Consultation Response from Change Mental Health

Health, Social Care and Sport Committee: Pre-budget scrutiny 2026-27 on mental health spending

August 2025

Who We Are

For over 50 years, Change Mental Health has provided transformational support for people – ensuring that everyone has access to the support they need, when they need it and in a way which works best for them. We seek to change society by changing attitudes, fighting stigma and influencing policy to ensure a better quality of life for those affected by mental illness. Our team of over 180 members of staff support over 10,000 people with mental illness per year in Scotland across a variety of services, including: Community Link Workers, Hearing Voices, employability services, resource centres, peer-support and talking therapies.

Introduction

Change Mental Health recognises the fiscal constraints facing Scotland, but with growing need, and in line with refreshed Scottish Government policy, all mental health partners must prioritise active early intervention and prevention measures as a matter of urgency.

Action should be based on sound evidence and rigorous analysis of impact. Saving lives and budget can go hand-in-hand, but there are limits to what is possible in the face of resource scarcity, workforce pressures, delivery hurdles and demographic challenges.

We welcome the opportunity to contribute to the debate, and our submission will respond to the 6 questions posed by the Committee:

1. Is the level of spending on mental health services appropriate?
2. What information can help support assessment and evaluation of the allocation of the mental health budget?
3. Do you consider there to be evidence of preventative spending activities in relation to mental health (and if so, can you provide examples)?
4. Do you consider these to be the right priorities for mental health investment?
5. To what extent are these priorities reflected in mental health service delivery?
6. How could transparency in relation to decisions around mental health spending in Scotland be improved?

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

a) Can current spend be agreed and quantified?

It is not currently possible to determine with precision the total level of public spending on mental health services in Scotland. Audit Scotland's September 2023 review of adult mental health[1] found long-standing issues with the availability, consistency, and quality of data, with variation in the way mental health spending is reported across NHS Boards. This lack of transparency makes it difficult to track total public investment across the NHS, local government, and third sector, or to assess whether funding is targeted effectively. as mental health spending is reported across NHS Boards. This lack of transparency makes it difficult to track total public investment across the NHS, local government, and third sector, or to assess whether funding is targeted effectively.

The Scottish Government's Mental Health Directorate budget provides one partial view. Over the past three years, allocations have remained nominally flat at £290.2 million per year, but have been reduced in real terms by inflation and repeated in-year cuts:

- **2025-26:** Allocation of £270.5 million, down from £290.2 million in the previous four years, which is a real-terms reduction of around £54 million compared with maintaining the prior cash level, according to Royal College of Psychiatrists in Scotland analysis.[2]
- **2024-25:** Initial allocation of £290.2 million; reduced in September 2024 by £18.8 million to £271.4 million, with reductions affecting programmes such as Distress Brief Interventions and student mental health measures.[3]
- **2023-24:** Allocation of £290.2 million; in November 2023, close to £30 million was cut from the budget mid-year.[4]

In 2021, the Scottish Government committed to dedicate 10 per cent of frontline NHS spending to mental health by the end of the current parliamentary term[5]. However, RCPsych analysis shows that NHS frontline spend on mental health has instead moved further away from that target - from 9.12% in 2011/12 to 8.53% in 2022/23. In cash terms, this represented a shortfall of £238.5 million in 2022/23 against the 10% pledge. However, the Royal College of Psychiatrists (RCPsych) analysis shows that NHS frontline spend on mental health has instead moved further away from that target - from 9.12% in 2011/12 to 8.53% in 2022/23. In cash terms, this represented a shortfall of £238.5 million in 2022/23 against the 10% pledge.

This combination of static or reduced real-terms allocations, repeated in-year cuts, and the failure to meet the 10 per cent target suggests that current investment is neither at the level committed to in government policy, nor sufficient to meet rising demand, yet this is difficult to determine due to dispersed and poor-quality data.

b) What is the need?

