Pre-budget scrutiny 2026-27: Summary of call for views submissions

Introduction

The Health, Social Care and Sport Committee is undertaking budget scrutiny for 2026-27. The Committee sought stakeholders' views on current levels of mental health spending including preventative spend, priorities for mental health spending and how decisions on mental health spending are made.

The call for views was open for submissions between 26 June 2025 and 15 August 2025. 51 respondents completed the Committee's call for views: 39 organisations and 12 individuals.

Key Issues Raised in the Responses

This paper identifies the key themes raised in the submissions and summarises the responses – quotes are provided to highlight issues and ideas.

Contents

Current mental health spending

Is the level of spending on mental health services appropriate?

Several submissions referred to what they perceive as a mental health emergency in Scotland. Respondents argued there is:

- a significant rise in mental health issues with prevalence more than doubling since 2011 causing a high and growing demand for services;
- significant pressure for the mental health workforce, with high vacancy rates and turnover across many areas and specialities, leading to staff burnout and unsustainability of services;
- inconsistent access to services across NHS boards and poor integration between NHS, social care, and third sector services;
- long waiting lists including multiple delays, with some submissions describing situations where individuals are placed on pre-assessment lists or initial triage queues before being added to the formal waiting list for treatment;
- community services under increasing pressure and facing funding uncertainty; and
- budgets cut across statutory and third sector services meaning that services are increasingly striving to deliver more with less.

Within this context, most respondents did not consider the current level of spending on mental health services in Scotland to be appropriate. There was a consensus that while spending £1.5 billion (or the equivalent of 9% of total NHS expenditure) on mental health services sounds significant, it is not sufficient to meet demand.

Funding sources

Some responses made the distinction between two discrete funding sources for statutory mental health services:

1. Direct funding from the Scottish Government Mental Health Directorate, which funds national programmes such as the Communities Mental Health and Wellbeing Fund and the Suicide Prevention Strategy.
2. Funding to NHS boards: most mental health funding comes from general NHS allocations to territorial boards. NHS boards, via Integration Authorities, then take decisions on allocating funds to mental health services locally.

Regarding direct funding, some submissions detailed calculations to demonstrate resource has reduced over the current parliamentary term. Organisations used this to raise concerns of deprioritisation through central budget funding, arguing that this is happening at a time of significantly increased need. Focusing on the central Scottish Government budget line for mental health services (as distinct from the amounts spend by individual boards and integration authorities), the Royal College of Psychiatrists in Scotland (RCPyschiS) submission stated:

> "Despite a record investment of £21.7bn in Health and Social Care, the budget allocation to mental health services for 2025-26 decreased from the £290.2m commitment of the past 4 years (despite this being cut in-year each year), to just £270.5m. RCPsych data analysis indicates that this amounts to a £54m cut when adjusting for inflation."

In relation to funding for NHS boards, submissions demonstrated a widespread concern that there is a lack of clarity and transparency around how funds are distributed across NHS Boards, IJBs, and third-sector organisations. As an example, in its submission, RCPyschS argues there is a lack of accountability between Health Boards, IJBs and Scottish Government) over funding allocation to mental health:

> "Funding is received by the boards, but service provision is often managed by IJBs and HSCPs, creating a mismatch in planning and accountability."

Several organisations who submitted responses also point to the SNP's 2021 election manifesto, where the SNP committed to "ensuring that by the end of the parliament, 10% of our frontline NHS budget will be invested in mental health services". Many of these organisations have concerns that both this, and the Scottish Government's commitment that 1% of NHS frontline spending should be allocated specifically to Child and Adolescent Mental Health Services (CAMHS)[1] has not been met by most NHS boards. Many noted that only one health board, NHS Lothian, met the target to invest at least 1% of its funding into CAMHS services. The British Psychological Society (BPS) submission argues that "at a minimum, the Scottish Government should urgently meet its own commitments for increased mental health spending."

Ringfencing

Some submissions suggested the implementation of a legislative mechanism to ringfence funding to meet both targets, arguing that without enforcement, NHS boards will continue to deprioritise mental health. Scottish Action for Mental Health (SAMH) supported this type of ringfencing in its submission:

> "We believe the Committee and Scottish Government should explore all legal levers available to Ministers, including ministerial directions to Health Boards,

[1] The Scottish Government's commitment that 1% of NHS frontline spending should be allocated specifically to Child and Adolescent Mental Health Services (CAMHS) is set out in the NHS recovery plan: progress report 2023.

