Scottish Government
Riaghaltas na h-Alba

Evidence Narrative to inform the Scottish Government Mental Health and Wellbeing Strategy

HEALTH AND SOCIAL CARE

social research

Contents

1.0 Introduction

This report draws on published evidence to set out the current situation and trends regarding mental health and wellbeing in Scotland. In doing so, it sits as a companion piece alongside engagement work with people with lived experience and other stakeholders providing context for, and guiding the development of, the new Scottish Government mental health strategy (1) and delivery plan (2). A related report (3) examines issues around inequalities in mental health and wellbeing in detail. This evidence narrative is not intended to offer a complete coverage or appraisal of the published evidence on mental health and wellbeing in Scotland, but rather to be illustrative of the relevant and robust published data and research available.

The development of the new mental health and wellbeing strategy and its related delivery plan, is drawing on the experiences of the production, implementation process and outcomes of the previous mental health strategy (4), and taking into account the Scottish Government's Covid Recovery Strategy (5). As such, the intention from the outset is to take a population-based approach to mental health and wellbeing, aimed at improvements for the whole population, while also focussing on the provision of care and support for those with specific needs. With increasing understanding and awareness of the many influences on population mental health, a central tenet of the work is adopting a broader scope beyond mental health policy to the role of wider government policy in shaping and influencing mental health and wellbeing.

This evidence narrative takes these principles as a starting point for guiding the scope of the report. Based upon data and research from predominantly Scotland, but also from the wider UK and internationally, this report begins by looking at levels of population mental wellbeing, prevalence and burden of mental health conditions, trends within these and what influences mental health and wellbeing. It then reflects on some of the key challenges impacting upon population mental health and wellbeing that the strategy needs to tackle. Finally, in response to this, it goes on to consider evidence-based approaches to addressing these challenges in both the immediate and longer term.

While the focus of the report is mental health and wellbeing, it also refers to neurological conditions, substance use disorders and cognitive and intellectual disabilities. This is because all of these can be, and often are, linked with mental health conditions. Likewise, there is some discussion of suicide and self-harm within this report given their inter-relationship with mental health. However these topics are more fully covered in the Scottish Government suicide strategy (6) and the self-harm strategy (which is due to be published by the end of 2023). When describing particular pieces of research and data the terminology used is that used within the original publication. It should be noted that this may not be the same as the definitions adopted within Scottish Government or used within the mental health strategy.

2.0 Methods

The scope of this report and topics it covers were informed by the starting principles of the new strategy as discussed in the Introduction and determined in discussion with members of the Scottish Government Mental Health Research Advisory Group (MHRAG). Membership of the MHRAG comprises academic experts in mental health, members of organisations involved in delivering mental health support, Scottish Government mental health policy team leads and clinical advisors to the Scottish Government. Based upon their knowledge of the subject, learning from consultation and stakeholder events, and existing government policy work, areas of key importance to cover here were agreed.

Given the very broad scope of population and individual mental health and wellbeing, this review does not attempt to systematically appraise the literature, but rather to identify the most relevant and robust recent literature and data to inform policy discussions. It thus comprises published literature from peer reviewed journal publications - focussing on systematic reviews if available, reports from NHS bodies, government and third sector organisations, and routinely gathered statistical and administrative data from Scotland and the UK. This literature and data was identified through searches of bibliographic databases such as the Cochrane Database of Systematic Reviews and Medline, websites providing collated evidence resources, searches of websites of key organisations and through discussion with MHRAG and mental health policy teams.

3.0 Understanding the current mental health and wellbeing of the population of Scotland

3.1 Definitions and measurement

The field of mental wellbeing and mental health is characterised by different definitions and understanding of what commonly used terms mean, and how they relate to each other. These are influenced by underlying beliefs, attitudes and practices (7).

