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Submitted to Pre-budget scrutiny 2026-27, with a focus on mental health spending
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Organisation

Organisation details

1 Name of organisation

Name of organisation:
Royal College of Psychiatrists in Scotland

2 Information about your organisation

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As the professional medical body for psychiatry in Scotland, we set standards and promote excellence in psychiatry and mental healthcare.

We lead, represent and support psychiatrists nationally to government and other agencies, aiming to improve the outcomes of people with mental illness, and the mental health of individuals, their families, and communities.

We are a devolved nation and council of the Royal College of Psychiatrists. We have over 1,400 Members, Fellows, Affiliates and Pre-Membership Trainees in Scotland.

Current mental health spending

1 Is the level of spending on mental health services appropriate?

Please use this textbox to provide your answer:

Scotland is facing a mental health emergency, and whilst it may be tempting to respond with a blanket answer that the current level of spending is not appropriate, it is actually currently impossible to answer this question without a completely clear, universally agreed understanding and documentation of the scope and purpose of the mental health budget. The lack of clarity regarding this is a root cause of many of the budgeting issues which we will discuss throughout this response.

Lack of clarity:

One of the most significant challenges is the lack of clarity and transparency around what constitutes “mental health services.” The budget is understood by many to encompass a wide range of areas - from clinical treatment of mental illness to broader mental wellbeing initiatives (and now also an expectation for this to include assessment, treatment, and support for neurodevelopmental conditions) - but there is no clear, unified understanding and delineation. This makes it impossible to assess whether the funding is sufficient or appropriately targeted. If the budget is expected to support everything from specialist clinical services through to preventative and/or community-based wellbeing programmes, then an allocation of 9% of the frontline NHS budget is unlikely to ever be adequate. The conflation of mental illness, mental wellbeing and mental health (and associated initiatives and budgetary streams) further compounds this lack of clarity. It is absolutely essential that we caveat all of our recommendations in the continuation of this response

with the need for the delivery of a clear and universally understood scope of what the budget is expected to cover and how it is expected to be spent.

Unprecedented increase in demand for mental health services:

Mental health services in Scotland are under unprecedented pressure, with demand vastly surpassing resourcing. The 2022 Scottish Census found that the number of people reporting a mental health condition in Scotland has more than doubled since 2011, rising from 4.4% to 11.3% of the population (2022). This upsurge was the largest increase across all health condition types in the Census. Young people are particularly affected, with reports of mental health conditions among respondents aged 16-24 increasing sixfold between 2011 and 2022. Adequate funding is critical in addressing this rising demand. However, we have seen no such corresponding increase in resourcing.

Reduction rather than matching resource to demand:

The Scottish mental health public sector receives funding through the Scottish Budget in two ways: 1) direct funding allocated to mental health services and 2) the majority of funding goes to NHS territorial health boards - where health boards then allocate their own spending to mental health as they choose.

We have taken expert advice in calculating resource allocation in real terms and in the face of a lack of transparency and clarity. The following paragraphs spell out how we conclude that resource has reduced rather than increased over the current parliamentary term.

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. There was also no guarantee that this would not be cut further, as has happened in recent years (the 2024-25 allocation was cut by £18.8m). NHS Territorial Boards were allocated £14.387bn in the Budget. Despite the Scottish Government commitment to dedicate 10% of this spend to mental health, there is still no mechanism in place to ensure that this target is met.

In their 2021 election manifesto, the SNP committed to 'ensure that, by the end of the parliament, 10% of our frontline NHS budget will be invested in mental health.' This commitment was then reiterated in the Scottish Government and Scottish Green Party's shared policy programme. Unfortunately, every year since the 10% budget allocation commitment was made, NHS frontline spend has moved away, not toward, the Government's spending commitments.