> to ensure boards increase the proportion of their budgets allocated to mental health services."

However, not all were in favour of ringfencing. The VOX Scotland submission quotes one of its members:

> "I am uncomfortable with the idea of allocating a percentage of the existing NHS budget. I want to see an increase in funding, not a different way of dividing unnecessarily scarce resources."

A number of submissions also outlined concerns on constraining budgets when preventatitive activities, such as those that tackle the social determinants of health and can directly affect a person's mental health, are not solely under the purview of 'health services'. Respondents highlight the effectiveness of early intervention programmes, for example in schools, youth wellbeing hubs, and community organisations.

Third sector funding

Many submissions highlighted the contribution of the third sector for supporting positive mental health and those with mental health needs. Many of these described services as fragile and constrained by a short-term fundng culture. In its submission, the Scottish Recovery Network told the Committee that "…funding is often fragmented, short-term, and difficult to quantify nationally, as it flows through multiple routes..." In its submission, Central Wellbeing stated that the charity is "continually having to search for funding, which takes time away from our frontline tasks", and SAMH said that "third sector providers in some cases are operating commissioned services at a loss, using their own charitable funds to effectively subsidise the delivery of public services."

Many third sector respondents called for fairer, multi-year funding settlements, transparent commissioning models and ringfenced funding for community mental health. However, again, there was also mixed opinion on ringfencing of budgets in this context. Some submissions called for protected funding to ensure sustainability and parity with statutory services, but others cautioned against commissioning practices that could restrict local flexibility, exclude small providers and create over-centralisation or control. In its submission, LinkLiving argues for more flexible and outcomes focussed commissioning:

> "Third sector mental health services should move to outcomes focussed commissioning which allow for better measurement of successes. Mental health is variable and as such the support we provide to help people manage it should be flexible and responsive to prevent crisis and costly interventions."

How funding is allocated

While there was a consensus that funding levels are inadequate, some respondents highlighted that they thought it was a substantial investment. These respondents

raised concerns that the real issue was not simply a question of adequate funding assigned, but more of where and how effectively money is allocated, whether it is appropriate to meet the diverse and growing needs of individuals and communities, and whether it produces measurable outcomes.

Dr Will Ball, an individual respondent, argued that funding needs to shift from the acute towards preventative interventions:

> "A significant proportion of current spending may be absorbed by crisis-driven and unplanned care, which is costly and often less effective than early intervention. There is a strong case for rebalancing spending towards earlier, preventative, and community-based support to reduce reliance on acute services and improve outcomes."

Many submissions, particularly those from third sector organisations agreed with the perspective that a significant proportion of current spending is reactive, responding to crisis interventions. These respondents advocate for a move towards more early intervention and preventative work and usually cite community-based support services as a key delivery mechanism.

However, others took a different view, arguing that there is a lack of definition over what mental health is, what a mental health service is, and what type of service should receive statutory mental health funding. The RCPyschiS submission argues that these terms are often conflated in policy and budgeting which leads to confusion about what services should be funded, what outcomes should be measured, and who qualifies for support. The submission from the Senior Medical Managers in Psychiatry argue that current services covered by mental health budgets can group interventions together and this risks diluting investment in specialised care:

> "There is currently no clarity on what mental health services are included when coming to the £1.5 billion figure… What is meant by 'Mental Health' needs to be more clearly defined. In grouping 'mental health services' under one umbrella, the vastly heterogenous range of presenting needs and types of services are unhelpfully homogenised, making meaningful benchmarking and assurance on spending 'levels' impossible. Highly specialised services for those with very complex clinical needs are placed in the same category as services to support milder, potentially self-limiting, presentations."

The RCPyschiS submission argues that "without a clear definition of what the mental health budget is meant to achieve, and without mechanisms to align investment with real-time data and need, it is impossible to say that the current level of spending is appropriate." The RCPyschiS also argue that broad societal interventions, such as poverty reduction or early years education are crucial to mental wellbeing, but should be funded separately.

Gaps in funding

Several organisations advocate for more funding to be allocated to specific populations, such as those requiring palliative care, services for children and older people, perinatal mental health support and those with chronic illnesses. Others, notably the RCPyschiS and the Senior Medical Managers in Psychiatry, warn that current funding is increasingly directed toward wellbeing and distress pathways, while services for schizophrenia, bipolar disorder, and complex trauma are currently under-resourced.

