy rate, 2004-2013
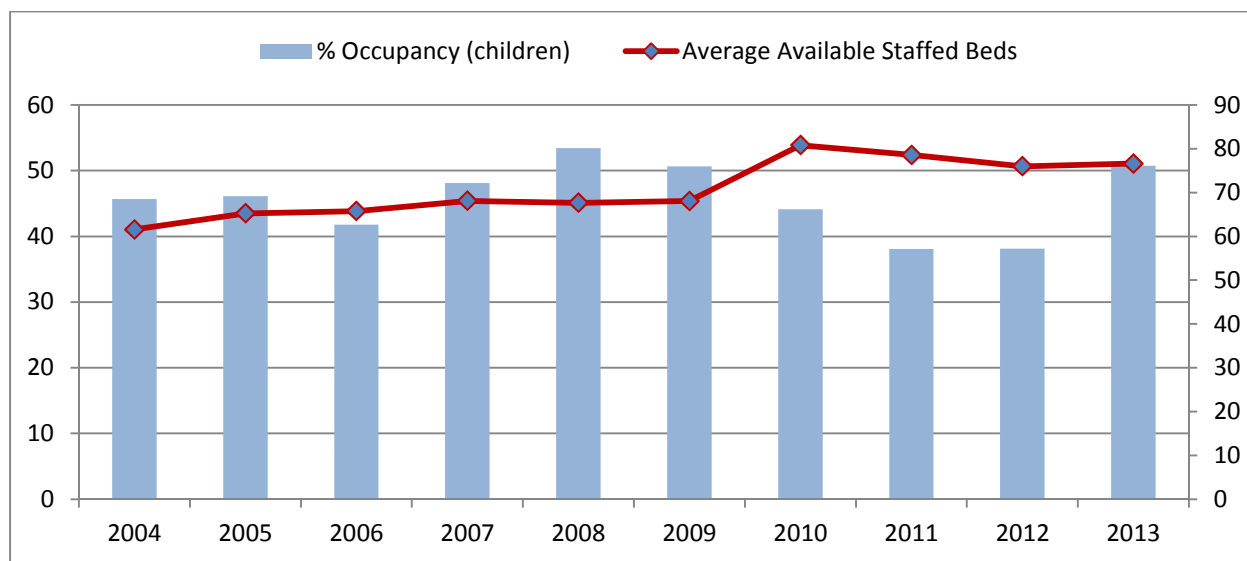
Source: ISD (2013d), Available Beds by Specialty & NHS Board of Treatment *[Online]. Available* http://www.isdscotland.org/Health-Topics/Hospital-Care/Beds/

Outpatient services for children and adolescents

118.   The Child and Adolescent Mental Health Services (CAMHS) provide services for children suffering from serious mental health disorders, which are delivered by psychiatrists, psychologists, nurses and social workers. These services are based mainly in outpatient clinics and in the community.

119.   The work of the CAMHS has been considerably developed and continuously updated since its establishment. The Scottish Needs and Assessment Programme (SNAP) Report on Child and Adolescent Mental Health 2003 assessed the pivotal role of the CAMHS. The SNAP also set the broad direction for the subsequent decade in order to support the further development of the CAMHS. In 2005, the Scottish Government set a policy commitment of developing the CAMHS services in the Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care. Getting the Right Workforce Getting the Workforce Right (Scottish Executive, 2005a) set out the implications arising from the work undertaken to realise an earlier Ministerial commitment to prioritise the development of the CAMHS workforce. Delivering for Mental Health (2006) contained specific commitments to provide a CAMHS link worker for every school, to make basic mental health training available for all those working with or caring for looked-after and accommodated children, and to reduce the number of admissions of under 18s to adult wards by 50%. Towards a Mentally Flourishing Scotland (2009) was both a reminder of the importance of mental health improvement, for communities and individuals, and an action plan to drive mental health improvement. A number of its commitments relate directly to infants, children and young people. Two important examples of tangible outcomes of this work are the "Hands on Scotland" toolkit web portal (commitment one) (Scottish Government, 2012c) and the children and young people's mental health and well-being indicators (commitment four) (NHS Health Scotland, 2012).

120.   The CAMHS is organised around a 4 Tier system. The first 3 Tiers are mainly constituted of a multidisciplinary staff coming from a range of professional backgrounds. Tier 4 is mainly composed of highly specialised services for young children, including psychiatry, psychotherapy, clinical psychology and language development (see Figure 11).

Figure 11. CAMHS organisation chart

```
┌─────────────────────────────────────────────────────────────────────┐
│                    Tier 1: Primary level of care                      │
│  (for example, GPs, health visitors, school nurses, social workers,   │
│                    teachers, volunteer services)                      │
└─────────────────────────────────────────────────────────────────────┘
                                  ↓
┌─────────────────────────────────────────────────────────────────────┐
│                    Tier 2: Secondary level care                       │
│  Services provided by specialist individual professionals relating to │
│  workers in primary care (primary mental health workers, psychologists│
│  and counsellors working in GP practices, paediatric clinics, schools │
│                        and youth services)                            │
└─────────────────────────────────────────────────────────────────────┘
                                  ↓
┌─────────────────────────────────────────────────────────────────────┐
│              Tier 3: Specialist Multi-Disciplinary Services           │
│  Specialised multi-disciplinary services for patients with severe,    │
│  complex, persistent disorders (child and adolescent psychiatrists,   │
│  social workers, clinical psychologists, community psychiatric nurses,│
│  child psychotherapists, occupational therapists, art, music and      │
│                          drama therapists)                            │
└─────────────────────────────────────────────────────────────────────┘
                                  ↓
┌─────────────────────────────────────────────────────────────────────┐
│              Tier 4: Highly Specialised Tertiary Services             │
│  Tertiary level services such as day units, highly specialised        │
│  outpatient teams and inpatient units (secure forensic adolescent     │
│  units, eating disorders units, specialist neuro-psychiatric teams)   │
└─────────────────────────────────────────────────────────────────────┘
```

121.	A total of 1 067 clinical staff (908.5 WTE) were working for CAMHS in Scotland as at September 30th 2013, representing 17.1 WTE clinical workers per 100 000. This shows an increase of 1.5% (WTE) since June 2012 (1.4% decrease for headcount) (ISD, 2013e). The increase relative to 2008 is 35%, reflecting targeted action and resources to increase the specialist workforce (ISD, 2014).

122.	A HEAT target developed in 2009 by the Scottish Government states that, "By March 2013 no one will wait longer than 26 weeks from referral to treatment for specialist CAMH services." By December 2014, the wait should be reduced to 18 weeks. To date, approximately 94% of children seeking help at the CAHM received a treatment within 26 weeks of referral, whilst 85% within 18 weeks (ISD, 2013b).

123.	CAMHS Intensive Home Treatment Teams (IHTTs) services have developed in recent years in a number of Health Board areas, representing an alternative to hospital admission (Mental Welfare Commission, 2012). The IHTT service is designed to intervene during periods of crisis and acute illness, to monitor medication and to solve problems adopting a person-centered approach. There are currently four CAMHS IHTT services across Scotland (in Borders, Lothian, Tayside and Western Isles). Between October 2011 and February 2012, the staff numbers varied from 2 WTE in a rural setting to 7.4 WTE staff in an urban setting (Mental Welfare Commission, 2012).

124.	This new approach emphasises the child's strengths and uses the expertise within the family and the local community to maximise the support available, working on the assumption that a small change in a child's familiar environment will be less significantly detrimental to their recovery than a larger change in a setting alien to them (Simpson *et al*, 2009). When provided in conjunction with practices such as proactive discharge (planning discharges from the date of decision to admit) and flexible approaches to in-reach and out-reach work, a number of benefits have been demonstrated. Some admissions are avoided altogether. Many are significantly shortened. Where evaluation and research has been undertaken, good patient outcomes have been demonstrated.

4.3. Forensic mental health

Mental health services in prison settings

125.   The prison population in Scotland has increased significantly over the last decade, with an average daily population of 7 964 during 2009-2010 (Scottish Government, 2010c), and the figure is expected to increase up to 9 500 by 2019-20 (Scottish Government, 2011b). There is wide evidence of a much higher prevalence of mental illness within prisons than within the general population; a UK study on the prevalence of mental disorders suggested that approximately 90% of prisoners in the UK have some type of mental health problem, with the main diagnostic groups being depression and anxiety (Singleton *et al.,* 1998).

126.   "A very large proportion of prisoners have some form of mental health problem. Of these, only a small proportion have severe and enduring mental health problems" (Scottish Government, 2008:18). However, the figures here differ, as huge gaps exist in information pertaining to this area. For instance, Tickle (2005) assessed that 60% of prisoners suffered from some kind of mental disorder, whilst the Mental Health Foundation has suggested that nine out of 10 prisoners have a mental disorder (Tickle, 2005). The HMIP Thematic Report reported that, in 2008, 4.5% of prisoners held in Scotland's prisons were suffering from severe and enduring mental health problems, with 323 cases reported[9] (Scottish Government, 2008). Even though the figure has increased in recent years, this might be due to the overall rise in the number of prisoners. The most common types of severe and enduring mental disorder were schizophrenia, bipolar disorders and personality disorder. In addition, 219 cases of self-harm were recorded in Scottish jails in 2010, meaning an increase of 140% from 91 cases in 2004 (SAMH, 2010).

127.   The process of identifying a mental disorder in a prison setting takes place through observation by prison staff, other workers and other prisoners and through self-referral (Scottish Government, 2008). This results in a wide gap in the identification of mental health problems and needs due both to the inability of staff to identify mental illness and to problems with information transferred from courts and the community to the prisons. As a consequence, many prisoners requiring treatment for mental health disorders might not receive it (SAMH, 2010).

128.   Once the prisoner is judged to be suffering from some form of mental health problem, and so long as they do not require transfer to a hospital, mental health care treatment is generally provided in the prison. The treatment usually includes medication and consultation with a mental health nurse or a psychiatrist. However, as stated in the HMIP Thematic Report, there is an overall concern about the lack of staff trained sufficiently to tackle the needs of mentally ill prisoners.

129.   The 2003 MHCT Act requires a person suffering from a severe mental problem to undergo an assessment or some form of treatment in a hospital, rather than a prison setting. Remand prisoners may be transferred to hospitals on either an Assessment Order (Section 52D) or a Treatment Order (Section 52M). The arrangements for convicted prisoners are set out in Section 136 of the Act. A protocol governing the detailed liaison arrangements to apply between SPS and the NHS was agreed in 2006.