In 2011/2012, 9.12% of NHS spending went towards mental health, over a decade later (and since the commitment to 10% has been made), the share of overall NHS funding has decreased to 8.53% in 2022/23. While the headline finding for 2023/24 is that the share increased to 9.03%, it must be highlighted that this includes for the first time the spending for clinical psychology services (based upon a recommendation from Audit Scotland). If this is excluded to ensure a more consistent data series, the share of spend is just 8.55%. Public Health Scotland note that 'some Clinical Psychology expenditure by some boards is included under the category 'Other mental health expenditure' but this is only expected to account for a relatively low proportion of total Clinical Psychology expenditure.' Clinical psychology spend amounts to £79.3m in 2023/24 and the 'Other mental health expenditure' was only £8.4m in 2022/23 (falling to £2.2m in 2023/24). Even if all that difference in the 'other' spend was accounted for by clinical psychology and then would need to be included to have a like-for-like comparison, spending would still only be 8.59% in 2023/24 and remain below the pre-election percentage.

After adjusting for inflation, the spending on mental health in 2023/24 (£1.486bn) was just 2.1% above the level of 2021/22 (£1.455bn). Once again, if clinical psychology spending is excluded for consistency, then real terms spending remained 3.3% lower in 2023/24 (£1.407bn) than two years earlier.

No health boards achieved the 10% goal in 2023/24, after adjusting for clinical psychology spending. In 2022/23, no health board achieved the 10% spending target set by the Scottish Government to achieve over this parliamentary term and only one health board (NHS Lothian) met the target to invest at least 1% of its funding into CAMHS services. Board-level statistics demonstrate significant regional variation in budget allocation to mental health, with some boards spending as much as 7% more of their frontline budgets on mental health than others. The lowest proportion of spending on mental health was as little as 2.31% in 2022/23.

Consequences – and causes - of failure to deliver promised share of budget:

Although 8.53% (average spend in 2022/23) may not seem terribly far from the Scottish Government's 10% target, in cash terms, this means that the Scottish Government was £224,702,220 short of meeting their own spending commitment. Adjusting both the total NHS spend and the mental health spend for inflation (2023/24 prices), there would need to have been £238.5m more invested into mental health in 2022/23 in order for the 10% pledge to have been fulfilled. This funding gap could cover the cost of any one of the following:

1. 1774 more consultant psychiatrists
2. 5,400 more nurses
3. 55, 827 more patients treated by Community Mental Health Teams
4. 3,272 more patients treated through crisis resolution
5. 17,112 more patients treated through outreach
6. 1084 extra acute psychiatric beds

So why are spending targets not being met? Government representatives have explained to us that the onus is on individual Boards to enact the division of NHS funding, but our own Managers in the Boards tell us they have no basis to insist on their share of funding, and are often expected to enact disproportionate cuts to mental health services (we will discuss this accountability gap in our answer to later questions). We require a mechanism to cut this cycle. RCPyschiS recommends the implementation of a legislative mechanism to ringfence this budget – recognising the importance of protecting and delivering investment in mental health (akin to measures in place in England and Wales). This would mean the mandatory spending of at least 10% of allocated budgets to mental health by each health board and 1% on CAMHS, alongside the mandatory reporting of this.

Funding based on outdated models of care and skewed by inequitable targets:

Another issue is that investment decisions are often based on historical precedent rather than real-time data. There is a pressing need for a more dynamic and responsive approach to budgeting, one that is guided by clinical need, referral patterns, and outcomes data. Without this, the system risks perpetuating outdated funding models that do not reflect current realities.

Since the introduction of CAMHS and Psychological Therapies targets, Health Boards have largely depended on a dedicated funding stream from the Scottish Government as the primary source of investment in mental health services. However, this reliance has not been matched by robust accountability for improving other areas of mental health provision.

In many Boards, the core funding for mental health services is still based on historical budgets designed around an inpatient model of care, which focused intensive support on a relatively small number of individuals. Today, services are expected to reach significantly larger populations through a community-based model, yet the foundational funding remains tied to outdated structures. This disconnect is reflected in the persistent positioning of Boards within the mental health spending "league table", which correlates closely with their historical investment in institutional care models.

Scotland's mental health services need to be funded with parity of priority in relation to our physical health services, and in a joined-up approach. A persistent and unacceptable mortality gap endures in Scotland: people with severe mental illness (SMI) living in Scotland have a life expectancy which is 15-20 years less than the general population. This gap is even wider for those with learning disabilities. Approximately 5% of deaths from SMI are from suicide – however, 95% are due to other, predominantly physical, causes – and 2 in 3 of these deaths are from preventable causes: by conditions such as cancer, respiratory, cardiovascular and liver disease. This stark, predominantly preventable, and entirely unacceptable mortality gap makes the clear case for improved investment in Scotland's mental health sector and services.