Some organisations emphasised the importance of integrated health and social care in supporting people with mental illnesses, noting that support and interventions can be inextricably linked yet the budget model used does not reflect this. The Mental Welfare Commission for Scotland (MWC) said:

> "An integrated approach and joint investment would ensure that people are able to leave hospital and live with robust community mental health support and social care support thus reducing the number of hospital admissions, shortening the length of stay of any hospital admission and ensuring people's rights to recover, flourish and live the lives of their choosing."

Many respondents also thought that spending in mental health is too driven by what they describe as an 'outdated medical model of care' and that there are several ways to access mental health support in Scotland. Social Work Scotland state in its submission:

> "A fundamental tension exists between the medical model, which prioritises diagnosis and treatment, and the social model, which considers the broader context of mental health, including relationships, environment, and community."

In its submission COSLA state that Local Government and Integration Joint Boards (IJBs) face severe financial pressures, with limited flexibility due to committed funding and rising costs. They argue that the disparity between NHS and social care investment continues to grow, undermining efforts to shift towards upstream, preventative approaches that could alleviate long-term pressures on health and social services.

What information can help support assessment and evaluation of the allocation of the mental health budget?

The submissions received offer a range of recommendations to improve how the Scottish Government assesses and evaluates its mental health budget.

Responses from professional organisational organisations tended to call for data to be broken down to ensure funding aligns with clinical need and service delivery and track whether funding is reaching the right services and populations.

Suggestions to assess equity and unmet need included:

- Waiting times data for all mental health services, some respondents noted that this was only available for a small proportion of mental health services.

- Referral volumes and rejection rates, some respondents suggested there is a need to understand not just how many people are referred and why some are turned away.

- Unscheduled care usage, for example A&E and crisis admissions. Some submissions also suggested tracking cross-sector crisis responses as part of budget evaluation, with the aim of improving efficiencies and redirecting funding to more creative solutions.

Many third sector organisations called for disaggregated data to improve tracking of unmet need and hidden inequalities, and to ensure that community-based and preventative services are properly funded. Suggestions included disaggregation by age, gender, ethnicity, deprivation, geography, service type and discreet conditions.

Several organisations also pointed to the need for better insights into how well the system supports delivery. Suggestions to assess this included data on:

- The workforce, including vacancy rates, training levels and burnout indicators for staff. Some suggested that workforce could be a helpful proxy measure for tracking NHS investment in mental health.

- The third sector contribution, such as funding levels and commissioning models, service reach and sustainability. This should include the need to track demand vs. allocation to assess sustainability.

- Integration, for example, in terms of effective collaboration across health, social care, housing, education.

Referring to data quality and evaluation, many organisations noted that the data used to allocate mental health spend was inadequate. Social Work Scotland stated in its submission that its members reported a strong sense that “we count things that are easy to count, but we don’t count what really matters”. They continue, saying that “without meaningful outcome data, it is difficult to assess whether spending is delivering value or improving lives.”

Many submissions also called for outcomes-based data and evaluation to inform budgets and spending. For example, SAMH argued that “there is no public data on the impact of the treatment itself.” Lynnor Byers, an individual respondent, suggested a process of “moving beyond simply reporting on inputs (spending) and outputs (number of appointments) to demonstrate tangible outcomes for individuals”.

Suggestions of outcome-based evaluation included the following:

- Clinical outcomes, such as relapse rates, recovery duration, suicide/self-harm rates, medication adherence. Some respondents felt this could be useful in evaluating the effectiveness of mental health spending, as well as identifying examples of best practice.

- Functional outcomes, such as returning to work, education, housing stability, and social inclusion. Some respondents argued that these should be tracked alongside clinical outcomes to assess the real-world impact of services.

- Patient-reported outcome measures, which many argue would provide valuable insight into what works and what does not.

- Longitudinal tracking of preventative interventions, which could be "analysed relative to funding changes to assess efficiency and impact". (Dr Will Ball)

Several submissions also call for health economic analysis to support policy learning around how to allocate budgets. These included using measures such as quality adjusted life years (QALYs[2]) and that approaches such as cost-effectiveness of different ways of delivering specific care or treatments, or Societal-perspective Cost-Effectiveness Analysis[3], but for society as a whole.

Preventative spend on mental health

Do you consider there to be evidence of preventative spending activities in relation to mental health (and if so, can you provide examples)?