Rising pressure and limited metrics

While recent data shows improvement - 91.6% of people in CAMHS started treatment within

18 weeks by March 2025, up from 86% in March 2024[6] - this coincides with fewer children entering treatment (a 6.6 % drop year-on-year) and higher waiting list numbers (an increase of 7%). Data collated by SPICe[7] suggests there were over 42,000 children and 23,000 adults waiting for a neurodevelopmental assessment in Scotland as of March 2025. This number has increased dramatically since 2020, with increases of over 500% for children and 2200% for adults in some areas since 2020, suggesting the 'waiting list for a waiting list' dynamic - where diagnosis is the gatekeeper - may distort demand measurement by this metric.

Deprivation and inequality as drivers

Scotland's mental health burden links strongly to poverty, inequality, and cost of living pressures, impacting some groups, such as people from minority ethnic groups and disabled people[8]. Research by the Joseph Rowntree Foundation indicates more than 1 in 5 Scots are currently living in poverty, including 1 in 4 children in Scotland[9]. These social determinants often correlate with both higher need and lower access, as services are variably funded and geographically inconsistent. Data in these domains can struggle to take into account rurality, and figures have been criticised previously for these limitations.[10] Rising pressures across these linked factors could signal a rise in future demand for mental health services.

Adult wellbeing (last 3 years)

Scottish Health Survey data shows a dip then partial recovery in adult mental wellbeing (WEMWBS mean): 48.6 (2021) to 47.0 (2022, lowest since 2008) to 48.9 (2023), still below 2019 (49.8). Wellbeing is lower in more deprived areas.[11]

Have IJBs increased mental-health spend—and is it driving deficits?

IJB funding fell 9% in real terms in 2022/23 (or 1% excl. Covid) and the projected 2023/24 gap almost tripled, with many boards balancing via non-recurring savings and reserves.[12] On mental health specifically, the Scottish Government consolidated ring-fenced MH allocations into a £120m "Enhanced Mental Health Outcomes Framework" in 2024/25, but this represented a 5.48% reduction versus expected levels in this instance[13]. This may be an interesting area of further study, to investigate whether a factor in worsening IJB finances has indeed been increasing demands and pressures on mental health services.

c) Does the spend match the need/demand?

While detailed national spend-versus-demand datasets are limited, using waiting lists for mental health services as proxy indicators point to resource lagging behind need.

A December 2024 Scottish Government report acknowledges staff in Primary Care report higher referral volumes, longer waits, and more complex presentations[14] – highlighting the difficulty in parsing need through waiting list data when one case may vastly differ from the next. Yet Scotland has faced real-terms mental health budget decline in the face of rising demand. It is little wonder waiting lists have become a chokepoint for those seeking help.

Using waiting-list growth as a proxy has limits:

- Access thresholds can exclude people in need.
- "Waiting list for a waiting list" dynamics (delays before assessment) obscure total unmet demand.
- Regional variation in eligibility criteria distorts comparisons.

Even with these caveats, sustained or rising waiting-list numbers - combined with underfunded service budgets - indicate demand is outstripping resources, particularly in high-deprivation areas where mental ill-health prevalence looms[15].

Conclusion

Scotland's current level of public spending on mental health services is neither meeting the commitments set out in government policy nor keeping pace with rising demand. The absence of up-to-date, consistent, and transparent spending data masks the true scale of investment, but the evidence available paints a clear picture: real-terms reductions in budget, repeated in-year cuts, and the failure to meet the pledged 10% share of frontline NHS spending have coincided with increasing complexity of need and sustained or growing waiting lists.

Demand indicators - including a 7% rise in CAMHS waiting lists, higher rejection rates for referrals, persistent gaps in adult wellbeing scores, and general IJB overspends - point to services under significant strain. This is exacerbated by the strong correlation between poor mental health and deprivation, with the cost-of-living crisis widening inequalities in both prevalence and access.

Without targeted investment, protected from mid-year reductions, and supported by robust data on spending and outcomes, Scotland risks locking in a cycle where resources trail behind need, backlogs persist, and the most vulnerable communities bear the heaviest burden of mental ill health.

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

A robust evaluation requires a unified and transparent dataset capturing total public sector spend on mental health, including allocations via the NHS, local authorities, Scottish Government, and - where relevant - universities, public bodies, and other statutory agencies. This should differentiate between direct service delivery, training and workforce development, and early intervention/prevention programmes. Public Health Scotland's Mental Health Quality Indicators[16] are useful, but use of existing data from a limited number of statutory services should not be the summit of ambition but merely the start.