With the onset of severe mental illness occurring in the 15 – 30 age range and evidence of mental ill health increasingly affecting the young, there are powerful economic as well as ethical and humanitarian arguments for redressing the neglect of mental health resource.

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. What is clear, however, is that demand is rising, outcomes are worsening, and the current approach to funding is not fit for purpose. A redefinition of the budget, greater transparency, and a data-driven investment strategy are urgently needed.

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

Please use this textbox to provide your answer:

To support a meaningful assessment and evaluation of how the mental health budget is allocated in Scotland, we need to begin by acknowledging a fundamental and highly concerning issue: there is currently no clear or transparent framework guiding how these decisions are made.

Lack of framework for accountability:

While the Scottish Government allocates frontline NHS funding to health boards and has set an unmandated (and thus unenforceable) target of 10% allocation to mental health services and 1% to CAMHS services, what happens next, and how that money is distributed within board areas, IJBs and HSCPs (particularly to mental health) is unclear and inconsistent.

There is a major lack of transparency and accountability (between Health Boards, IJBs and Scottish Government) over funding allocation to mental health - which has led to inefficiencies and waste. Mental health services have also experienced disproportionately large cuts to budgets in recent years.

Health and social care integration has created confusion over who is responsible for what, and Scotland's mental health services are disjointed and fragmented, which is impacting the quality of care that patients are receiving. Issues of leadership and accountability between Health Boards, IJBs and HSCPs remain unclear.

Audit Scotland has highlighted a major gap between strategy and delivery. Money is being wasted through duplicated structures, poor coordination, and ineffective interventions while patients wait for care.

Spending variation as inequity rather than reflecting different regional needs:

There is significant variation in spending across health boards, and this variation is difficult to account for due to the lack of publicly available information about the decision-making process. The fragmentation between Health Boards, IJBs and HSCPs further complicates matters. Funding is received by the boards, but service provision is often managed by IJBs and HSCPs, creating a mismatch in planning and accountability. This split has led to challenges in service delivery, particularly in psychiatry, where long-term investment is needed to observe meaningful change.

Without a defined process or principles for how mental health budgets should be allocated (or justified to be cut), it is nearly impossible to evaluate whether decisions are equitable, evidence-based, or responsive to local need. This is especially problematic given the short-term nature of many funding decisions, which undermines the ability to plan for workforce development, training, and sustainable service models. Psychiatry, as a discipline focused on mental health outcomes and societal function, requires longer-term investment to measure outcomes effectively, and short bursts of funding are insufficient.

To address these issues, we need a clear and transparent framework for budgetary decision making and allocation. This framework should be consistent across Scotland and include:

• Evidence-based decision-making, informed by both quantitative data and qualitative insights from clinicians and communities.
• Public health principles, ensuring that funding supports prevention as well as treatment.
• Transparency and accountability, with each health board required to nominate an accountable officer, support them through appropriate governance structures and publish regular reports report detailing how decisions were made and justified.
• Monitoring and evaluation, with outcomes tracked from the outset to demonstrate value and impact.

Due to this lack of accountability and transparency, mental health services have been disproportionately affected by service cuts in recent years. While there were no real-terms cuts reported across Scotland overall when comparing total spend and investment in adults, older adults and CAMHS in 2023/24 with 2022/23, concerningly there were only 2 boards that had no real-terms cuts in 2023/24 (NHS Forth Valley and NHS Lanarkshire). Lothian (0.4%) and Shetland (13.3%) reported an overall real-terms cut in mental health spending (this doesn't even account for the addition of clinical psychology), a majority of boards cut spending in real-terms on adult psychiatry (ranging from 0.5% in Greater Glasgow & Clyde to 30.1% in Shetland), three boards have a cut in older adults psychiatry (ranging from 3.6% in Ayrshire & Arran to 8.2% in Shetland) and three boards had cuts in CAMHS (from 0.5% in Shetland to 10.9% in Highland). A framework, as above, is necessary to remedy this with immediacy.