Respondents to the call for views were overwhelmingly of the view that preventative work in mental health is an essential and urgent priority. Respondents set out a strong moral, clinical, and economic case for prevention and early intervention.

However, there were differences in views as to priorities for where resources should be invested to achieve prevention, with some arguing that prevention must be strategically defined and systemically supported.The Senior Medical Managers in Psychiatry's submission argues that preventative action needs to be applied in the right way and in the right part of the system, cautioning that prevetion is often seen as a way to reduce demand on clinical services, but this may not be always the case with severe mental illness. Crossreach call for more support for those already in crisis in its submission:

> "…there is a growing need for more acute services, rather than a diminished need. If money was invested differently, outcomes further down the line would be achieved,"

[2] Quality-Adjusted Life Years (QALYs) are a measure of health outcome that combines both the quantity and quality of life.
[3] Societal-perspective Cost-Effectiveness Analysis is a type of economic evaluation that looks at the overall costs and benefits of a healthcare intervention not just for the healthcare system.

While organisations such as Parenting Across Scotland advocate for increased resourses to prioritise early interventions:

> "Investing in the wellbeing of the youngest members of our society can help to support lifelong mental health across the generations."

The Senior Medical Managers in Psychiatry's submission calls for systemic reform, pointing to the need to create environments where people can access support before they reach crisis point. Notably, the submission emphasises that normal human experiences such as, grief, stress and social isolation, should not be over-medicalised due to the need for people to have a diagnosis before they are able to access support.

Most respondents agree that prevention must extend beyond health services. Some organisations call for whole-society change and public health and social policy measures, others call for the introduction of a 'mental health in all policies' approach across the public sector. The BPS is one example of the latter, its submission said:

> "tackling the social determinants of mental ill health is crucial for an effective preventative approach, beyond health services and across other policy areas and budgets. This is why we call for the introduction of a "mental health in all policies" approach across the public sector, to include use of a Mental Health Impact Assessment to enable initiatives in areas such as economic development, social security, education and the natural environment, to be aligned with improving mental health and wellbeing and mitigate harm from policy intervention."

Most respondents to the Committee's call for views believe there is evidence of preventative spending in mental health and provided a range of examples. However, respondents consistently qualify this with concerns about fragmentation, underfunding, lack of strategic coherence, and poor evaluation.

Examples of preventative activities

There is widespread concern among submissions that prevention can often be poorly defined, with some arguing that prevention can be conflated with general wellbeing initiatives rather than specific mental health initiatives.

Many organisations chose to frame examples in their submissions under primary, secondary and tertiary prevention activities, as set out in the Public Health Scotland classification of preventative activities. There were too many examples to list all individually, but below are a range of examples used within submissions.

Primary prevention was typically used by respondents to describe mental health problems before they arise, usually to tackle the social determinants of health. This was often considered to be delivered outside the health budget and some submissions expressed concern that this made it hard to demonstrate effectiveness. Examples of primary prevention referenced in the submissions include:

- Dr Will Ball describes the Scottish Child Payment as “one of the most impactful examples” of primary prevention, arguing it targets “root causes of mental ill-health before they arise.”

- Parenting Across Scotland describe whole family support such as Open Kindergartens, which they argue “prevent poor mental health for parents and carers as promote positive relationships between parents, carers and their young children”.

- Several submissions referred to the The Communities Mental Health and Wellbeing Fund for Adults and the Children and Young People's Community Mental Health and Wellbeing Supports. The National Carer Organisations submission states “these grants support peer networks, early wellbeing initiatives, and social connection—important pillars of early intervention.”

Secondary prevention was typically used by respondents to describe early detection and intervention, when mental health issues begin to emerge and before they escalate into crisis or require specialist care. Respondents reported that these sorts of interventions could be inconsistent across different areas and complained there was a lack of sustained funding. Examples of secondary prevention referenced in the submissions include:

- Children First recounted Lucy’s story of accessing its Family Wellbeing Service, which offered preventative support breaking isolation and raising confidence. This was used as an example of providing support before a referral to CAMHS was needed.

- Angus Health and Social Care Partnership detailed a range of initiatives, including Distress Brief Intervention (DBIs) and embedding specialist mental health nurse roles in GP practices.

- The Edinburgh Children’s Hospital Charity detailed the work of The Haven, a children’s mental health service which is a self-referral, whole family, early intervention hub supporting children and young people with a range of mental health challenges. The organisation reports “We are seeing evidence that this service is transformational for the young people and their family members who have been able to access mental health support without the need for lengthy waiting lists and tight criteria”.