130.   From 1 November 2011, responsibility for provision of primary healthcare services in Scottish prisons was transferred from the Scottish Prison Service (SPS) to the Health Boards. As such, funding and staffing are now managed by the NHS Scotland through the Health Boards rather than by the SPS. Mental health services for severe and enduring mental disorders have always been delivered by the NHS.

---

[9]   This figure excludes HM Young Offenders Institution (YOI) in Polmont.

Forensic facilities: Low, medium and high secure services

131.   Scotland provides a varied range of forensic services, such as secure health facilities, whose dual aim is to assess and treat mentally disordered offenders while protecting them and the public from harm. The Forensic Mental Health Services Managed Care Network (Forensic Network) was established in 2003 as one of the Scotland's Managed Clinical Networks to advise on policy and service development around forensic mental health services. The Forensic Network is a multidisciplinary agency that works in collaboration with the SPS, Social Work Services, Policy and Criminal Justice agencies. In addition, it gives supports to local, regional and national forensic services across the variety of security levels.

132.   Scotland provides a range of secure health facilities deployed among high, medium, or low secure services. At a national level, The State Hospital at Carstairs in Lanarkshire in central Scotland is Scotland's only high-secure forensic facility. Carstairs was established in 1948, but only became part of NHS Scotland as a Special Health Board (the State Hospital Health Board for Scotland) in 1995. Its status is the same as all other health boards. Under this status, the hospital is directly accountable to Ministers in the Scottish Government. Carstairs is one of four high-secure hospitals in the UK, and currently holds up to 140 patients from Scotland and Northern Ireland, a reduction from the 240 patients held until recently.

133.   Most people arriving at the State Hospital have been transferred from prisons, courts or other low- and medium-security facilities. All of the patients at the State Hospital are subject to legal restrictions, and restricted patients must be managed in accordance with the Care Programme Approach (CPA) and Multi Agency Public Protection Arrangements (MAPPA) requirements[10].

134.   According to The State Hospital, The Clinical Model "A Framework of Principles" (NHS Scotland, 2009), the average age of patients at Castairs State Hospital is 38, with ages ranging from 18 to 68. The average length of stay is approximately six-and-a-half years, although some patients have stays as short as three months or as long as forty years. The report details that most patients have a diagnosis of schizophrenia, whilst a smaller portion of individuals have an intellectual disability. Most patients have a history of personal deprivation, have experienced trauma or adverse life events or have histories of sexual abuse (NHS Scotland, 2009). As shown in Table 3, the number of forensic beds has increased quite evenly since 2004. However, this increase was accompanied by the reduction in beds at the State Hospital (from 240 to 140).

135.   At the regional level, there are three main medium-security services: in the North, the Rohallion Clinic, Perth, in the South East, the Orchard Clinic, Edinburgh; and in the West, the Rowanbank Clinic, Glasgow. With regards to local services, Health Boards provide low-security services, Community Forensic Mental Health Teams and Forensic Learning Disabilities Teams.

Table 3. Average available beds in forensic hospitals*, % occupancy, mean stay (days) per episode

	2004	2006	2008	2010	2012	2013
Average Available Staffed Beds	193	192	218	247	249	276
% Occupancy	78.7	85.7	83	85.8	87.3	85
Mean Stay (Days) per Episode	187.9	169.2	148.2	215.8	185.8	213.8

Source**:** ISD (2013d), Available Beds by Specialty & NHS Board of Treatment [Online]. Available http://www.isdscotland.org/Health-Topics/Hospital-Care/Beds/

*The figures do not include beds within the Carstairs State Hospital.

---

[10]   CEL 13 (2007) – Care Programme Approach, Risk Assessment and Management of Restricted Patients, Clinical Governance.

4.4. Minority and excluded groups

The elderly population

136.   In the wake of lower birth rates and greater life expectancy, Scotland's ageing population has been a topic of national concern, including for mental health policy and services. *Mental Health and Well-Being in Later Life* (Scottish Executive 2005b), dating from 2005, is the most recent three-year programme led by NHS Scotland. This programme was designed to improve mental health and well-being for the older population by encouraging research, supporting local initiatives and developing resources for further projects.

137.   The average number of psychiatric beds allocated to older people has decreased from 2004 to 2013, in line with the overall downward trend of psychiatric beds (see Figure 12).

Figure 12. Psychiatry of old age: average available beds in hospitals, % occupancy, mean stay (days) per episode
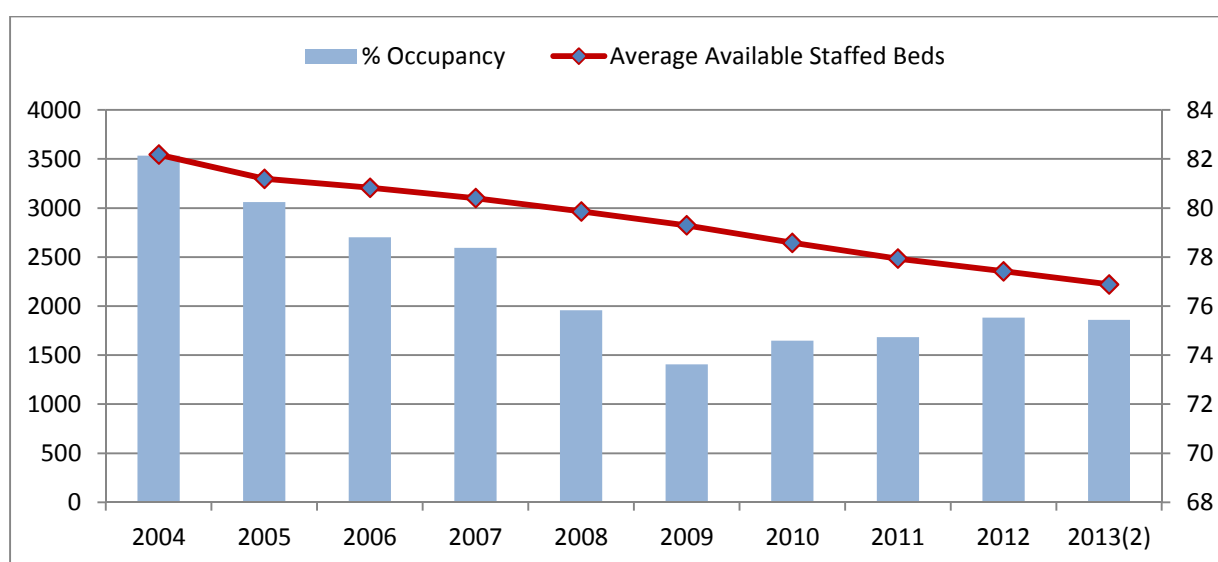
Source: ISD (2013d), Available Beds by Specialty & NHS Board of Treatment [Online]. Available http://www.isdscotland.org/Health-Topics/Hospital-Care/Beds/

Minority ethnic groups

138.   In Scotland, even though routine recording is required in order to be in compliance with the Race Relations Amendment Act 2000, there is a lack of up-to date data on mental health prevalence and access to services for Black and Minority Ethnic (BME) communities. Public bodies still rely on figures from 2001, when only 2% of the Scottish population were from BME communities (Scottish Executive, 2005b). In general, however, mental health morbidity within BME groups is not significantly higher than the Scottish average.

139.   NHS Scotland has established a range of programmes aimed at tackling mental health prevalence and access to treatment among BME communities. The Mental Health and Race Equality Programme was funded by the Scottish Government's Mental Health Division from 2006 to 2011, and aimed to ensure equal chances at achieving good mental health and well-being for people from BME groups. A wide range of community organisations, the voluntary sector, NHS Scotland and local authorities participated in the implementation of the programme. The 2008-2011 programme "Equally Connected" was launched by NHS Scotland in collaboration with BME community groups, with the goal of improving access to primary

mental health care services. This programme, funded by the Scottish government, was directly managed by NHS Health Scotland. Ethnicity in Mind (EIM), the Scottish Mental Health and Ethnicity Special Interest Network, was launched in 2009 by NHS Health Scotland, in partnership with the Mental Health Foundation and the Coalition for Racial Equality and Rights (CRER), with the purpose of creating a special interest network in Scotland with regards to mental health, ethnicity and race equality. The network is a valuable means for sharing knowledge with other network members, ensuring access to up-to-date research and developing skills in order to enhance service delivery. The "Ethnicity in Mind Network Evaluation May 2012" was recently conducted by the Mental Health Foundation[11].

4.5. Human resources

140.   The total number of staff for General Psychiatric services per 100 000 population in 2010 was 198.5 Whole Time Equivalents (WTE)[12]. The staff groups reported include nurses, consultants, psychiatrists and psychologists (ISD, 2013f) (see Figure 13).