Whilst we are calling for a standardised minimum of 10% of NHS frontline funding to be allocated and delivered to mental health across all health boards and 1% to CAMHS, there is also a need to consider equity and targeted funding. Not all areas of Scotland have the same level of need, and budget allocation should reflect this. This requires a shift in accountability, moving away from purely managerial decision-making at the top of structures, and towards greater involvement of senior clinicians who have an 'on the ground' understanding of local needs into decision making. Psychiatrists, as senior doctors with extensive expertise in mental health, must be central to reform. Their clinical insight and experience on the ground are essential to ensure services are safe, effective, and targeted to the areas of greatest need.

Currently, there is a major gap in data and reporting. Real-time spending data is limited, and there is no consistent process for ongoing monitoring of mental health expenditure. Calculations show that even a modest increase to meet a 10% threshold of NHS spending could unlock significant improvements in service provision, but without robust data and a clear operating model, it's difficult to make the case effectively.

Summary of our recommendations:
- a full review and restructuring of mental health funding systems and clinical governance to reduce waste, simplify processes, and ensure every pound delivers value for patients
- alongside transparent annual reporting of how mental health funding is allocated and spent - with oversight from the Scottish Government
- and the mandatory collection and bi-annual reporting of mental health data - going beyond waiting times to reflect the true scale of need.

We are also calling for:
- the next Scottish Government to declare a public health emergency in mental health, with leadership and action to guide us out of this.
- a clear plan to address fragmentation and improve accountability, ensuring that every pound spent on mental health services delivers maximum value for patients
- action proportionate to the scale and seriousness of the public health emergency, with national coordination, oversight, and accountability
- and that psychiatrists are involved in all major decisions about mental health services and funding - to ensure resources are directed where they will have the greatest impact.

Preventative spend on mental health

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

Please use this textbox to provide your answer:

Prevention and public health:

When discussing preventative spending in mental health, it's essential to begin with a caveat: the expression 'prevention' is often misunderstood to mean only primary prevention as a quick fix when, in reality, it requires long-term investment and patience to see meaningful outcomes (particularly in the case of mental health at a societal level). The public and political discourse around prevention tends to oversimplify the concept, failing to recognise that preventative measures do not immediately reduce demand for treatment services. Much of the work of primary prevention occurs in non-medical settings across communities and may be considered as part of the field of Public Health.

Such public mental health prevention work would not be appropriately funded within the specialist mental health budget. Just as we wouldn't cut cancer treatment services because we're investing in smoking cessation, we must avoid framing prevention and treatment as competing priorities. Instead, we need a parallel process: investing in prevention, while continuing to meet the urgent needs of the population.

It's important to clarify that mental health services cannot and should not be expected to fund primary prevention alone. For example, cardiology departments are not responsible for funding obesity reduction campaigns. Similarly, mental health budgets should not be stretched to cover broad societal interventions like poverty reduction or early years education, even though these are crucial to mental wellbeing. As discussed above, the scope of the mental health budget must be explicitly clear, and any additional responsibilities or outcome expectations must be adequately funded and resourced.

Secondary and tertiary prevention:

Where mental health services can contribute most meaningfully is in secondary and tertiary prevention. Secondary and tertiary prevention don't decrease incidence and may not significantly affect prevalence of the target condition, but they do reduce morbidity and mortality and may reduce prevalence of other conditions. For instance, effective treatment of ADHD is likely to protect against the development of depressive and anxiety disorders, as well as reducing the accidents and suicide risk associated with the untreated condition.

Secondary prevention includes early intervention services, such as support for people experiencing first episodes of psychosis, or targeted programmes for children and young people showing early signs and symptoms. 'Early intervention' need not mean early in life – it involves swift attention to presenting problems without the patient suffering on long waiting lists or receiving inadequate assessment and treatment when they finally reach the top of the list.

Tertiary prevention involves reducing the impact of long-term mental illness through the prescribing and monitoring of medication, appropriate use of mental health legislation, rehabilitation, peer support, and integrated physical health care - areas where psychiatry plays a vital role. It is often overlooked that with excellent psychiatric and multidisciplinary care maintained intensively over many years, people with severe mental illnesses can often experience the same achievements and fulfilments as those unaffected.