Wellbeing, while a widely understood and used term, can be particularly challenging to define (8). It is included within the WHO definition of mental health which is "a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". However this definition has been challenged for its over emphasis on positive emotions and functioning (9). Further work set out a proposed WHO definition of well-being which states that "well-being exists in two dimensions, subjective and objective. It comprises an individual's experience of their life as well as a comparison of life circumstances with social norms and values" (10).

Wellbeing has also been defined as the combination of how we feel and how we function. As such it comprises experience of positive emotions such as happiness and contentment as well as the development of one's potential, having some control over one's life, having a sense of purpose, and experiencing positive relationships (11). This is encapsulated in a definition from the Royal College of Psychiatrists which defines wellbeing as 'a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment' (12).

In clinical practice and research studies, mental wellbeing is often measured using the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS), a scale of 14 positively-worded statements designed to provide a population measure of mental wellbeing. Scores range from 14-70 and the average score of adults is a national indicator of performance in Scotland, with the goal of increasing the mean WEMWBS score for the population.

Mental wellbeing and mental health fluctuate across our lives and from day to day. Mental wellbeing affects, and is affected by, mental health, but the relationship is complex. Someone with poor mental health may report reasonably good levels of wellbeing, and vice versa, poor levels of wellbeing may be noted by an individual with no mental ill health. Tudor-Hart's dual continuum model with mental health on one axis and wellbeing on the other axis, encapsulates this (13, 14).

A definition of mental health has also been debated and discussed for many years without consensus. What is not contested however is that mental health constitutes a component of someone's overall health, alongside their physical health (15).

Mental health impacts on how people think, feel and behave, and as with wellbeing, an individual's state of mental health can change frequently and be influenced and is influenced by many internal and external factors. Certain mental health states, if they persist for a period of time and cause the individual distress, are said to constitute mental health conditions, and can be classified according to clinical diagnostic criteria (16). These include depression, generalised anxiety disorder, panic disorder, phobias, social anxiety disorder, obsessive-compulsive disorder (OCD), eating disorders and post-traumatic stress disorder (PTSD), as well as bipolar disorder, schizophrenia, and other psychosis (17).

Many screening and diagnostic tools, assessment approaches and questionnaires exist for assessing potential or actual presence and severity of specific mental health conditions, some for use within clinical setting and with specific population groups (17), and others within population surveys such as the Scottish Health Survey (18). The General Health Questionnaire (GHQ12), a self-completion screening instrument, is widely used to score for common mental health conditions, with a score of 4 or more indicating the possible presence of a mental health condition (19).

3.2 Prevalence of mental health conditions and low wellbeing

Prevalence of a mental health condition can be estimated from data from population surveys. Indications can also be drawn from how many people are prescribed medicines for certain mental health conditions, hospital admission and referral data , information on GP

consultations and how many people have been referred for therapy. Some of this data is available at a Scottish level but sometimes it is necessary to derive estimates based on UK or international data.

It can be difficult however to know the exact number of people experiencing a mental health condition at any given time. Not all people with a mental health condition may feel that they need or want to seek support, or to tell others. This may be partly due to the stigma still surrounding mental health conditions resulting in an unwillingness to respond accurately to surveys or to seek help from services (20).

The Scottish Health Survey suggested that in 2021, 22% of all adults aged over 16 and living in a private household in Scotland may be experiencing a mental health condition. The proportion of adults displaying symptoms of moderate to severe depression was 11%, and for moderate to severe anxiety, 14%. Approximately 6% of adults in Scotland report having ever attempted suicide and 11% have self-harmed (21).

Turning to psychotic illness, prevalence is estimated to be around 0.5% of the population and approximately 12,000 people in Scotland may be in contact with healthcare services for support (22, 23). Around 2% of the population are thought to suffer from bipolar disorder, and at least 2%, an eating disorder. The prevalence of obsessive-compulsive disorder in adults is 1% to 3% (24). It should be noted that these figures reflect adults living in private household settings and not, for example, within any kind of institutional care where levels would likely be higher.

Data from the Scottish Burden of Disease study, covering the period from 2014 to 2019, indicates the leading cause of ill health (as defined by years lost to disability) in men to be depression, followed by anxiety disorders in third place. For females depression is in third place, closely followed by anxiety disorders in fourth place (25).