Clear, agreed definitions are essential, particularly for what constitutes frontline spend and how preventative or community-based interventions are categorised. Current reporting often focuses narrowly on NHS budgets, overlooking substantial third sector and community-based provision that may derive from local government, health board or IJB contracts. Such contracts may leverage finance external to the public purse, mental health resource 'gain' to Scotland's wider mental health spend which are not yet holistically captured.

An agreed framework should acknowledge mental health spending across multiple portfolios and funding streams, with consistent terms of reference to categorise all investment, including third sector grants and contracts.

There is also an inherent tension between contractual or service outcomes and the complex, often non-linear nature of mental illness and recovery. While throughput, case closures, and time-in-service can provide a baseline measure of performance, such metrics risk oversimplifying progress and missing the nuanced, fluctuating reality of mental health. Many individuals may sit between diagnostic categories or move in and out of support over long periods; purely quantitative KPIs can fail to capture this. Commissioners should therefore be cautious in applying standard performance templates to mental health contracts and instead consider the co-design of outcomes and KPIs with service users and service providers, backed by leading academic research.

This may be an opportunity to develop a nationally agreed performance framework - co-designed with the third sector, service providers, lived experience voices, and local public bodies - that blends quantitative data with qualitative measures of recovery, resilience, and social outcomes.

England's National Service Framework for Mental Health (1999)[17] and subsequent NHS England strategies[18] have set national standards, performance indicators, and outcomes-based measures for mental health services, balancing mandatory quality benchmarks with local flexibility. Northern Ireland is currently developing a Regional Mental Health Outcomes Framework in partnership with service users, showing that co-designed, nationally agreed performance frameworks are both feasible and effective (Action 34)[19].

At present, no such national, cross-sector framework exists in Scotland, though elements of outcome measurement appear in specific NHS and local authority contracts; a unified approach would better reflect the distinct nature of mental health work.

Following Audit Scotland's 2023 recommendations - to improve consistency, completeness, and timeliness of mental health spend data - would enable better tracking of how funding aligns with strategic priorities, supports early intervention, and addresses inequalities.

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

Yes, although current examples are often isolated and not yet embedded systematically across Scotland's mental health system. Workstream 6 in Scotland's Public Service Reform Strategy[20] explicitly acknowledges that existing budgeting processes make it difficult to invest in prevention while meeting immediate need. Budgets are siloed within service or organisational limits, meaning savings generated in one portfolio (e.g. health) cannot easily be reallocated to fund preventative interventions in another (e.g. housing or social care). The Workstream proposes explicitly acknowledging that existing budgeting processes make it difficult to invest in prevention while meeting immediate need. Budgets are siloed within service or organisational limits, meaning savings generated in one portfolio (e.g. health) cannot easily be reallocated to fund preventative interventions in another (e.g. housing or social care).

The Workstream proposes:

- Redesigning the approach to identifying, tracking, and monitoring preventative spend.
- Allowing resources to move between portfolios and organisations to support upstream investment.
- Expanding the "Invest to Save" Fund to support preventative activity.

This signals an important policy intent to reform accounting practices so that cost savings from prevention - particularly those realised in other sectors - can be recorded, shared, and reinvested.

Change Mental Health's research for their Stafford Centre in Edinburgh, provides a tangible case study. In making the evidence case against proposed cuts to community mental health services by the Edinburgh Integration Joint Board, we found the Stafford Centre's early intervention and prevention work with people experiencing severe and enduring mental illness saved an estimated £2.2–£4.4[21] million in prevented psychiatric hospitalisations. This estimate was based on:

- The average length and cost of a psychiatric hospital stay.
- Internal service user survey data on the likelihood of hospitalisation without the service.
- Comparative analysis with NHS data from both Scotland and England (pre-pandemic) to benchmark costs.