Evidence of effective preventative activity:

Professor Sir Gregor Smith's work has emphasised the importance of prevention in mental health, particularly in relation to the broader societal and economic benefits. Investment in mental health does not just improve outcomes in that domain, it has ripple effects across physical health, the justice system, education, and the workforce.

We recommend consideration of two options for promoting prevention in parallel with treatment, without compromising outcomes. The first option would be to introduce a separate funding stream (specific to prevention of poor mental health, and perhaps within this a specific fund for secondary and tertiary prevention for severe mental illness). The second option might be to gradually adjust the budget over time via a gradual escalator which rebalances the budget from reactive services to proactive services each year.

In summary, to make prevention work, we need:
• Long-term funding commitments, not short-term project grants.
• Clear outcome measures and data recording, tailored to mental health, that reflect the time it takes to see change.
• Recognition of psychiatry's unique role, which requires longer observation periods than other areas of acute medicine.
• A shift in accountability, ensuring that clinicians and communities have a voice in how preventative strategies are designed and delivered.

There is a field of growing, robust scientific evidence highlighting what works, and what does not with regards to public mental health prevention measures. Over the last few years, this evidence has been helpfully summarised through reviews by the Royal College of Psychiatrists (summarising what works), the Mental Health Foundation (summarising which interventions bring the greatest economic benefits compared to what they cost) and the Lancet (identifying how dementia can be prevented).

Across the life course these interventions can be summarised as follows:

During pregnancy:

• Perinatal interventions targeting parent tobacco, alcohol and substance use during pregnancy have strong evidence of effectiveness. This can include more robust policies, mocking cessation services and psychosocial interventions for maternal alcohol use.
Early years

• Parenting programmes
Universal parenting programmes for all of the population, as well as targeted programmes for at risk groups have been shown to be effective and can provide returns on investment of up to £15.80 per £1 spent. This, together with home visiting programmes, and trusted adult support interventions have strong evidence as being effective- both in terms of improving child/parent attachment (problems in this area are associated with later antisocial and criminal behaviours) and also through preventing childhood adversity (which contributes to nearly 1/3 of adult mental disorder).

• Anti-bullying programmes in schools
Being subjected to bullying early in life is particularly strongly associated with the later development of mental health conditions and poorer outcomes in life. There is strong evidence that measures targeted universally at school populations to address bullying help reduce the incidence of bullying and have positive benefits for mental health. They also provide better outcomes for the perpetrators of bullying. Over a four-year period, they provide a return of investment (ROI) of £1.58 for every £1 spent. When lost adult earnings and increased use of mental health-related health services to age 50 are considered the long-term ROI increases to £7.52

• Emotional & social educational programmes
There is strong evidence that educational programmes offered in preschool and during years of education that focus on social and emotional skills can decrease aggressive behaviours, later substance use, emotional distress and increase academic performance.

• Exercise
There is moderate to strong evidence that exercise prevents depression in young people and improves depressive symptoms when it is present. School-based interventions such as the daily mile support this, and also highlight a wide array of other benefits.

• Cognitive behavioural therapy programmes delivered in schools
Within two years, £2.11 in costs can be avoided for every £1 investment in these programmes. This is due to immediate health, school and absenteeism-related costs being averted. In the very long term, costs averted rise to £14.38, due to a reduction in the number of young people failing to meet GCSE success thresholds as a result of depression. Only a very small 2% reduction in risk of depression is required for there to be a positive ROI because of the magnitude of longer-term education-related impacts on life chances.

• Targeted interventions for young people at risk
The transition from adolescence into adulthood is a period of mental health challenges. Young adults who are not in employment, education, or training (NEET) are at risk of long-term economic disadvantage and social exclusion. The risk of being NEET is linked to increase risk of mental health problems. In

Finland, the Time Out! case management model for young men at high risk of social exclusion was found to be potentially cost effective in a randomised controlled trial, mainly due to positive effects on employability. The breakeven point for cost effectiveness was a 3%-4 % increase in employment rate.

Working age adults:
• Debt advice services
These services can help protect mental health and have a positive ROI. Using very conservative assumptions on costs and benefits a ROI of £2.60 for every £1 can be achieved over five years. These services are especially effective when embedded in GP surgeries.