We know that prevalence of all psychiatric disorders varies across age groups, and that certain groups within the population have higher rates of mental health conditions than others. These include people who identify as LGBTI+, Black or Black British people, young women, and those with co-occurring problems such as substance use or homelessness. People with neurological conditions or learning disabilities, and from neurodiverse communities experience higher prevalence of mental health issues (26-28).

Poor mental health impacts on individuals' overall mortality. In Scotland, the age and sex standardised mortality rate for people in contact with mental health services was 2.71 times higher than for the general population in 2021/22. This has increased from 2.62 times higher in 2020/21 (29).

The Scottish Health Survey conducted in 2021 indicated a mean WEMWBS score, measuring mental wellbeing, for adults of 48.6. WEMWBS has a mean score of 51 in the overall UK population, with the top 15% of scores ranging from 60 to 70 and the bottom 14 to 42. Prevalence of lower mental wellbeing was higher in younger adults and among those in the most deprived areas (21).

3.3 Trends in mental health and wellbeing in Scotland

To understand future needs and to enable an assessment of the impact of existing support, care and challenges, it is important to consider how the incidence and prevalence of mental ill health is changing and levels of wellbeing are fluctuating.

3.3.1 Mental health and wellbeing in adults

The Scottish Health Survey provides data that enables trends in the mental health and wellbeing of the population of Scotland living in private households to be studied (18). This data indicates that the prevalence of possible psychiatric disorders (as measured by individuals recording a GHQ12 score of four or more) fluctuated between 14% and 19% between 2008 and 2019. No data was gathered for 2020 but in 2021 as the pandemic continued, prevalence rose significantly from previous years to 22%. Prevalence over the whole time period studied has been consistently higher in women than men. Prevalence is also generally greater in the younger age groups, and this divergence is seen more in latter years.

Prevalence of depression rose between 2008/2009 and 2018/19, and then remained fairly similar from 2018/2019 to 2021. Among men, there was a significant increase, while the figures for women were more variable. Likewise anxiety levels increased over the period 2008/2009 to 2019, and then remained similar in 2021. Throughout the period levels have been consistently higher in women, with the difference between men and women greatest in 2021.

Many factors influence prescribing decisions, however it can be seen from routine prescribing data that the dispensed volume of antidepressant medicines increased steadily over the period 2009 to 2019, in line with the trends for depression and anxiety seen in the Scottish Health Survey. In 2019/2020 almost 22% of adults in Scotland were prescribed an antidepressant compared with 15.7% in 2010/11 (30).

The proportion of adults reporting that they had ever attempted suicide increased between 2008/2009 and 2019, before a reduction in 2021. The figure has been consistently higher in women than men although the size of this difference lessened in the most recent years. The proportion of adults reporting that they had ever self harmed also increased over the ten year period, but continued to increase in 2021 to its highest level. Levels have been consistently higher in women but the difference was smaller in 2021.

There were 762 probable suicides in Scotland in 2022. This is a small increase of 9 from 2021. Suicides decreased between 2011 and 2014, but generally rose again to 2019 (31). More than 70% of people dying from suicide were male in every year since 1985 (31). 2020 saw a 45% increase in maternal suicide across the UK and Ireland, when compared with the preceding 3 years (32)

Mental wellbeing in adults (as measured by WEMWBS score) remained relatively stable between 2008/2009 and 2019. Generally wellbeing was slightly higher in men than women during this time but the difference has not always been signficiant. Overall mental wellbeing then fell significantly in 2021, with both men and women experiencing the lowest levels recorded. Scores have generally been higher, indicating better wellbeing, in older than younger adults across the time period.