Figure 13. Total mental health staff (WTE) per 100 000 population, by category, 2008-12
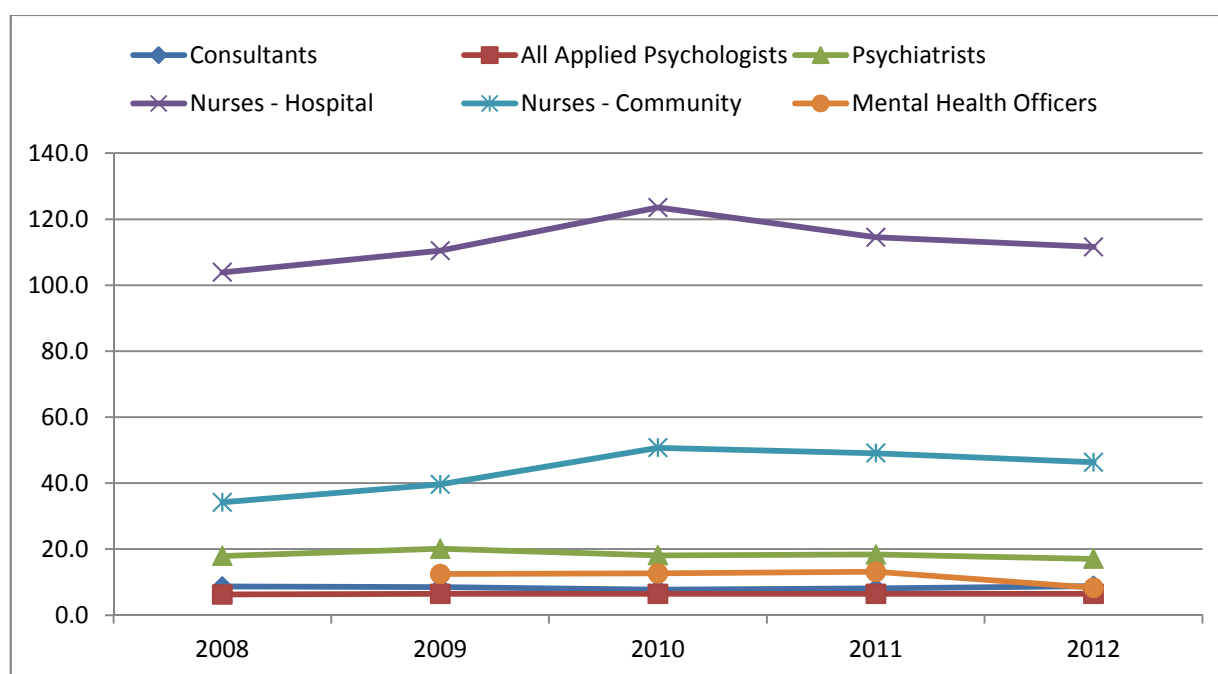
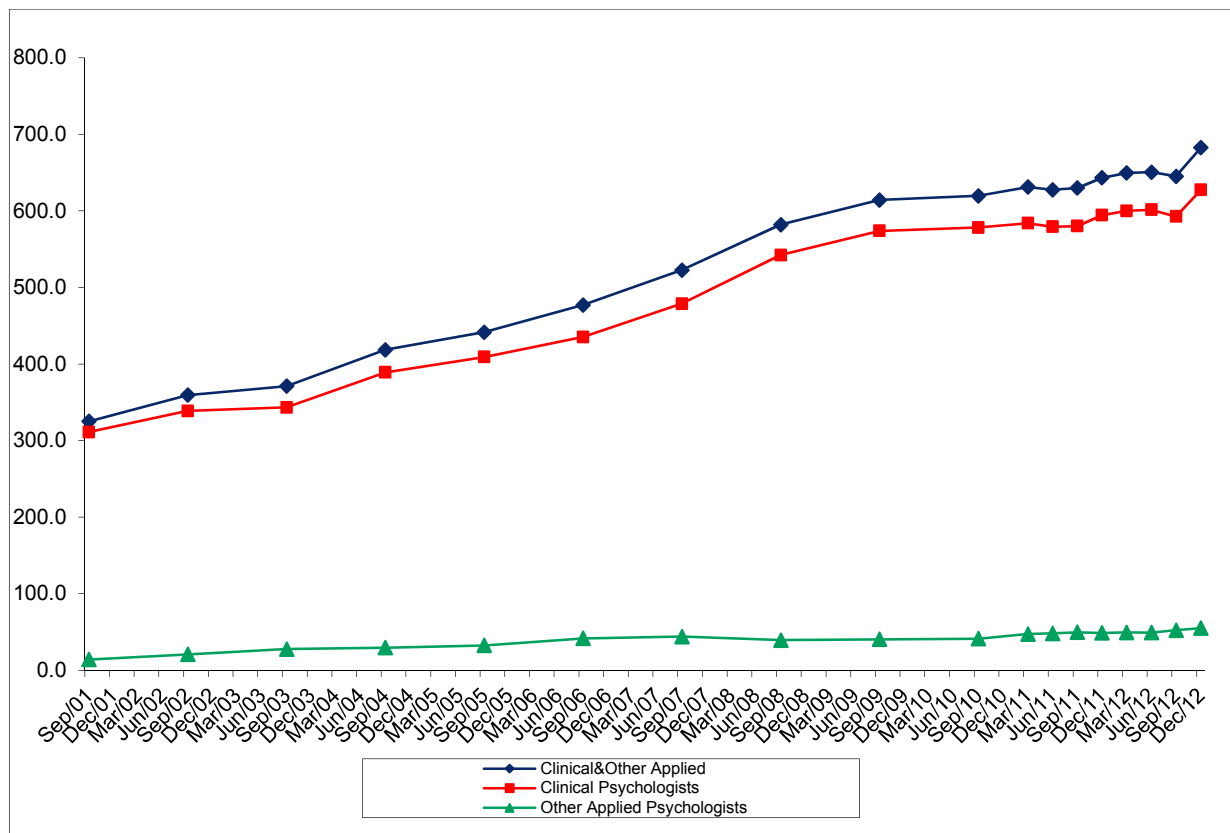141.   The number of "clinical and other applied psychologists" employed in NHS Scotland has steadily increased over the last 10 years (see Figure 14).

---

12   Whole time equivalent (wte) adjusted staff headcount to take account of part-time staff.

Figure 14. Clinical and other applied psychologists, NHS Scotland psychology services (2001-2012)

142.   As of 31 December, there were 808 (682.4 WTE) "clinical and other applied psychologists" in Scotland (ISD, 2013f). However, of those 682.4 WTE clinical and other applied psychologists, only 361.9 WTE work within the mental health field. This is an increase of 5.6% compared to the WTE Mental Health figure as at 31 December 2011. The remaining workforce tackle people with learning disabilities, physical health and neuropsychology and work within other specialty services (ISD, 2013f).

5. ORGANISATION AND DELIVERY OF FINANCING

5.1. Provider Payment Mechanisms

143.   Primary care services are ensured throughout Scotland by a series of practices and contracts agreed either between GPs and the NHS Boards, or nationally between GPs and the NHS Scotland.

144.   In April 2004, The National Health Service (Scotland) Act 1978 was amended with regards to provision of primary health services. The Primary Medical Services (Scotland) Act 2004, which followed the amendment, required NHS Boards to provide or secure "primary medical services" for their populations. As a result, primary care services are offered by NHS Boards, which have three main ways of providing primary healthcare services to the local population:

- *Directly*: Under what is called "2C practice" referring to a section of the Primary Medical Services (Scotland) Act 2004, the NHS Board can provide the service directly. Approximately 4% of Scottish general practices are of "Section 2C type" (ISD, 2013g).

- *Through new "General Medical Services'' (GMS) practices*: The recently (2004) introduced "General Medical Services" (GMS) practice is nationally negotiated with some local flexibility for GPs to 'opt out' of certain services or 'opt in' to the provision of other services. Approximately 87% of Scottish general practices operate under a new GMS contract.

- *Through arrangements with "Personal Medical Services" (PMS)*: The "Personal Medical Services" (PMS) (otherwise referred to as "Section 17C") involve locally negotiated agreements which are more flexible in accordance with local circumstances. Approximately 8% of Scottish general practices operate under this "Section 17C" contract (ISD, 2013g).

The Quality & Outcomes Framework (QOF)

145.   The Quality & Outcomes Framework (QOF) was established in 2004 as a major part of the new GMS. The innovation of QOF consists in providing a pay-for-performance mechanism by measuring achievements through a set of indicators and attributing points and payments accordingly. The indicators span four domains: clinical, organisational, patient experience and additional services. After a number of revisions introduced since 2004 and agreed between NHS Employers and The General Practitioner Committee, from 2009-2010 a GP can currently score a maximum of 1000 points over 134 indicators.

146.   QOF payments are part of a total of around GBP 740 million invested annually in Primary Medical Services across Scotland. Total QOF funding to practices in Scotland for the year 2011-12 was approximately GBP 134 million, compared to roughly GBP 130 million in 2010-11 (ISD, 2013g).

147.   Mental health indicators apply to patients suffering from severe and enduring mental health disorders, such as schizophrenia, bipolar disorder and other psychoses, whilst a separate set of indicators is devoted to depression. There are currently 6 indicators for mental health and 3 for depression (ISD, 2013g).

148.   Indicators for depression have been the subject of particular concern in recent years. Among the whole indicators set, the depression indicator group scored lowest achievement level. Nevertheless, this figure showed an increase from 85.6% in 2009-2010 to 88.3% in 2010-2011, to 91.6% in 2011-2012, and to 92.8% in 2012-2013. This means that in 2012-2013, 92.8% of GPs have succeeded in treating depression – the success being here defined as avoiding early cessation of treatment. However, this measure is not considered to be reliable as it is partly comulative and will therefore rise each year (ISD, 2013g).

5.2. Mental health care expenditures

149.   It was calculated that in 2011-2012 the total expenditure for adult mental health services within the NHS Scotland was GBP 877 million, an average of GBP 167 spending for every person in Scotland. This represents a decrease of 1.1% since 2010-11 (ISD, 2013a). In 2011-2012 about 35% of the total mental health expenditures in Scotland is spent on community health care. This is a slight increase from 34% in 2010-11.

150.   Overall mental health expenditure by boards is a little under 10% of all expenditure. If non-specialist expenditure is removed (e.g. GPs) then the proportion of specialist expenditure is about 13% (Huggins, 2012). It is difficult to calculate the exact spending by councils on mental health services, given the cross-cutting nature of the services delivered and the way data is collected and the budget recorded. From 1991 to 2006-2007, the Mental Health Specific Grant (MHSP) was allocated to councils to "accelerate the development of community-based services for people with mental illness". The Scottish Government provided 70% of the funding, and the remaining 30% was to be provided by councils. From 2007-2008 onwards, councils have continued to receive grants from the Scottish Government, but now have discretion over their use, hence the difficulty of gathering high-quality data about councils' expenses undertaken to provide mental health services. The key issue is linked to older age and dementia – in terms of care at home and care home provision to individuals with cognitive or other illness we are probably looking at a further billion, but attribution is complex (Huggins, 2012).

151.   Budgeting and funding for mental health has steadily decreased over time. In 2007, research conducted by Dr Seán Boyle of the London School of Economics and commissioned by the Parliament's Health Committee showed that whereas NHS Scotland spending had increased substantially since 1999, mental health expenditures had fallen as a proportion of the overall budget. However, part of this phenomenon may be due to the increase in the cost of some mental health medication over the past years (see Figure 15 and 16). In the wake of the *Local Provision of Mental Health Care in Scotland report,* the Health Committee agreed on 20 June 2006 that its scrutiny of the 2007-08 Draft Scottish Executive Budget should focus on the proportion of funds allocated to mental health.