Tertiary prevention was typically used by respondents to describe supporting people to live well with mental health conditions, reducing the impact of existing conditions, preventing hospitalisation and preventing relapse. Some respondents noted that these types of services are often underfunded and vulnerable to funding cuts. Examples of tertiary prevention referenced in the submissions include:

- The Scottish Recovery Network gave examples of Recovery colleges which they state “improve self-management, reduce hospital use, and increase hope and confidence”, and peer-led third sector mental health and wellbeing

programmes, which offer “open-access activities, group learning, and one-to-one support that prevent escalation to acute services.”

- The Royal Pharmaceutical Society detail Clozapine and lithium monitoring in community pharmacies where Pharmacists routinely provide blood test coordination and medication supply, ensuring adherence and monitoring to prevent serious side effects or relapse.

- The Mental Health and Wellbeing in Advanced Illness Network (MAIN) cite evidence to support “psychological support interventions [which] can enhance wellbeing for people with advanced illness and for those close to them.” The submission references My Grief My Way, which is an online bereavement support intervention based on Acceptance and Commitment Therapy.

- The Association for Family Therapy and Systemic Practice (AFT) (Scotland Branch) also cite evidence of family therapy models for persons with schizophrenia, and those experiencing substance abuse, arguing “family therapy has been shown to reduce future inpatient admissions (number and duration) and relapse…”

However, many respondents to the Committee’s call for views argued that funding preventative activities alone is not enough. Submissions argued there was a need for robust frameworks to assess and monitor long-term impact and cost-effectiveness of preventative spend. Some organisations called for economic modelling and outcome tracking, while also cautioning that short-term metrics can miss the more long-term relational impact. In its submission, Social Work Scotland argued that this was not compatible with short funding cycles:

> “Preventative work often takes years to show measurable outcomes, making it difficult to demonstrate value within annual budget cycles. This is particularly problematic in a political and funding environment that favours short-term, quantifiable results.”

Priorities for mental health spending

The Scottish Government’s Mental Health and Wellbeing Strategy identifies the following priorities for early investment:

- CAMHS and psychological therapies
- Addressing waiting times backlogs
- An extension of support for distress
- Ongoing implementation of our Suicide Prevention Strategy
- Delivering improved community-based mental health and wellbeing support for children, young people and adults.

Do you consider these to be the right priorities for mental health investment?

Most respondents to the Committee's call for views expressed support for the priorities for early investment as set out by the Scottish Government. Overall respondents thought they reflected current pressures and address the most urgent needs within mental health. However, support for the priorities was often qualified. Many respondents raised concerns about how these priorities would be framed, resourced, and implemented. The Scottish Recovery Network's submission said:

> "While nobody could disagree with any of these priorities, the question isn't about whether they are the right priorities or not but about how they are going to be achieved."

Framing of priorities

Some submissions challenged terms like "support for distress" and "community-based support" arguing that they are vague and lack definition.

The Senior Medical Managers in Psychiatry's submission argues that distress is a normal human experience, not a clinical condition. The submission implies that vague definitions of distress risk over-medicalising the population, and could lead to inappropriate use of these services, which should be reserved for acute clinical need. The submission argues that distress should be addressed through other means rather than being treated as a mental health issue requiring clinical intervention or dedicated government funding.

Conversely, other organisations, such as VOX Scotland, argue that support for distress is essential. Other submissions focused on delivery of the Distress Brief Intervention (DBI) program under this heading, with Change Mental Health regarding it "as a proven and compassionate model of early intervention". Emilia Machala, an individual respondent, argues that "DBI is effective for youth avoiding formal CAMHS due to stigma fears, aligning with early intervention goals". However, Emilia futher added that "limited scaling restricts its impact".

The MWC challenged the term "community-based support" in its submission arguing that the phrase can often be used in policy terms but can mean multiple things to different people. The MWC argues that terms like this need to be defined, resourced, and delivered in ways that are transparent and meaningful to those seeking help.

Some respondents expressed concern over diagnosis-led service models within the Scottish Government's priorities that could exclude people who do not have a formal diagnosis. In its submission, Social Work Scotland told the Committee:

> "This approach risks excluding individuals who are struggling but do not meet diagnostic criteria, and it fails to address the broader social determinants of mental health."