The exercise highlighted both the fiscal value of preventative mental health services and the challenges in evidencing savings. Prevention policy is, by nature, harder to quantify and even harder to successfully implement in the maelstrom of daily politics.[22]

Scotland's preventative budgeting reforms are therefore an opportunity to embed mechanisms for capturing the economic impact of avoided costs in mental health, drawing on cross-sector data, third sector insight, and lived experience. A national framework that accounts for both direct and avoided costs - and allows these to be reinvested - would help shift the system towards sustainable prevention rather than costly crisis intervention.

The Institute for Government/UK Youth report in May 2024[23] proposed a framework for how a Government could fully imbed a system of early intervention and prevention spend – the ideas are out there. In our view, this is a vital area of public policy debate that must develop if the ideals of the 2011 Christie Commission[24] are ever to be fully realised.

4. [As set out by the Scottish Government in its Mental Health and Wellbeing Strategy] Do you consider these to be the right priorities for mental health investment?

Child and Adolescent Mental Health Services (CAMHS)

Yes - this is a critical priority, as CAMHS represents one of the clearest opportunities for early intervention and prevention. Around 75% of mental illnesses emerge before the age of 25[25], and severe conditions such as schizophrenia or psychosis often first present in adolescence. Intervening early can alter the trajectory of these illnesses, reducing severity, improving recovery rates, and lowering long-term service demand[26]. These outcomes are not only clinically important but fiscally sound - as early support can significantly reduce later reliance on high-cost crisis or inpatient care. Prioritising CAMHS therefore delivers both immediate benefit and long-term savings, making it an essential focus for investment.

Addressing waiting times backlogs

Yes - reducing backlogs is important, as delays to assessment and treatment can exacerbate distress, worsen symptoms, and increase the risk of crisis. However, as set out in our earlier evidence, waiting times are a narrow and sometimes misleading metric for measuring demand. In many cases, access to a waiting list is itself contingent on receiving a formal diagnosis or meeting strict referral thresholds. This can create a "waiting list for a waiting list" effect, whereby individuals in significant need remain invisible in official figures because they have not yet passed the diagnostic gateway. Efforts to reduce waiting times should therefore be accompanied by broader access measures, including lower-threshold, community-based supports which can be accessed without diagnosis, and the use of both quantitative and qualitative indicators to capture unmet need beyond those formally in the queue. Without this, waiting time improvements may mask the true scale of demand and risk excluding those most in need of early intervention.

Extension of Support for distress

Yes - we can speak to the Distress Brief Intervention (DBI) programme, coordinated by Change Mental Health across Highland, Dumfries & Galloway, Argyll & Bute, and Western Isles, as a proven and compassionate model of early intervention. National evaluation of the DBI pilot in 2022[27] shows it delivers rapid, person-centred support: individuals referred in distress are contacted by Level 2 practitioners within 24 hours and offered up to 14 days of tailored, community-based, problem-solving assistance. The programme is co-delivered

through strong local partnerships involving frontline services (GPs, A&E, Police Scotland, Scottish Ambulance Service) and third-sector organisations.

All 31 Health and Social Care Partnerships across Scotland have now signed up[28], supporting over 75,000 people in emotional distress nationwide. This universal adoption reflects DBI's adaptability and effectiveness in meeting complex needs through local delivery within a national framework. Change Mental Health believes the same focused, coordinated approach should be applied to other nationally organised but locally delivered initiatives - notably Suicide Bereavement Support services. Like DBI, these services could benefit from consistent national investment, local partnership delivery, and clear referral pathways from frontline agencies, ensuring that people affected by suicide receive timely, compassionate, and effective support during an exceptionally vulnerable period., supporting over 75,000 people in emotional distress nationwide. This universal adoption reflects DBI's adaptability and effectiveness in meeting complex needs through local delivery within a national framework. Change Mental Health believes the same focused, coordinated approach should be applied to other nationally organised but locally delivered initiatives - notably the Suicide Bereavement Support Service, which currently is only available in Highlands, Ayrshire and Arran. Like DBI, these services could benefit from consistent national investment, local partnership delivery, and clear referral pathways from frontline agencies, ensuring that people affected by suicide receive timely, compassionate, and effective support during an exceptionally vulnerable period.