Spending on pharmaceuticals

152.   The total expenditure on prescription mental health drugs increased by 2% to GBP 92.4 million in 2011-12. The cost per head of population equates to GBP 17.60. This is in line with a corresponding increase in the number of defined daily doses (DDDs) per head of population from 48.7 in 2010-11 to 50.9 in 2011-12 (ISD, 2013a).

153.   Data is available for the number of patients who were dispensed a pharmaceutical used in the treatment of mental health problems, along with the Gross Ingredient Cost to the NHS Scotland associated with each specific medicament (ISD, 2013h).

154.   In 2012-13, 358 273 people were prescribed an hypnotic, anxiolytic or barbiturate were dispensed in Scotland, a decrease from the previous year (Table 4). The total cost of dispensing a hypnotic,
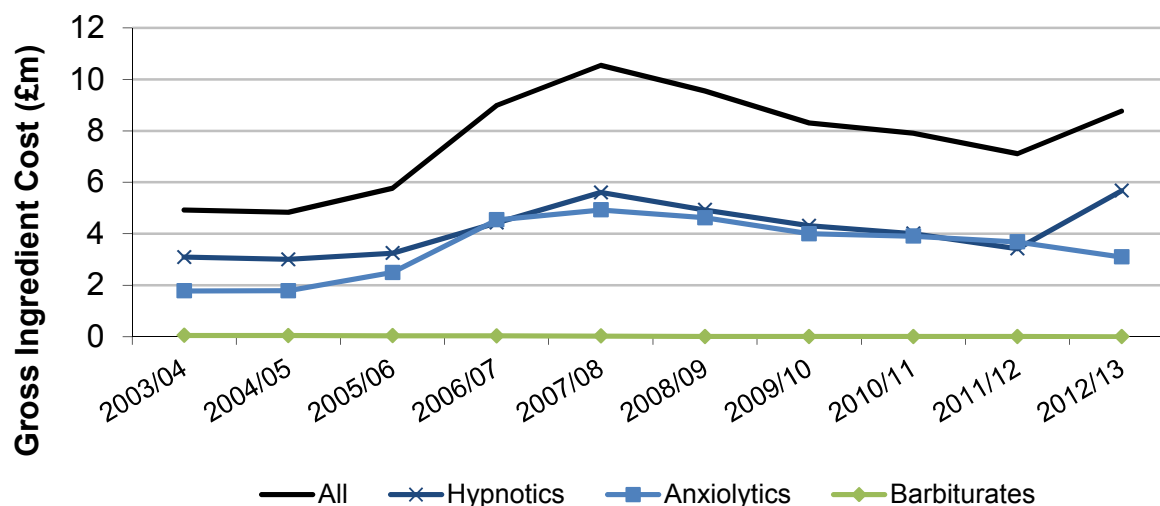
anxiolytic or barbiturate was GBP 8.77 million, an increase of 23.3% on the cost in 2011-12 (ISD, 2013h) (Figure 15).

Table 4. The number of patients who received treatment with a hypnotic or anxiolytic drug, by gender, for financial years 2009-10 to 2012-13

Financial Year	Total	Female	Male
2009-10	350 377	126 341	224 016
2010-11	358 588	129 294	229 294
2011-12	363 823	131 659	232 164
2012-13	358 273	130 326	227 947

Source: ISD (2013h), *Prescribing & Medicines: Medicines for Mental Health*. Available: https://isdscotland.scot.nhs.uk/Health-Topics/Prescribing-and-Medicines/Publications/2013-09-24/2013-09-24-PrescribingMentalHealth-Report.pdf?72420901061

**Figure 15. Gross ingredient cost – Hypnotics and Anxiolytics – 2002-03 to 2012-13**

Source: ISD (2013h), Prescribing & Medicines: Medicines for Mental Health. Available: https://isdscotland.scot.nhs.uk/Health-Topics/Prescribing-and-Medicines/Publications/2013-09-24/2013-09-24-PrescribingMentalHealth-Report.pdf?72420901061

155.   In 2012-13, there were 80 479 patients who were dispensed drugs for psychoses and related disorders, a significant increase from the previous year (see Table 5). The Gross Ingredient Cost (GIC) of drugs used for the treatment of psychoses and related disorders has decreased from GBP 34.73 million in 2011-12 to GBP 19.8 million in 2012-13, a decrease of 43%. However, the upward trend of GIC for these disorders is apparent since 2003 (see Figure 16).

Table 5. Number of patients who received treatment with a drug for psychoses or related disorders, by gender, for financial years 2009-10 to 2012-13

Financial Year	Total	Male	Female
2009-10	72 811	32 937	39 874
2010-11	75 770	34 513	41 257
2011-12	78 471	35 879	42 592
2012-13	80 479	36 920	43 559

Source: ISD (2013h), *Prescribing & Medicines: Medicines for Mental Health*. Available: https://isdscotland.scot.nhs.uk/Health-Topics/Prescribing-and-Medicines/Publications/2013-09-24/2013-09-24-PrescribingMentalHealth-Report.pdf?72420901061

Figure 16. Gross Ingredient Cost – Psychoses and related disorders – 2002-03 to 2012-13
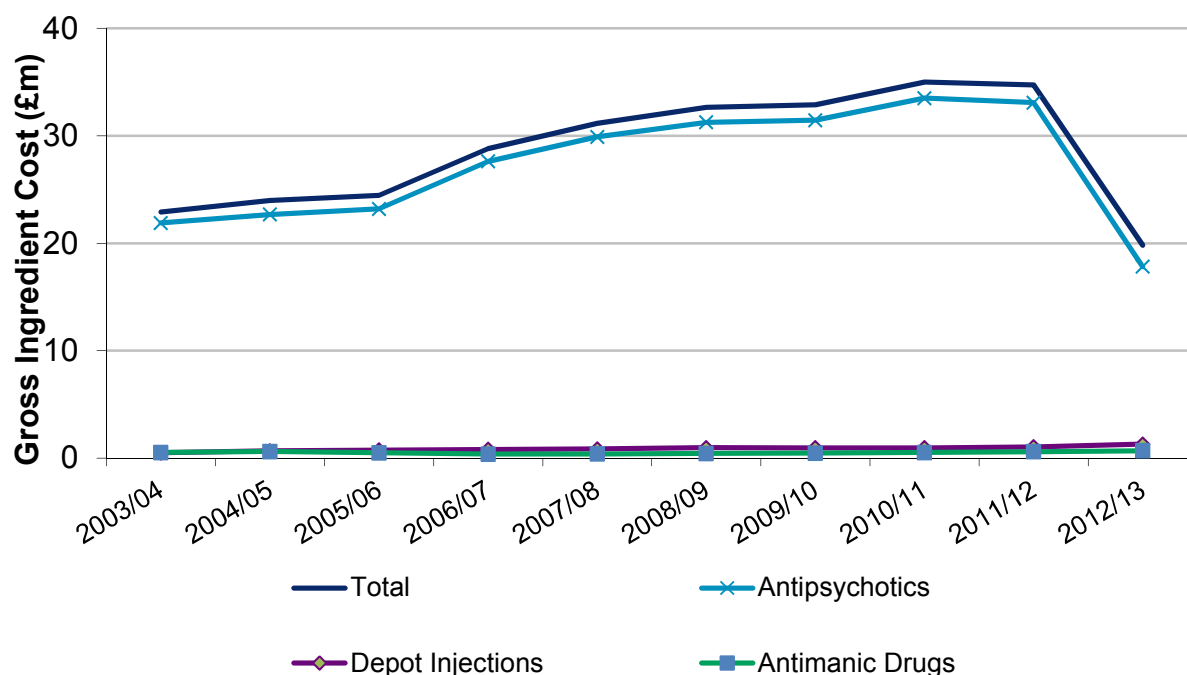
156.   There were 747 158 patients in 2012-13 who were dispensed an antidepressant, a slight increase from the previous year. The total cost of dispensing antidepressants was GBP 29.5 million, a decrease of 5.9% on the cost in 2011-12 (see Figure 17).

Table 6. Number of patients who received treatment with an antidepressant, by gender, for financial years 2009-10 to 2012-13

Financial Year	Total	Male	Female
2009-10	633 791	204 119	429 672
2010-11	675 948	219 071	456 877
2011-12	718 330	234 899	483 431
2012-13	747 158	246 925	500 233

Figure 17. Gross Ingredient Cost – Antidepressants – 2002-03 to 2012-13

Source: ISD (2013h), *Prescribing & Medicines: Medicines for Mental Health*. Available: https://isdscotland.scot.nhs.uk/Health-Topics/Prescribing-and-Medicines/Publications/2013-09-24/2013-09-24-PrescribingMentalHealth-Report.pdf?72420901061
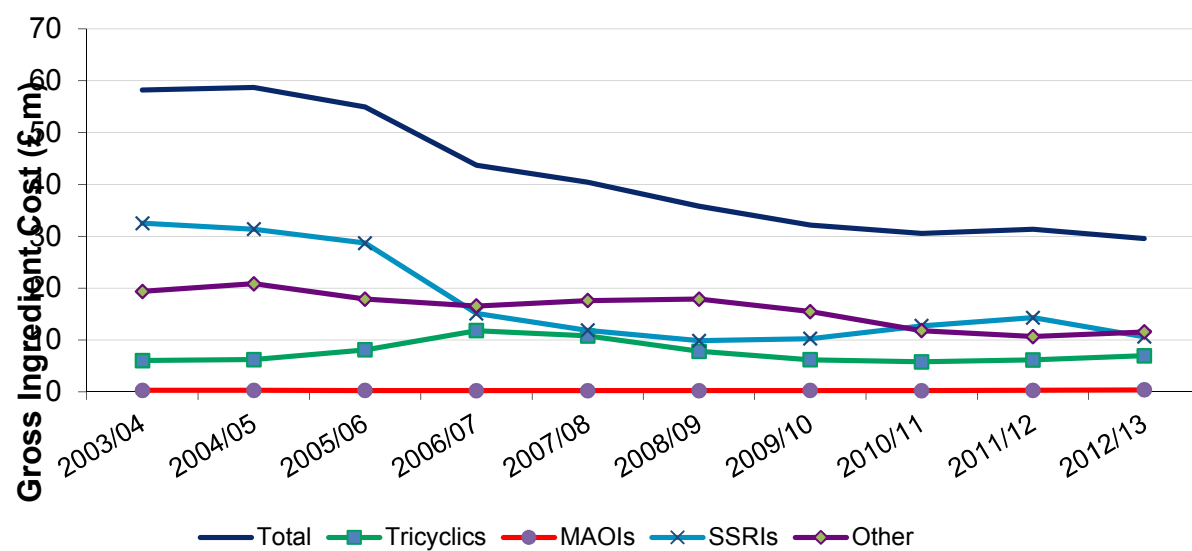
6. DISCUSSION, INNOVATIVE PRACTICES AND CONCLUSIONS

6.1. Discussion and key messages

157.   The mental health system in Scotland has an incredibly strong focus on improvement and delivery, and as such it is evaluated and monitored on a regular basis. Scotland has elaborated methods to improve and evaluate the mental health system that are considerably more sophisticated than those today implemented in other OECD countries.