Several stakeholder submissions also raised concerns that some groups or communities are excluded or under-represented in the Scottish Government's priorities, such as older adults, those requiring palliative care, carers, neurodivergent people, and those with severe mental illness.

Notably, while most submissions supported the priorities set out by the Scottish Government, the Senior Medical Managers in Psychiatry disagreed. Its submission calls for clearly defined needs, population and outcomes arguing that without this detail the Scottish Government cannot design services, make decisions about priorities or have any accountability.

Resourcing of priorities

As highlighted in responses to previous questions earlier in this document, many respondents expressed concerns over how these early priorities would be resourced.

Many submissions thought that the budget did not match the scale or urgency of the Scottish Government's priorities. The following are examples from the call for views:

- SAMH's submission states that the Scottish Government investment in suicide prevention of £2.8 million by 2026 is small compared to other UK and European countries. It argues that "this level of funding makes it impossible to take the necessary action at a scale which will meaningfully address the suicide rate and associated distress."

- Children in Scotland's submission highlights reported changes to the delivery of the Children and Young People's Community Mental Health and Wellbeing Fund. The submission argues that the Scottish Government allows local authorities to use this for funding core mental health services, with funding redirected from the community services it had previously supported. The organisations argues "This suggests a deprioritisation of these vital community services, all of which will affect the support available to children, young people and families."

Several respondents cited workforce issues when commenting on the resourcing of priorities, stating that recruitment, retention, and burnout are cited as major barriers to mental health service delivery. The following are examples from the call for views:

- The British Association for Counselling and Psychotherapy said "we are seeing workforce gaps holding back delivery of psychological therapies across Scotland"

- Change Mental Health said "the mental health sector in Scotland faces a deepening workforce crisis - staff across the NHS, local authorities, and the third sector struggle with burnout, recruitment challenges, and retention problems. Investing in workforce wellbeing is vital; it ensures services remain sustainable, supports staff morale, and preserves the quality of care."

Many submissions also pointed to increasing strain on third sector delivery organisations, reporting increased referrals without matching investment, which can jeopardise service viability. The following are examples from the call for views:

- The British Association for Counselling and Psychotherapy said "many third sector services report increased NHS referrals without corresponding funding. We have seen many services close in the current financial climate, due to cost of living and pressures from changes to National Insurance, leading to reduced specialism and client choice."

- SAMH said "In the context of an ongoing crisis for community and social care services the Scottish Government must make quicker progress on ensuring multi-year funding is available for commissioned third sector services as part of a fair funding settlement to local government. Without fair funding for the third sector, vital community services supporting people's mental health and wellbeing will be lost, placing more strain on statutory social care, social work and health services and undermining progress against the strategic objectives and vision of the MH&WS, PHF and SRF."

Implementation of priorities

To what extent are these priorities reflected in mental health service delivery?

Most respondents agree that implementation of the Scottish Government's strategic priorities is inconsistent and fragmented, with many respondents surmising that the policy ambition outpaces delivery capacity and resource. Many argue there is a disconnect between the Scottish Government's stated priorities and the actual delivery of mental health services in local areas. Scotland's Mental Health Partnership states in its submission that "the connection between national strategy and local decision making appears to be weak."

Various organisations argue that there is a postcode lottery within community services, where access to services varies widely by region. Several organisations state that localities are dependent on decisions of integration authorities, not Scottish Government strategic priorities, again creating inconsistencies. In its submission, Beat said: "Mental health services are particularly vulnerable to difficult decisions taken by Joint Integration Boards."

Many organisations state there is fragmentation within services, characterised by poor integration across health, social care, and third sector services. Social Work Scotland said:

> "Mental health service delivery is not a cohesive entity across Scotland. It is fragmented and often siloed, particularly in multidisciplinary practice. For example, information and support provided by children and families services may not be shared with substance use teams, mental health services, or learning disability services, even when they are working with the same individual or family.

This lack of integration leads to duplication, inefficiency, and missed opportunities for holistic care."

Decisions on mental health spending

How could transparency in relation to decisions around mental health spending in Scotland be improved?

There is widespread concern throughout submissions that it is difficult to understand how funding for mental health is spent. Respondents attributed this to fragmentation of management and accountability, arguing there is a complex picture of responsibility between the Scottish Government, NHS Boards, Integration Joint Boards (IJBs), Health and Social Care Partnerships (HSCPs), and third sector organisations. Respondents agreed that this makes it difficult to trace who makes decisions, how funds are allocated, and whether spending aligns with local need. As an example, Social Work Scotland said in its submission:

> "To improve transparency, we must first understand how opaque the current system is. Headline figures may dominate public discourse, but without clarity on which services benefit, which lose out, and how decisions are made, it is impossible to assess whether spending is fair, effective, or aligned with need."