• Brief interventions in primary care for those at risk of developing depression
Bibliotherapy using a self-help manual supplemented with brief telephone calls has been shown to be cost-effective in preventing depression with a cost per DALY averted of just €1,400.

• Workplace measures
There are also a number of different workplace measures that have been estimated to generate returns on investment over a one-year period of between £0.81 to £13.62 for every £1 spent. The greatest returns on investment came in programmes that improved the knowledge of line managers and workers regarding risks mental health, as well as the provision of personalised exercise programmes for employees.

• Psychological support for people living with long term conditions.
In studies this has taken the form of cognitive behavioural therapy (CBT) and mindfulness interventions delivered in person or online, usually offered to individuals diagnosed with cancer. Overall, these studies show improved mental wellbeing, and reduced cost to the health care system.

• Appropriate psychosocial assessment and aftercare following hospital presentations
There is a ROI of around £3:1 when the use of health, police and local government services are examined. This increases to £15:1 when impacts on time out of the labour force due to injury and premature mortality are factored in.

• multicomponent workplace suicide prevention strategies
Such as the 'Mates at work' programme used in the Australian building industry. The economic value of suicides averted of $A 1.79 million was then compared with the $A 0.39 million costs of implementing the programme, with a positive ROI of $A 4.6 for every $A 1 invested.

Older adults:

• Dementia prevention
There is currently no effective treatment or cure the condition. In Scotland, we have an ageing population. We currently spend around £42 billion a year in this area across the UK.

A Lancet Commission review identified 12 modifiable risk factors which could prevent or delay 40% of dementia. These factors include cardiovascular risks (high blood pressure, high cholesterol, diabetes, obesity) hearing loss, late-life depression, physical inactivity, smoking, and social isolation. Effective interventions to prevent dementia include treatment of hypertension, reduction of obesity and associated diabetes, physical activity, limiting alcohol use, avoiding smoking, prevention of air pollution and head injury, addressing insomnia and use of hearing aids for hearing loss.

Economic modelling conducted by the Lancet on England states that reductions in excess alcohol use through minimum unit pricing would lead to cost-savings of £280 million and 4767 quality-adjusted life-years (QALYs) gained over an indefinite succession of age cohorts. Reformulation of food products to reduce salt would lead to cost-savings of £2.4 billion and 39 433 QALYs gained, and reformulation to reduce sugar would lead to cost-savings of £1.046 billion and 17 985 QALYs gained. Reducing dementia risk from air pollution by introducing low emission zones in English cities with a population of 100,000 or more (that do not already impose restrictions) would lead to £260 million cost-savings and 5119 QALYs gained. Raising cigarette prices by 10% to reduce dementia risk from smoking would lead to 2277 QALYs gained and cost-savings of £157 million. Making bicycle helmets compulsory for children (aged 5–18 years) to reduce dementia risk from head injury would lead to cost-savings of £91 million and 1554 QALYs gained.

As far as we are aware, no healthcare system in any economically developed country has implemented a robust programme or strategy across its population to address the modifiable risks of dementia. In our view, the vast costs associated with this condition, which remains untreatable and incurable, there is potentially major savings to be made through adopting a coordinated public health informed prevention and screening strategy.

• Brief psychological therapies delivered to at risk older populations
Stepped care approaches for those bereaved can be cost-effective and protect mental health. Evidence from the Netherlands suggest €4,367 can prevent a year of depression/ anxiety year prevented in those offered the intervention (2007 prices).

• Loneliness
There is a growing evidence base suggesting that interventions that can tackle loneliness and isolation in older people can also be protective of both their physical and mental health.

Priorities for mental health spending

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

Please use this textbox to provide your answer:

Whilst our members acknowledge and agree that these are of course important areas, there is some concern that the current prioritisation risks reinforcing existing inequities and overlooking the needs of those with the most serious mental health conditions. As discussed in previous answers, a persistent and unacceptable mortality gap endures in Scotland: people with severe mental illness living in Scotland have a life expectancy 15-20 years less

than the general population. This gap is even wider for those with learning disabilities. 5% of deaths from SMI are from suicide, 95% are due to other, predominantly physical, causes. 2 in 3 of these deaths are from preventable causes - by conditions such as cancer, respiratory, cardiovascular and liver disease. This stark mortality gap makes clear the case for improved investment and prioritisation in Scotland's mental health sector – specifically for severe mental illness.