158.   Combining qualitative data and consistency, the Information Service Division (ISD) Scotland provides health information – including mental health information – and statistical services. It serves as a tool in support of the NHS to improve the quality of health services and it facilitates planning and decision-making. For example, the *Mental Health Benchmarking Toolkit* was developed by the Scottish Government and Health Boards with support from the ISD in order to identify opportunities for improvement, identify gaps and monitor performance specifically in the adult mental health care sector. Together with the Toolkit, which publishes adult mental health indicators on a yearly basis, other monitoring surveys on the mental health status of the population are regularly conducted in Scotland. These include the "*Well? What Do You Think?*" survey, which gives an indication of the (self-assessed) mental health and wellbeing of the population; the set of 54 national mental health indicators, which first highlighted the difference between positive mental health and mental health problems; the Scottish Recovery Indicators (SRI); and the CAMHS Balanced Scorecard BSC, which is the most recent method to evaluate mental health services delivery for children and adolescents in Scotland and is still under development.

159.   Within this context, the HEAT targets represent the practical tool that turns mental health data and indicators into a management tool for policy makers. HEAT targets are part of the overall performance framework of the NHS and there is a clear expectation of delivery. This mirrors a target culture of evidence-based improvements, regular monitoring and accounting of the mental health system. Pay for performance mechanisms, such as those developed within the context of primary care under the Quality & Outcomes Framework (QOF), fits well within this target culture.

160.   The willingness of the Health Boards to undergo and facilitate monitoring is dependent on the fact that their priorities and approaches tally with those of the government, and would not be sustainable without such a consensus. As Davies (2005) points out, the use of performance indicators typically assumes, in a principal-agent framework, that those whose performance is being measured (the agents) have diverging goals from the principals and also know more about their own performance than the principals do: performance measurement aims to reduce this informational asymmetry. The approach taken by the Scottish government of selecting indicators for quality improvement in partnership with providers, conversely, can be seen as working instead to align the interests of providers with those of government. The concept of a "trust model" evoked by Coia and Glassborow (2009) illustrates an important point about health sector governance: the trust model refers to the attitudes governments have towards providers, but it also requires that providers "trust" government to not use information opportunistically.

161.   Having committed policy and resources to community-based care, it is appropriate for Scotland to focus indicators on assessing integration and the coordination of care (*e.g.* through monitoring readmissions and delayed discharges). In another setting where the majority of care was still delivered

institutionally, with limited resources, it might be more appropriate to emphasise the assessment of the quality of hospital care, as this would more accurately capture the experiences of most patients. However, although it is true that Scotland is highly performing in terms of gathering and publishing high quality data in the mental health sector, Scotland is still lagging behind in terms of publishing data on community-based mental health services, whilst focus is still on hospital-based services. In fact, although community mental health services have developed substantially over the last 10 years, there is almost no information available on how these services work (see section 4.1.).

162.	One other characteristic of Scottish mental health policy is the conscious effort to integrate mental health promotion and protection into other aspects of public policy. Other OECD countries where mental health remained a neglected issue could have developed in isolation, as in the number of countries where data collection is currently viewed as a burden (Garcia-Armesto *et al.*, 2008). A further way in which these findings may be specific to the Scottish context is the particular enthusiasm generated by the process of devolution, and the consequent desire to define a Scottish "new politics" (Cairney, 2008:350) in opposition to what were perceived to be top-down, adversarial policy styles in England.

6.2. Ongoing mental health agenda

163.	Mental Health for Scotland 2015 is the current mental health strategy of the Scottish Government. For further information about the ongoing mental health agenda, see section 3.3.

6.3. Outstanding and Innovative Initiatives: best practice examples

- Balance scorecard (BSC)
- HEAT targets
- Positive mental well-being indicator
- Mental health toolkit
- Intensive Home Treatment Teams (IHTTs) services
- Psychological therapies
- User involvement
- Anti-stigma campaigns
- Use of data.

ANNEX 1:
MENTAL HEALTH STRATEGIES ESTABLISHED BY THE SCOTTISH GOVERNMENT
FOLLOWING DEVOLUTION

Name of document	Year	Summary
Framework for Mental Health Services in Scotland	Sep 1997	Sets out strategy for shifting the balance of mental health services from inpatient to community-based care, and includes a matrix of elements of a comprehensive service.
Our National Health: A plan for action, a plan for change	Dec 2000	Identifies mental health as one of three National Clinical Priorities, along with cancer and coronary heart disease.
National Programme for Improving Mental Health and Well-being	Oct 2001	Sets commitments to promote Key Aims of • Raising awareness and promoting mental health and well-being • Eliminating stigma and discrimination • Preventing suicide • Promoting and supporting recovery
Choose Life: A National Strategy and Action Plan to Prevent Suicide in Scotland	Dec 2002	National strategy and action plan to prevent suicide in Scotland, with a target of a 20% reduction in suicide by 2013.
Mental Health (Care and Treatment) (Scotland) Act 2003	Apr 2005	Legislation superseding Mental Health (Scotland) Act 1984. It covers emergency detentions, short-term detention, and compulsory treatment orders. It also specifies the mechanisms to protect rights of people covered by the Acts, and requires that local authorities provide services for people who have or had a mental disorder.
Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland	Apr 2006	Chief Nursing Officer's review to examine the role of nursing in promoting priorities in mental health policy. Key messages include shifting focus away from risk-averse practice towards "therapeutic management"; enhancing capacity and capability; anticipatory care.
Delivering for Mental Health	Dec 2006	Presents targets and commitments for mental health services development, including introduction of integrated care pathways for five common mental disorders.
Mental Health Project Final Report: National Benchmarking Project	Nov 2007	Uses a Balanced Scorecard approach to compare the delivery and outcomes of mental health services across NHS Boards.
Establishing a core set of national, sustainable mental health indicators for adults in Scotland	Dec 2007	Includes 55 indicators designed to measure population mental health and well-being.

Name of document	Year	Summary
Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011	Apr 2009	Strategy focusing on: promotion of mental well-being; reducing prevalence of common mental disorders, suicide and self-harm; and improving quality of life for those experiencing mental health problems. TAMFS was a successor to the former National Programme for Improving Mental Health and Well-being, "aiming to secure commitment from more partners, and encouraging and supporting more locally driven action".
The Healthcare Quality Strategy for NHS Scotland	May 2010	Sets out six dimensions of quality adopted from Institute of Medicine (Efficient, Effective, Person-centred, Safe, Equitable, and Timely) and three Quality Ambitions: • Person-centred care: Partnerships between patients, families, and those delivering services. • Safety: No avoidable injury or harm. • Effectiveness: Appropriate treatment and eradication of "wasteful or harmful variation".
Keeping Going: Progress toward implementation of the refreshed action plan for Rights, Relationships and Recovery	Mar 2011	Aligns RRR to the three quality ambitions for the NHS (person-centred care, safety, effectiveness).
Mental Health Strategy for Scotland: 2012-2015-A Consultation	Sep 2011	Consultation on 4 priority areas: • Improving access to psychological therapy • Implementing National Dementia Strategy • Examining the balance between community, inpatient and crisis services • Preventing suicide
Suicide Prevention Strategy 2013-2016	Dec 2013	Sets 5 key themes: • Responding to people in distress • Talking about suicide • Improving the NHS response to suicide • Developing the evidence base • Supporting change and improvements.

ANNEX 2: A COMPREHENSIVE LIST OF HEAT TARGETS RELATED TO MENTAL HEALTH

Name	Priority	Date set	Due date	Description	Outcome
Suicide reduction	Health	2003	2013	*"Reduce the suicide rate between 2002 and 2013 by 20 per cent"* (Scottish Government, 2012a)	Not yet due.
Access to specialist CAMHS	Access		Nov 2009	*"Agree a target for Child and Adolescent Mental Health Services (CAMHS) referral to treatment waiting times"* (NHSScotland, 2011)	Met: target agreed.
Readmission	Treatment	Dec 2006	Dec 2009	*"Reduce the number of readmissions within one year for those that have had a psychiatric hospital admission of over 7 days by 10 per cent by the end of December 2009."* (NHSScotland, 2010)	Met: Readmissions reduced from 4 576 readmissions in the baseline year (year ending Dec 2004) to 3 426 readmissions in the year ending Dec 2009 (decrease of 25.1%) (NHSScotland, 2012)
Use of Anti-depressants	Treatment	Dec 2006	Mar 2010	*"Reduce the annual rate of increase of defined daily dose per capita of anti-depressants to zero by 2009/10, and put in place the required support framework to achieve a 10 per cent reduction in future years."* (NHSScotland, 2011)	Not met: DDD per capita increased every year from 2006 to 2010 (ISD, 2010)
Suicide prevention training	Health	Dec 2008	Dec 2010	*"[Ensure] 50 per cent of key frontline staff in mental health and substance misuse services, primary care, and accident and emergency [are] educated and trained in using suicide assessment tools/suicide prevention training programmes"* (NHSScotland, 2012)	Met: all NHS Boards had trained between 50-56% frontline staff, with a national average of 52% (NHSScotland, 2012).

Name	Priority	Date set	Due date	Description	Outcome
CAMHS (18 weeks referral to treatment)	Access	Nov 2009	Dec 2014	*"26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013; reducing to 18 weeks by December 2014"* (Scottish Government, 2012a)	Not yet due.
Psychological Therapies Waiting Times	Access	Mar 2010	Dec 2014	*"18 weeks referral to treatment for Psychological Therapies"* (Scottish Government, 2012a)	Not yet due.