Ongoing implementation of the Scottish Government's Suicide Prevention Strategy

Yes - this area of work should indeed remain a priority. Change Mental Health, in partnership with Penumbra, is actively delivering Outcome 3 of 'Creating Hope Together: Scotland's Suicide Prevention Strategy (2022–2032)'[29], which ensures that "everyone affected by suicide is able to access high quality, compassionate, appropriate and timely support — which promotes wellbeing and recovery" - encompassing those experiencing suicidal thoughts or behaviour, their caregivers, and others impacted by suicide.

Progress in year one (2023–2024) has established the vital Suicide Prevention Scotland delivery collective, including Strategic Outcome Leads such as Penumbra and Change Mental Health, delivering Outcome 3 at a national level with local action. The strategy embeds the guiding principles of Time, Space, Compassion, ensuring that responses are timely, safe, and empathic - a framework that resonates deeply with lived experience-informed care.[30]

Delivering improved community-based mental health and wellbeing support for children, young people and adults

Yes - Change Mental Health's work with children and young people through 'Bloom' and 'Your Resilience' illustrates the value of early intervention within community settings. In 2024/25, Bloom's mental health training reached 78 teachers, supported 2,623 young people, and engaged 20 secondary schools in building skills for mental health awareness, resilience, and early support. 'Your Resilience' delivered tailored mental health training to 97 staff across 17 youth organisations, directly supporting 223 young people to develop coping strategies and strengthen their emotional wellbeing. Our own programmes equip young people and those who support them with practical tools to identify, understand, and manage

mental health challenges before they escalate – therefore we strongly support this as a wider priority area for government investment and action.

Additional Priority Areas

Whilst we appreciate the very nature of prioritisation will mean not all workstreams can receive the same level of institutional resource and focus, Change Mental Health would make the case for two other priority areas of focus for future mental health investment:

a) ***Workforce Wellbeing and Retention***

The mental health sector in Scotland faces a deepening workforce crisis[31] - 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. Priorities should include dedicated funding for robust supervision, continuing professional development, and peer support networks, alongside measures to ensure manageable caseloads, flexible working arrangements, and competitive compensation. Without these supports, staff turnover could increase, leading to fragmented care, higher costs, and reduced continuity- ultimately undermining service effectiveness and resilience as warned Audit Scotland last year[32]. These challenges exist outwith the NHS – third sector mental health service providers continue to feel the squeeze too.[33]

b) ***Rural and Island Mental Health***

Between 2017 and 2022, mental wellbeing declined across all regions in Scotland while remaining highest in rural areas[34] - but this surface-level advantage masks significant vulnerabilities in other factors which can influence mental health and mental wellbeing. The underlying stressors - high transport costs, limited access to services, more expensive housing, and household goods - remain persistent pressures in rural and island communities[35]. Moreover, rural residents face higher living expenses - estimates suggest 15-30% higher than in urban regions - due to factors such as fuel dependency, grocery pricing, and delivery surcharges.[36] There remains vigorous academic debate[37] on the utility or otherwise of the Scottish Index of Multiple Deprivation to rural and island communities[38].

Through the National Rural and Islands Mental Health Forum, Change Mental Health has developed a network capable of reaching over 500,000 individuals collectively in rural and island communities to share best practice, encourage collaboration, further knowledge, mental health train workplaces & communities and build resilience. As with prevention policy, further investment is needed in this priority space to scope out the evidence base and safeguard the mental health and wellbeing of rural and island communities, where nearly 1 million people live.

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

The Scottish Government has made a concerted effort in recent months to address concerns around CAMHS and psychological therapies, though these services still face challenges rooted in long-term workforce shortages, funding pressures, and a system ill-equipped to manage the surge in demand. Waiting times backlogs have also been a policy focus, but we caution against using waiting times alone as a measure of overall unmet mental health need. Support for distress has expanded to all 31 health board areas, which we see as a strong, scalable model for other programmes. We remain an active partner in delivering the 'Creating Hope Together' Suicide Prevention Strategy and can confirm strong commitment from the Scottish Government, COSLA, and delivery partners. Community-based mental health support for children, young people, and adults is a clear priority - yet as seen with proposed IJB cuts for community mental health in Edinburgh, implementation can be undermined by local budget constraints that impact early intervention and prevention work.