Role of governmental priorities and methods of implementation of these priorities in directing resource:

As we will discuss in our next answer, the Scottish Government's priorities for mental health exert a strong influence over how services are delivered – this cannot be underestimated. What is held accountable at national and Governmental level tends to shape the focus and direction of activity at local level. However, if not prioritised with precision, this influence is not without drawbacks. While it has improved access for certain groups, it has also unintentionally drawn focus and funding away from other vital areas - particularly services for adults living with severe and enduring mental illness. Conditions such as schizophrenia and profound learning disabilities continue to receive disproportionately low levels of investment and focus, despite their complexity and the significant associated mortality gap.

For example, in recent years, there has been much focus on CAMHS and psychological therapies, driven in part by national targets and political visibility. Public Health Scotland data shows a significant uplift in funding and workforce in these areas. For example, spending on psychological therapies has increased, yet services for people with complex, enduring conditions often remain under-resourced (however we have heard from our members that in some health boards there have been major cuts to these departments recently). This imbalance raises concerns about equity: those with the most severe and life-limiting conditions are not receiving proportionate investment, even though they experience the greatest mortality gap.

Community mental health teams are the keystone of the secondary care mental health system and have been critical for the successful shift in the balance of care from hospitals into the community over the past two decades. The overwhelming majority of adults who receive care and treatment for a major mental disorder will be seen within a CMHT. The narrow focus on CAMHS and psychological therapies has resulted in underinvestment and lack of prioritisation of these critical services. The very real consequences of this lack of prioritisation, combined with a consistent increase in demand, have been longer waits for access to services and a deterioration in the quality of care for the vast majority of people with mental disorders.

Role of third sector:

Another overlooked area is the third sector, which plays a vital role in delivering community-based and preventative mental health support. Despite being central to the Scottish Government's vision for community wellbeing, third sector organisations often operate on short-term funding cycles, limiting their ability to plan, retain staff, and embed services sustainably. If non-specialist mental health support is a priority, then funding mechanisms must reflect that, with longer-term investment and clearer communication pathways with NHS statutory services.

Dementia and NDCs:

The priorities also lack sufficient emphasis on neurodevelopmental conditions (NDCs) and dementia, both of which have significant public health and economic implications. For dementia, we know that modifiable risk factors could reduce prevalence and delay onset, yet preventative investment remains minimal. Dementia already costs Scotland billions annually, and without a shift towards prevention, this burden will only grow.
Similarly, investment in NDCs may not reduce prevalence, but it can improve outcomes across education, justice, and employment. In recent years, there has been as much as a 2200% increase in adult ADHD and autism referrals across Scotland in just 5 years. Yet there has been no corresponding increase in resourcing allocated to the mental health sector and secondary care services to meet this need. The RCPsychiS have developed a fully costed 4-tiered, step-care approach to this.

Undiagnosed NDCs are having a major impact on our economy: evidence suggests that the economic burden of undiagnosed and untreated ADHD in the UK could run into billions of pounds each year – which has been concluded to be significantly higher than the cost of diagnosing and treating these cases. Loss of productivity and income, alongside increased healthcare costs of untreated symptoms are major contributing factors to this. A report by the Mental Health Foundation estimated the average lifetime cost of each untreated case of ADHD to be £102,135 per case. The Scottish Government's own estimate of the total value of payments for cases where ADHD has been identified as the primary or secondary condition since the launch of Adult Disability Payment in 2022 to 23 April 2024 is a staggering £31,642,840. These are areas where cross-sectoral and economic benefits are clear, yet they are not adequately reflected in current spending priorities.