GLOSSARY

- **Governance** refers to the exercise of political, economic and administrative authority in the management of a country's affairs at all levels (WHO).

- **Mild** generally refers to relatively few core symptoms (although sufficient to achieve a diagnosis), a limited duration and little impact on day-to-day functioning (NICE, 2011).

- **Moderate** refers to the presence of all core symptoms of the disorder plus several other related symptoms, duration beyond that required by minimum diagnostic criteria, and a clear impact on functioning (NICE, 2011).

- **Severe** refers to the presence of most or all symptoms of the disorder, often of long duration and with very marked impact on functioning (for example, an inability to participate in work-related activities and withdrawal from interpersonal activities) (NICE, 2011).

- **A user / consumer / patient** is a person receiving mental health care. These terms are used in different places and by different groups of practitioners and people with mental disorders (WHO, 2011).

- **Family** comprises members of the families of persons with mental disorders who act as carers (WHO, 2011).

- **Mental health policy:** The official statement of a government conveying an organized set of values, principles, objectives and areas for action to improve the mental health of a population (WHO, 2011).

- **Mental health strategy/plan:** A detailed pre-formulated scheme that details the strategies and activities that will be implemented to realize the objectives of the policy. It also specifies other crucial elements such as the budget and timeframe for implementing strategies and activities and specific targets that will be met. The plan also clarifies the roles of different stakeholders involved in the implementation of activities defined within the mental health plan. Mental health programmes are included within the mental health plan category. A mental health programme is a targeted intervention, usually short-term, with a highly focused objective for the promotion of mental health, the prevention of mental disorders, and treatment and rehabilitation (WHO, 2011).

- **Mental health legislation:** Mental health legislation may cover a broad array of issues including access to mental health care and other services, quality of mental health care, admission to mental health facilities, consent to treatment, freedom from cruel, inhuman and degrading treatment, freedom from discrimination, the enjoyment of a full range of civil, cultural, economic, political and social rights, and provisions for legal mechanisms to promote and protect human rights (e.g. review bodies to oversee admission and treatment to mental health facilities, monitoring bodies to inspect human rights conditions in facilities and complaints mechanisms) (WHO, 2011).

- **Psychiatrist**: A medical doctor who has had at least two years of post-graduate training in psychiatry at a recognized teaching institution leading to a recognized degree or diploma (WHO, 2011).

- **Nurse**: A health professional who has completed formal training in nursing at a recognized, university-level school for a diploma or degree in nursing (WHO, 2011).

- **Psychologist**: A health professional who has completed formal training in psychology at a recognized, university-level school for a diploma or degree in psychology (WHO, 2011).

- **Social worker**: A health professional who has completed formal training in social work at a recognized, university-level school for a diploma or degree in social work (WHO, 2011).

- **Mental health outpatient facility:** A facility that specifically focuses on the management of mental disorders and related clinical problems on an outpatient basis. These facilities are staffed with health care providers specifically trained in mental health (WHO, 2011).

- **Mental health day treatment facility:** A facility that provides care for users during the day. The facilities are generally available to groups of users at the same time and expect users to stay at the facilities beyond the periods during which they have face-to-face contact with staff and / or participate in therapy activities. Attendance typically ranges from a half to one full day (4 – 8 hours), for one or more days of the week (WHO, 2011).

- **Psychiatric ward in a general hospital:** A ward within a general hospital that is reserved for the care of persons with mental disorders (WHO, 2011).

- **Community residential facility**: A non-hospital, community based mental health facility that provides overnight residence for people with mental disorders. Usually these facilities serve users with relatively stable mental disorders not requiring intensive medical interventions (WHO, 2011).

- **Mental hospital:** A specialized hospital-based facility that provides inpatient care and long-stay residential services for people with severe mental disorders. Usually these facilities are independent and standalone, although they may have some links with the rest of the health care system. The level of specialization varies considerably; in some cases only long stay custodial services are offered, in others specialized and short-term services are also available (WHO, 2011).

- **Forensic units**: forensic units care for people with mental disorders who have come into contact with the criminal justice system. They may also be called secure units or special hospitals (WHO, 2008).

- **Community mental health services**: secondary or specialist care (care that cannot be provided by a primary care physician). At its most basic, it may be office-based private care or, more often, outpatient clinic (polyclinic) provision for assessing and treating mental illness by a trained mental health professional (such as a psychiatrist or psychologist). It can also be provided by a multidisciplinary team (community mental health team) comprising psychiatrists, mental health nurses and often psychologists and social workers. They usually provide care for the inhabitants of a clearly defined catchment area (such as a borough or town). Care is provided in a variety of settings (such as clinics, people's homes and day centres). An alternative structure is the

community mental health centre, where several teams run a range of services, one of which is assessment and care outside the hospital (WHO, 2008).

• **Secure psychiatric beds "**Secure mental health services provide accommodation, treatment and support for people with severe mental health problems who pose a risk to the public. Sometimes known as 'forensic' mental health services, secure services work predominantly with people who have been imprisoned or admitted" directly to hospital through the 1983 Mental Health Act following a criminal offence. (Centre for Mental Health, 2011)

• **Stigma**: A stigma is a distinguishing mark establishing a demarcation between the stigmatized person and others attributing negative characteristics to this person. The stigma attached to mental illness often leads to social exclusion and discrimination and creates an additional burden for the affected individual (WHO, 2008).

• **Prevention:** Mental disorder prevention focuses on reducing risk factors and enhancing protective factors associated with mental ill health with the aim of reducing the risk, incidence, prevalence and recurrence of mental disorders (WHO, 2008).

• **Primary health care (PHC)**: Encompasses any health clinic that offers the first point of entry into the health system. These clinics usually provide initial assessment and treatment for common health conditions and refer those requiring more specialized diagnosis and treatment to facilities with staff with a higher level of training and resources (WHO, 2011).

REFERENCES

Audit Scotland (2009), *Overview of mental health services*, Edinburgh: Audit Scotland.

Blane, D. & G., Watt (2012), "*GPs at the deep end. GP experience of the impact of austerity on patients and general practices in very deprived areas",* Glasgow University 2012. Available: http://www.gla.ac.uk/media/media_232766_en.pdf

Bradstreet, S. and Brown (eds.) (2004), *SRN Discussion Paper Series.* Glasgow: Scottish Recovery Network.

Burton, C. & C. Simpson (2010), "Newly initiated antidepressant treatment in Scotland: a database study", Edinburgh: Centre for Population Health Sciences.

Cairney, P. (2008), "Has Devolution Changed the 'British Policy Style'?", *British Politics,* 3**,** 350-372.

Cairney, P. (2009), "The 'British policy style' and mental health: beyond the headlines", *Journal of Social Policy,* 38**,** 671–688.

Cameron, I. M., K. Lawton & I.C. Reid (2009), "Appropriateness of antidepressant prescribing: an observational study in a Scottish primary-care setting", *The British journal of general practice : the journal of the Royal College of General Practitioners,* 59**,** 644-649.

Coia, D. & R. Glassborow (2009), "Mental health quality and outcome measurement and improvement in Scotland", *Current Opinion in Psychiatry,* 22**,** 643-647.

Darjee, R. & J. Crichton (2004), "New mental health legislation", *BMJ,* 329**,** 634-635.

Davies, H. (2005), Measuring and reporting the quality of health care: issues and evidence from the international research literature.

Disability Discrimination Act (1995), [Online]. Available: http://www.legislation.gov.uk/ukpga/1995/50/contents. Accessed 03 June 2013

Disability Discrimination Act (2005), [Online]. Available: http://www.legislation.gov.uk/ukpga/2005/13/contents. Accessed 03 June 2013

DOH (1999), *Review of the Mental Health Act 1983: Report of the Expert Committee* (The Richardson Committee). London: Department of Health.

Donnelly, R. (2008), *Mental Health Project Final Report: National Benchmarking Project Report 2,* Edinburgh: The Scottish Government.

European Commission (2005), *Green Paper, Improving the mental health of the population: Towards a strategy on mental health for the European Union*, Brussel: European Commission, 2005

Freeman, H. (1998), "Mental health policy and practice in the NHS: 1948-79", *Journal of Mental Health,* 7**,** 225-239.

Garcia-Armesto, S., H. Medeiros & L. Wei (2008), "Information availability for measuring and comparing quality of mental health care across OECD countries", *OECD Health Technical Papers.*

Huggins (2012), Telephonic interview, November 2012

Human Rights Act (1998), [Online]. Available: http://www.legislation.gov.uk/ukpga/1998/42/contents. Accessed 03 June 2013

Institute of Medicine (2001), *Crossing the Quality Chasm: A New Health System for the 21st Century*, Washington, DC: National Academy Press.

ISD (2002), *Mental health in Scotland: Information sources and selected insights*, Edinburgh: NHS Scotland Information and Statistics Division.

ISD (2010), *HEAT - Antidepressants* [Online]. Available: http://www.isdscotlandarchive.scot.nhs.uk/isd/6427.html [Accessed 08/08/2012].

ISD (2012), *Mental Health (Psychiatric) Hospital Activity Statistics*. Available: http://www.isdscotland.org/Health-Topics/Mental-Health/Publications/2012-12-18/2012-12-18-MentalHealth-Report.pdf

ISD (2013a), *Adult Mental Health Benchmarking Toolkit*, ISD Scotland 2013

ISD (2013b), *Child and Adolescent Mental Health Services, Waiting Times in Scotland,* ISD Scotland 2013, Available: http://www.isdscotland.org/Health-Topics/Waiting-Times/Publications/2013-11-26/2013-11-26-WT-CAMHS-Report.pdf?45022219420

ISD (2013c), *Practice Team Information (PTI)*. Available: http://www.isdscotland.org/Health-Topics/General-Practice/Publications/2013-10-29/2013-10-29-PTI-Report.pdf?97323244811

ISD (2013d), Available Beds by Specialty & NHS Board of Treatment *[Online]*. *Available http://www.isdscotland.org/Health-Topics/Hospital-Care/Beds/*

ISD (2013e), *Child & Adolescent Mental Health Services in NHS Scotland*. 2012. Available: http://www.isdscotland.org/Health-Topics/Workforce/Publications/2013-11-26/2013-11-26-CAMHS-Report.pdf?17571657897

ISD (2013f), *Psychology Services Workforce in NHSScotland.* Available: http://www.isdscotland.org/Health-Topics/Workforce/Publications/2013-02-26/2013-02-26-Psychology-Workforce-Report.pdf?75204104186

ISD (2013g), *Quality & Outcomes Framework (QOF) of the new GMS contract*. Available: http://www.isdscotland.org/Health-Topics/General-Practice/Publications/2013-09-24/2013-09-24-QOF-Report.pdf?94269961119

ISD (2013h), *Prescribing & Medicines: Medicines for Mental Health*. Available: https://isdscotland.scot.nhs.uk/Health-Topics/Prescribing-and-Medicines/Publications/2013-09-24/2013-09-24-PrescribingMentalHealth-Report.pdf?72420901061

ISD (2014), *CAMHS, Previous publications*, [Online], Available: http://www.isdscotland.org/Health-Topics/Workforce/CAMHS/previous-publications.asp. Accessed February 7th 2014

Lester, H. & J. Glasby (2010), *Mental Health Policy and Practice,* Basingstoke, Macmillan.