The recently published 'Scotland's Population Health Framework 2025–2035'[39] (PHF) and 'Health & Social Care Service Renewal Framework 2025–2035'[40] (SRF) reflect these priorities in depth. The PHF embeds mental health across the life course through early years investment, school-based wellbeing, and alignment with the Mental Health and Wellbeing Strategy. The SRF provides delivery mechanisms via community hubs, multidisciplinary teams, digital self-referral to therapies, and innovative models such as Community Appointment Days. Both frameworks incorporate the Enhanced Mental Health Pathway for crisis support and integrate suicide prevention within wider mental health strategies. Commitments to equitable access, local service design, and the GIRFE model ensure a person-centred approach, while infrastructure and partnership models in both plans directly support national suicide prevention aims. Overall, these frameworks substantively address the identified priorities, with the PHF setting a strong prevention strategy and the SRF focusing on operational delivery.

As with all good policy, budget must follow ambition.

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

Transparency around mental health spending in Scotland can be strengthened by addressing structural complexities in funding flows, improving the quality, consistency, and accessibility of financial data, and fostering open, interactive communication with both the public and key stakeholders. By simplifying the system where possible, ensuring spending data is collected and managed in a unified and consistent way, and making information readily understandable and available, decision-making processes can become clearer, more accountable, and better aligned with Scotland's mental health priorities.

The following recommendations set out practical steps to achieve these aims:

a) **Create a unified national dataset** covering all public sector and third sector mental health spending, with clear breakdowns for service delivery, workforce, and

prevention. Public Health Scotland's Mental Health Quality Indicators are a strong starting point but must be scaled.

b) **Standardise definitions and reporting** across NHS Boards, local authorities, and IJBs, ensuring consistent categories for 'frontline spend' and 'preventative spend.'

c) **Track spending across portfolios** (health, social care, housing, education) to show interdependencies and total system investment in mental health services.

d) **Link funding to mental health outcomes** through a co-designed national performance framework combining quantitative and qualitative measures. Performance monitoring of the 'Mental Health Strategy 2017-2027' and 'Delivery Plan' could form the basis of such a wider expansion policy framework covering other delivery areas still relevant to improving mental health outcomes.

e) **Organise and release mental health budget decisions and rationale** in plain language with quarterly updates, local/regional breakdowns, and interactive data tools.

f) **Record and reinvest savings from prevention**, embedding mechanisms to capture avoided costs and realised savings across differing portfolios.

g) **Require justification for mid-year budget changes**, including impact statements and formal parliamentary scrutiny for significant reductions.

Conclusion

The Scottish Government are taking meaningful policy strides to imbed early intervention and prevention in the delivery of mental health services across Scotland. However incomplete and fragmented data obscures and obfuscates available resources and the demands on them. Change Mental Health backs a step-change in data collection, reporting and scrutiny, and echoes calls from Audit Scotland and others for the Scottish Government to address serious concerns in funding, workforce planning and operationalising otherwise well-founded strategy.

A key systemic challenge remains the gap between **national ambition** and **local delivery**. National strategies such as the Mental Health and Wellbeing Strategy, the Suicide Prevention Strategy, and the Population Health Framework set clear priorities, but these are not always translated into resourced action at Integration Joint Board (IJB) level. Local budget constraints, competing statutory pressures, and the absence of ringfenced investment mean that some nationally agreed priorities, particularly in early intervention and prevention are deprioritised in practice. This leads to a postcode lottery in access, undermining the equity and consistency intended by national frameworks.

If Scotland is to meet its stated ambitions, national priorities must be consistently reflected in local commissioning and budgeting decisions, supported by:

- Clear accountability mechanisms to track delivery of national priorities at HSCP/IJB level.
- Protection of prevention and early intervention budgets from local reallocation during in-year pressures.
- Transparent reporting on how local plans and spend align with national strategy outcomes.

Without these safeguards, there is a risk that even the most progressive national policy frameworks will remain aspirational documents rather than engines for sustained improvement in mental health outcomes across all of Scotland’s communities.

Sources

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