The Voluntary Health Scotland (VHS) submission states that it is not currently possible to trace how much government mental health funding reaches voluntary organisations and that its members find accountability and commissioning decisions at the local level to be unclear.

Many respondents advocated for the Scottish Government to improve spending transparency through the following ways:

1. **Structural and reporting improvements**

There are repeated calls throughout the submissions for a detailed breakdown of spending. Recommendations often state data should be disaggregated by service type, population and/or age groups, delivery model (NHS or third sector), geography and prevention tier (primary, secondary and tertiary).

A focus on outcomes was overwhelmingly called for, with respondents arguing that reporting needs to move beyond activity metrics. Respondents thought this should include effectiveness of any intervention, patient satisfaction and prevention impact.

Respondents also ask for clear public dashboards with real-time data on spending, outcomes, and gaps, independent audit or evaluation to assess equity and value for money, and clear, published rationales for decisions. Several submissions also called for compulsory reporting on NHS board spending to ensure targets for mental health spending is met. One respondent went as far as suggesting a system of enforcement, with penalties.

2. Improving definitions and accountability

There was consensus that there should be standardised definitions and metrics, including clarity on what counts as mental health spending, as discussed previously within this paper. The submission from the Senior Medical Managers in Psychiatry submission went a little further arguing that "an understanding and application of the evidence in effective interventions to meet need" should also be demonstrated.

Respondents thought the focus should be on achieving transparency within mental health and across portfolios, by tracking mental health investment across portfolios including health, education, housing, and social care, as well as recognising interdependencies and the whole system impact.

There was also a consensus that the Scottish Government should ensure there are clear lines of accountability. The RCPyschiS set out its view that the Scottish Government should mandate a dedicated line of accountability within existing structures, stating that "there is no standardised process or publicly available reporting that outlines how boards determine the proportion of their overall budget allocated to mental health, nor how that funding is distributed across different services, or how cuts to services are decided and/or justified". The submission further stated that:

> "Scotland would benefit from the introduction of a nationally consistent framework of accountability for Mental Health Services that encompasses clinical standards, health improvement and service planning as well as mental health budget allocation. This could be achieved within the current Board, IJB and HSCP structures by mandating a dedicated line of accountability for mental health through those structures, with regular reporting to Scottish Government."

Several submissions also call for greater Parliamentary scrutiny of mental health funding and service delivery, both generally and when changes occur. Some suggested Scottish Parliament committees should take on regular, in-depth reviews that lead to actionable recommendations, while others thought there should be a process of formal parliamentary scrutiny for significant reductions to budgets.

Stakeholder Engagement

There was a consensus throughout submissions that transparency requires meaningful involvement of service users, carers, community organisations and frontline staff. Respondents called for plain English information on budgets, spending, commissioning processes and decisions to be published by the Scottish Government and other decision makers. The Association for Family Therapy and Systemic Practice (AFT) (Scotland Branch) also commented in its submission that in its view the public need more of an understanding of intersectionality and interconnectedness of services.

Many submissions went further calling for lived experience to be central to scrutiny, accountability, and service design, stating that this should not just be in an advisory capacity. The Scottish Recovery Network said:

> "It's about more than transparency, it's about who holds the power in shaping mental health services and how that power is shared. We must go beyond simply "consulting" people with lived experience. It's time to embed lived experience leadership at all levels of Scotland's mental health system, not as a token gesture, but as a core component of governance, strategy, and funding decisions across all sectors. This means creating senior roles for people with lived experience with decision-making parity, for example, at Director level, within Scottish Government, service governance structures and mental health ombudsman."

The RCPyschiS also called for more staff involvement, arguing senior clinicians and local stakeholders are involved in planning and prioritisation.

Some submissions, primarily those advocating for particular groups or populations, thought that mental health decisions, and scrutiny, should include stakeholders such as young people, racialised communities, and those with experience of involuntary treatment. The Allied Health Professionals Federation Scotland advocates for decision makers to "actively include the voices of the unheard" stating that "if people are not included and services are not delivered around the local population then people are less likely to engage and therefore the impact that services can have will be limited."

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