Loudon, J. & D. Coia (2002), "The Scottish scene", *Psychiatric Bulletin,* 26, 84-86.

McDaid, D. & A. Oliver (2008), "A Comparative Analysis of Health System Reform across England and Scotland", *Intereconomics,* 43, 195-200.

Mental Health Collaborative (2011), *Mental Health Collaborative April 08 – March 11: Programme Closure Report, June 2011*, Edinburgh: Mental Health Collaborative.

Mental Welfare Commission (2006), *Rights, risks, and limits to freedom. Principles and good practice guidance for practitioners considering restraint in residential care settings.* [Online]. Available:http://www.mwcscot.org.uk/media/51830/Rights%20risks%20and%20limits%20to%20freedom.pdf

Mental Welfare Commission (2012), *Intensive, not intrusive*, Available: http://www.mwcscot.org.uk/media/94425/intensive__not_intrusive_2012.pdf

Moore, M., H.M. Yuen, N. Dunn, M.A. Mullee, J. Maskell & T. Kendrick (2009), "Explaining the rise in antidepressant prescribing: a descriptive study using the general practice research database", *BMJ,* 339.

Myers, F., A. Woodhouse, I. Whitehead, A. McCollam, L. McBryde, V. Pinfold, G. Thornicroft, R. McBrierty & L. Wilson (2009), Evaluation of "see me" – the National Scottish Campaign Against the Stigma and Discrimination Associated with Mental Ill-Health, Edinburgh: Scottish Government Social Research.

NHS Greater Glasgow & Clyde (2007), More than Medication: a strategy to promote appropriate antidepressant prescribing in NHS GG&C, Glasgow: NHS Greater Glasgow & Clyde.

NHS Health Scotland (2012), Children and young people's mental health indicators, [Online]. Available: http://www.healthscotland.com/scotlands-health/population/mental-health-indicators/children.aspx. Accessed 03 June 2013

NHS Health Scotland (n.d.), Wellscotland.info, [Online] Available: http://www.wellscotland.info/ . Accessed 13 May 2013

NHS 24 (2012), NHS Inform, [Online] Available: http://www.nhsinform.co.uk/mentalhealth. Accessed 13 May 2013

NHS 24 (2013), Health Information and Sef Care Advise for Scotland, [Online] Available: http://www.nhs24.com/UsefulResources/LivingLife. Accessed 13 May 2013

NHS Quality Improvement Scotland (2007), Clinical Indicators Report, Edinburgh: NHS Quality Improvement Scotland.

NHSScotland (2010), HEAT targets due for delivery in 2007/08 and 2008/09, Edinburgh: NHSScotland Performance and Business Management.

NHSScotland (2011), HEAT Targets due for delivery in 2009/10: Summary of Performance, Edinburgh: NHSScotland Performance and Business Management.

NHSScotland (2012), HEAT Targets due for delivery in 2010/11: Summary of Performance, Edinburgh: NHSScotland Performance and Business Management.

Parkinson, J. (2006), "Establishing national mental health and well-being indicators for Scotland", *Journal of Public Mental Health,* 5**,** 42-48.

Parkinson, J. (2007), Establishing a core set of national, sustainable mental health indicators for adults in Scotland: Final report, Edinburgh: NHS Health Scotland.

Pilgrim, D. (2007), "New 'Mental Health' Legislation for England and Wales: Some Aspects of Consensus and Conflict", *Journal of Social Policy,* 36**,** 79-95.

Platt, S., J. McLean, A. McCollam, A. Blamey, M. MacKenzie, D. McDaid, M. Maxwell, E. Halliday & A. Woodhouse (2006), Evaluation of Phase 1 of Choose Life, Edinburgh: Scottish Executive.

Ridley, J., A. Rosengard, S. Hunter & S. Little (2009), Experiences of the Early Implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003: A Cohort Study, Edinburgh: Scottish Government Social Research.

Russell, P., C. Lardner, L. Johnston & D. Griesbach (2010), Evaluation of Phase 2 of Choose Life, Edinburgh Scottish Government.

SAMH (2010), *SAMH's research briefing* [Online]. Available http://www.samh.org.uk/our-work/policy-campaigns/criminal-justice Accessed 28 February 2013.

SCOTPHO (2012a), *Suicide: national trends* [Online]. Available: http://www.scotpho.org.uk/health-well-being-and-disease/suicide/data/national-trends [Accessed 14/08/2012].

SCOTPHO (2012b), *Mental health: policy context* [Online]. Scottish Public Health Observatory. Available: http://www.scotpho.org.uk/health-well-being-and-disease/mental-health/policy-context [Accessed 20/07/2012.

SCOTPHO (2012c), *Scotland's mental health*. Full Report, October 2012. NHS Health Scotland 2012 At:http://www.healthscotland.com/uploads/documents/19848Scotland'sMentalHealthAdults%202012%20-%20full%20report.pdf

Scottish Executive (2000), Our National Health: A plan for action, a plan for change, Edinburgh: Scottish Executive.

Scottish Executive (2001a), New Directions: Report on the Review of the Mental Health (Scotland) Act 1984 (Millan Committee), Edinburgh: Scottish Executive.

Scottish Executive (2001b), Renewing Mental Health Law: policy statement, Edinburgh: Scottish Executive.

Scottish Executive (2002a), Choose Life National Strategy and Action Plan, Edinburgh.

Scottish Executive (2002b), Well? What Do You Think? A National Scottish Survey of Public Attitudes to Mental Health, Well Being and Mental Health Problems, Edinburgh: Scottish Government Social Research.

Scottish Executive (2003), National Programme for Improving Mental Health and Well-Being: Action plan 2003-2006, Edinburgh: Scottish Executive.

Scottish Executive (2005a), *Getting the Right Workforce Getting the Workforce Right. A strategic review of the Child and Adolescent Mental Health Workforce*, Edinburgh, 2005

Scottish Executive (2005b), *Equal Minds. Addressing mental health inequalitites in Scotland*. National programme for improving mental health and well-being, Edinburgh, 2005.

Scottish Executive (2006a), Delivering for Mental Health, Edinburgh Scottish Executive.

Scottish Executive (2006b), Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland, Edinburgh: Scottish Executive.

Scottish Government (2007), Well? What Do You Think? (2006): The Third National Scottish Survey of Public Attitudes to Mental Health, Mental Well-being and Mental Health Problems, Edinburgh: Scottish Government Social Research.

Scottish Government (2008), *Out of Sight, Sever and Enduring Mental Health Problems in Scotland's Prisons*, Her Majesty's Chief Inspectorate of Prisons for Scotland (HMIP) Thematic Report, 2008.

Scottish Government (2009a), Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011, Edinburgh.

Scottish Government (2009b), "Well? What Do You Think? (2008): The Fourth National Scottish Survey of Public Attitudes to Mental Well-being and Mental Health Problems", Edinburgh: Scottish Government Social Research.

Scottish Government (2010b), Step for stress: a simple guide to stressing less and enjoying life more, [Online] Available: http://www.stepsforstress.org/. Accessed 13 May 2013

Scottish Government (2010c), *Prison statistics Scotland: 2009-10*. Statistical bullettin, Crime and justice series. The Scottish Government, 2010.

Scottish Government (2011a), *NHSScotland Performance* [Online]. Available: http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/17273 [Accessed 24/08/2012.

Scottish Government (2011b), *Scottish prison population projections: 2010-11 to 2019-20*. Statistical Release Crime and Justice Series. The Scottish Government 2011

Scottish Government (2012a), The Scottish health survey 2011: Vol. 1: Main report.

Scottish Government (2012b), Mental Health Strategy for Scotland: 2012-2015.

Scottish Government (2012c), Hands on Scotland, [Online] Available: http://www.handsonscotland.co.uk/homepage_centre.html. Accessed 03 June 2013

Scottish Government (2013a), Scottish Recovery Network, [Online] Available:
       http://www.scottishrecovery.net/. Accessed 13 May 2013

Scottish Government (2013b), Suicide Prevention Strategy 2013-2016, The Scottish Government 2013

Scottish Parliament (2003), Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13). UK: The
       Stationery Office Limited.

Scottish Recovery Network (2011), *Scottish Recovery Indicator 2* [Online]. Available: http://www.sri2.net/
       [Accessed 07/08/2012].

See Me (2005), *See me so far*. Available: http://www.seemescotland.org/images/pdfs/1.6.seemesofar.pdf

Simpson, W., L. Cowie, L. Wilkinson, N. Lock & G. Monteith (2009), *Child and Adolescent Mental
       Health. The Effectiveness of a Community Intensive Therapy Team on Young People's Mental
       Health Outcomes* Volume 15, Number 4, November 2010 , pp. 217-223(7), Wiley-Blackwell.

Singleton, N., H. Meltzer & R. Gatward (1998), *Psychiatric morbidity among prisoners in England and
       Wales*. London: Office for National Statistics, 1998.

Smith-Merry, J., R. Freeman & S. Sturdy (2010a), "Recovering mental health in Scotland", "Recovery'
       from social movement to policy goal.: KnowandPol Orientation 2.

Smith-Merry, J., R. Freeman & S. Sturdy (2010b), "Indicating mental health in Scotland", KnowandPol
       Orientation 3.

Smith-Merry, J., R. Freeman & S. Sturdy (2011), "Implementing recovery: an analysis of the key
       technologies in Scotland", *International Journal of Mental Health Systems, 5***, 11.

Smith, M. (2003), "Devolution and 'public psychiatry' in Scotland", *Psychiatric Bulletin, 27***, 41-43.