The emphasis on distress and suicide prevention must be part of a broader, long-term prevention agenda. Suicide is not in itself a mental disorder but a tragic outcome reflecting many factors, often but not always including a treatable mental condition. The RCPsychiS is dedicated to reducing both the suffering and loss of function caused by mental illness, and of course sees all deaths associated with mental illness as hallmarks of failure to provide timely and continuing treatment. Reduction in deaths by suicide can only come about as a result of a variety of different psychosocial interventions. Finally, any prioritisation must be accompanied by clear outcome measures and accountability structures. Without robust data and transparent reporting, it is impossible to evaluate whether investment is delivering value or addressing inequalities.

We recommend the following additional priorities for consideration:

- Reducing the all-cause 15-20 year mortality gap which exists between individuals with severe mental illness and those without.
- Stabilising general adult mental health services.
- Addressing the mental health workforce crisis, with a focus on retention.
- Adopting a multisector, whole-society approach to meet the needs of people with ADHD and autism in Scotland.
- Resourcing the third sector sustainably to complement the NHS.

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

Please use this textbox to provide your answer:

As already indicated, the Scottish Government's stated priorities for mental health investment are highly influential in shaping service delivery. What is prioritised at national level inevitably becomes the focus on the ground. Our members have reflected that this has been particularly evident in the way in which waiting times targets have driven investment and workforce expansion in psychological therapies and CAMHS. These targets have created strong incentives for boards to direct resources toward meeting them, often at the expense of other areas.

However, this influence is not always positive. While it has led to improvements in access for some groups, our members have fed back their experience that it has also diverted attention and funding away from other critical areas, particularly services for adults with severe and enduring mental illness. Conditions such as schizophrenia and severe learning disabilities continue to receive disproportionately low investment, despite their complexity and the significant mortality gap associated with them. We are concerned that the current priorities do not reflect need and have potentially contributed to a deterioration in the quality of care for the majority of people who access mental health services and a deepening workforce crisis.

While the Scottish Government's priorities are clearly reflected in service delivery, they have also created imbalances. The system tends to follow what is measured and mandated, which can lead to narrow interpretations of need and underinvestment in areas without specific targets. A more balanced approach is needed which ensures that national priorities do not unintentionally reinforce inequities or neglect the most vulnerable populations.

Areas where priorities are not reflected:

We should also highlight areas where these national priorities are not being reflected in service delivery, for example, around the recent waiting times initiative and associated investment. Despite the Health Secretary's announcement in February 2025 that "this record funding (30M) will help us ensure no one waits more than 12 months for a new outpatient appointment or inpatient/daycase treatment by March 2026", this appears to only have been intended to apply to physical health, whilst mental health and neurodiversity waiting lists continue to increase.

There is no consistent reporting across the majority of mental health services. Current standardised data collection only covers CAMHS and Psychological Therapies, which represent a small fraction of overall mental health activity. There is still no reporting on waiting times for individuals in mental health crisis, nor waiting times in accessing care for first presentations of psychosis.

Parity of action, nor the intention of the national priorities are being demonstrated here.

Decisions on mental health spending

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

Please use this textbox to provide your answer:

Improving transparency around decisions on mental health spending in Scotland is essential to ensure that funding is equitable, evidence-based, and responsive to local needs. At present, the process by which mental health budgets are allocated is fragmented and lacks transparency, making it impossible to evaluate whether resources are being used effectively or fairly.

As discussed already in this response, one of the central challenges in achieving transparency around mental health funding in Scotland is the absence of a clear, consistent framework guiding how financial decisions are made. While the Scottish Government allocates funding to health boards, what happens beyond that point is unclear. 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. This lack of clarity has resulted in wide variation in spending between board areas - variation that is difficult to explain or justify without transparent criteria or guidance. Compounding this issue is the division of responsibilities between health boards, IJBs and HSCPs. This fragmentation weakens accountability and transparency, making it challenging to trace who is making decisions, on what basis, and whether those decisions reflect the needs of the local population.

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.

As also already discussed in our response, transparency would also be improved by shifting accountability. Currently, decisions are often made limited input from clinicians or communities. A more transparent system would involve senior clinicians and local stakeholders in planning and prioritisation, recognising that qualitative insights and lived experience are just as important as quantitative data.

Finally, there must be ongoing public reporting and scrutiny. At present, there is a gap in real-time data and no consistent process for tracking mental health spend across Scotland. Without this, it is impossible to evaluate whether national priorities are being reflected in local delivery.