Taulbut, M., J. Parkinson, S. Catto & D. Gordon (2009), *Scotland's Mental Health and its Context: Adults
       2009*, Glasgow: NHS Health Scotland.

Tickle, L. (2005), *Is the Prison System Failing Mentally Ill People?* The Herald Society Supplement 19th
       July 2005.

Tudor, K. (1996), *Mental Health Promotion: Paradigms and practice,* London, Routledge.

WHO (2001), *Strengthening mental health promotion Fact sheet no. 220* [Online], Geneva: World Health
       Organization, available: https://apps.who.int/inf-fs/en/fact220.html [Accessed 23/07/2012].

WHO (2005), *WHO European Ministerial Conference on mental health. Facing the challenges, building
       solutions*, Helsinki: World Health Organization Europe, 2005

UN (2006), Conventions on the Rights of Persons with disabilities, [Online] Available:
       http://www.un.org/disabilities/convention/conventionfull.shtml. Accessed 13 May 2013

Woods, K. & D. Carter (2003), *Scotland's health and health services*, London: Stationery Office.

OECD HEALTH WORKING PAPERS

A full list of the papers in this series can be found on the OECD website: http://www.oecd.org/health/workingpapers

No. 73 *MENTAL HEALTH ANALYSIS PROFILES (MhAPs) Netherlands* (2014) Alessia Forti, Chris Nas, Alex van Geldrop, Gedrien Franx, Ionela Petrea, Ype van Strien, Patrick Jeurissen

No. 72 *MENTAL HEALTH ANALYSIS PROFILES (MhAPs) Finland* (2014) Pauliina Patana

No. 71 *MENTAL HEALTH ANALYSIS PROFILES (MhAPs) Italy* (2014) Alessia Forti

No. 70 *PRICING AND COMPETITION IN SPECIALIST MEDICAL SERVICES – AN OVERVIEW FOR SOUTH AFRICA* (2014) Ankit Kumar, Grégoire de Lagasnerie, Frederica Maiorano, Alessia Forti

No. 69 *GEOGRAPHIC IMBALANCES IN DOCTOR SUPPLY AND POLICY RESPONSES* (2014) Tomoko Ono, Michael Schoenstein, James Buchan

No. 68 *HEALTH SPENDING CONTINUES TO STAGNATE IN MANY OECD COUNTRIES* (2014) David Morgan and Roberto Astolfi

No. 67 *MEASURING AND COMPARING WAITING TIMES IN OECD COUNTRIES* (2013) Luigi Siciliani, Valerie Moran and Michael Borowitz

No. 66 *THE ROLE OF FISCAL POLICIES IN HEALTH PROMOTION* (2013) Franco Sassi

No. 65 *ALCOHOL CONSUMPTION AND HARMFUL DRINKING: TRENDS AND SOCIAL DISPARIETIES IN OECD COUNTRIES* (2013) Franco Sassi (Forthcoming)

No. 64 *MANAGING HOSPITAL VOLUMES: GERMANY AND EXPERIENCES FROM OECD COUNTRIES* (2013) Michael Schoenstein and Ankit Kumar

No. 63 *VALUE IN PHARMACEUTICAL PRICING* (2013) Valérie Paris, Annalisa Belloni

No. 62 *HEALTH WORKFORCE PLANNING IN OECD COUNTRIES: A REVIEW OF 26 PROJECTION MODELS FROM 18 COUNTRIES* (2013) Tomoko Ono, Gaetan Lafortune and Michael Schoenstein

No. 61 *INTERNATIONAL VARIATIONS IN A SELECTED NUMBER OF SURGICAL PROCEDURES* (2013) Klim McPherson, Giorgia Gon, Maggie Scott

No. 60 *HEALTH SPENDING GROWTH AT ZERO: WHICH COUNTRIES, WHICH SECTORS ARE MOST AFFECTED?* (2013) David Morgan and Roberto Astolfi

No. 59 *A COMPARATIVE ANALYSIS OF HEALTH FORECASTING METHODS* (2012) Roberto Astolfi, Luca Lorenzoni, Jillian Oderkirk

No. 58 *INCOME-RELATED INEQUALITIES IN HEALTH SERVICE UTILISATION IN 19 OECD COUNTRIES, 2008-09* (2012) Marion Devaux and Michael de Looper

No. 57 *THE IMPACT OF PAY INCREASES ON NURSES' LABOUR MARKET: A REVIEW OF EVIDENCE FROM FOUR OECD COUNTRIES* (2011) James Buchan and Steven Black

No. 56   *DESCRIPTION OF ALTERNATIVE APPROACHES TO MEASURE AND PLACE A VALUE ON HOSPITAL PRODUCTS IN SEVEN OECD COUNTRIES* (2011) Luca Lorenzoni and Mark Pearson

No. 55   *MORTALITY AMENABLE TO HEALTH CARE IN 31 OECD COUNTRIES: ESTIMATES AND METHODOLOGICAL ISSUES* (2011) Juan G. Gay, Valerie Paris, Marion Devaux, Michael de Looper

No. 54   *NURSES IN ADVANCED ROLES: A DESCRIPTION AND EVALUATION OF EXPERIENCES IN 12 DEVELOPED COUNTRIES* (2010) Marie-Laure Delamaire and Gaetan Lafortune

No. 53   *COMPARING PRICE LEVELS OF HOSPITAL SERVICE ACROSS COUNTRIES: RESULTS OF A PILOT STUDY* (2010) Luca Lorenzoni

No. 52   *GUIDELINES FOR IMPROVING THE COMPARABILITY AND AVAILABILITY OF PRIVATE HEALTH EXPENDITURES UNDER THE SYSTEM OF HEALTH ACCOUNTS FRAMEWORK* (2010) Ravi P. Rannan-Eliya and Luca Lorenzoni

No. 51   *EFFECTIVE WAYS TO REALISE POLICY REFORMS IN HEALTH SYSTEMS (2010)* Jeremy Hurst

No. 50   *HEALTH SYSTEMS INSTITUTIONAL CHARACTERISTICS A SURVEY OF 29 OECD COUNTRIES* (2010) Valerie Paris, Marion Devaux and Lihan Wei

No. 49   *THE CHALLENGE OF FINANCING HEALTH CARE IN THE CURRENT CRISIS* (2010) Peter Scherer, Marion Devaux

No. 48   *IMPROVING LIFESTYLES, TACKLING OBESITY: THE HEALTH AND ECONOMIC IMPACT OF PREVENTION STRATEGIES* (2009) Franco Sassi, Michele Cecchini, Jeremy Lauer and Dan Chisholm

No. 47   *HEALTH CARE QUALITY INDICATORS PROJECT: PATIENT SAFETY INDICATORS REPORT 2009* (2009) Saskia Drösler, Patrick Romano, Lihan Wei; and *ANNEX* Saskia Drösler

No. 46   *EDUCATION AND OBESITY IN FOUR OECD COUNTRIES* (2009) Franco Sassi, Marion Devaux, Jody Church, Michele Cecchini and Francesca Borgonovi

No. 45   *THE OBESITY EPIDEMIC: ANALYSIS OF PAST AND PROJECTED FUTURE TRENDS IN SELECTED OECD COUNTRIES* (2009) Franco Sassi, Marion Devaux, Michele Cecchini and Elena Rusticelli

No. 44   *THE LONG-TERM CARE WORKFORCE: OVERVIEW AND STRATEGIES TO ADAPT SUPPLY TO A GROWING DEMAND* (2009) Rie Fujisawa and Francesca Colombo

No. 43   *MEASURING DISPARITIES IN HEALTH STATUS AND IN ACCESS AND USE OF HEALTH CARE IN OECD COUNTRIES* (2009) Michael de Looper and Gaetan Lafortune

NO. 42   *POLICIES FOR HEALTHY AGEING: AN OVERVIEW* (2009) Howard Oxley

RECENT RELATED OECD PUBLICATIONS

OBESITY HEALTH UPDATE (2014) www.oecd.org/health/obesity-update.htm (electronic format only)

OECD REVIEWS OF HEALTH CARE QUALITY – KOREA (2012), *ISRAEL* (2012), *DENMARK* (2013), *SWEDEN* (2013), *NORWAY* (2014), *CZECH REPUBLIC* (2014)

MENTAL HEALTH AND WORK: SWITZERLAND (2014), *UNITED KINGDOM* (2014)

CANCER CARE – ASSURING QUALITY TO IMPROVE SURVIVAL (2013)

ICTs AND THE HEALTH SECTOR –TOWARDS SMARTER HEALTH AND WELLNESS MODELS (2013)

A GOOD LIFE IN OLD AGE? MONITORING AND IMPROVING QUALITY IN LONG-TERM CARE (2013)

STRENGTHENING HEALTH INFORMATION INFRASTRUCTURE FOR HEALTH CARE QUALITY GOVERNANCE (2013)

WAITING TIME POLICIES IN THE HEALTH SECTOR, WHAT WORKS? (2013)

HEALTH AT A GLANCE (2013)*: OECD INDICATORS* (2013)
See http://www.oecd.org/health/healthataglance for more information

OECD HEALTH STATISTICS 2014 (previously OECD Health Data 2013)
(Database available from http://www.oecd.org/health/healthdata

HEALTH AT A GLANCE: ASIA/PACIFIC (2012)

HEALTH AT A GLANCE: EUROPE (2012)

OECD REVIEWS OF HEALTH SYSTEMS - RUSSIAN FEDERATION (2012)

SICK ON THE JOB? MYTHS AND REALITIES ABOUT MENTAL HEALTH AND WORK (2011**)**

OECD REVIEWS OF HEALTH SYSTEMS - SWITZERLAND (2011)

A SYSTEM OF HEALTH ACCOUNTS (2011)

HELP WANTED? PROVIDING AND PAYING FOR LONG-TERM CARE (2011)

IMPROVING VALUE IN HEALTH CARE: MEASURING QUALITY (2010)

VALUE FOR MONEY IN HEALTH SPENDING (2010)

OBESITY AND THE ECONOMICS OF PREVENTION: FIT NOT FAT (2010)

For a full list, consult the OECD On-Line Bookstore at www.oecd.org,
or write for a free written catalogue to the following address:
OECD Publications Service
2, rue André-Pascal, 75775 PARIS CEDEX 16
or to the OECD Distributor in your country