There were changes to the 2021 Scottish Health Survey methdology as a result of the pandemic, so comparisons of this year with previous years requires some caution, also data from subsequent years will be required to examine post pandemic trends. These caveats need to be taken into account, but generally the data suggests a slight worsening of some aspects of mental health over the previous decade with an exacerbation of this by the pandemic. The data also indicates that trends have differed between the sexes and among age groups, and often it is women and young people who have been particularly badly affected. The exception is suicide in men. It seems that the factors resulting in any worsening of mental health in the pre-pandemic years did not impact on wellbeing, but the pandemic was damaging in this aspect.

Strong evidence of the particular effects of the pandemic comes from a meta-analysis (a study which uses statistical techniques to quantitatively combine the results of individual studies) using 11 longitudinal datasets from the UK (33). Although the results cover the whole of the UK, no differences between the four UK nations were identified. Three periods are analysed covering the first lockdown (March to June 2020), the first easing of restrictions (July to October 2020), and the second lockdown (November 2020 to March 2021). The analysis indicated a sustained deterioration in population mental health across the three periods, compared to pre-pandemic. The largest changes were among women, and those aged 25-44. While a larger study bringing together longitudinal data sets from across the world reported minimal changes in mental health, it also reported more pronounced negative effects for women (34). People's perspectives on how the pandemic has impacted on their mental health is captured in interviews conducted by the Poverty Alliance. These highlighted a worsening of existing problems (35).

Data on trends in prevalence of more complex mental health conditions in Scotland is generally less readily available than for anxiety, depression and general mental health and wellbeing. Some routinely gathered data can be used to give an indication of possible changes in incidence or prevalence, and inferences can be drawn from published studies from elsewhere, but this is limited. The recent Scottish Government review on Eating Disorder Services notes rising admissions to hospital for eating disorders between 2013 and 2018, and a particularly large rise in admissions for young people during the pandemic years (36).

3.3.2 Mental health and wellbeing in young people and children

Scottish Health Survey data provides a comparison of the WEMWBS scores of children aged 13 to 15 combined in 2017/2018/2019/2021 compared with those recorded in 2012-2015 combined and this does not show any significant difference. However there is a significant difference between boys and girls in the latter time period, with the score among girls significantly lower.

The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) also considered wellbeing in children and adolescents, and measured the mean WEMWBS score of adolescents (2nd and 4th year school pupils). This did report a drop between 2010 and 2018, but this is based on a slightly different age group to SHeS and only certain participating schools. The survey also measured the percentage of children in Scotland aged 4-12 reporting an "abnormal" or "borderline" emotional symptoms score, and found this increased from 14% in 2012-2015 to 17% in 2016-2019 (37). Again given the incompleteness of the sample, this finding can only be viewed as of interest rather than definitive.

A rapid review highlights several inter-related factors which may have contributed to any worsening wellbeing in young people, particularly girls. These include: social media use, disrupted sleep, body image concerns and school-related pressures (38).

As with adults, the covid pandemic impacted strongly on the mental wellbeing of children and adolescents. For example the Scottish Youth Parliament, Youth Link Scotland, and Young Scot surveyed over 6,000 young people (aged 11 to 26) from across Scotland between September and November 2020 (39) and found that 42% of respondents felt good about their mental health and wellbeing, compared to 60% of respondents feeling good about their physical health and wellbeing. The experience of living through the pandemic for younger children aged 0 to 11 years was examined in the Public Health Scotland (PHS) COVID-19 Early Years Resilience and Impact Survey (CEYRIS). Parents and carers for a large proportion of children noted negative impacts on the child's wellbeing, with the impact generally greater in families from low-income households (40).

3.3.3 Future projections

PHS published a report in 2022 which attempts to estimate the likely future burden of disease in Scotland over the next 20 years. It should be noted however that the figures are only based upon projected demographic changes, and that they assume that disease prevalence rates remain the same as 2019. This work estimated that mental health would remain 4th in the ranking of leading causes of disease. The number of disability adjusted life years due to mental health disorders is projected to rise by 3.8% (41).

No further modelling work predicting likely future prevalence and need specific to mental health in Scotland was identified**.** Likewise no projections around wellbeing in Scotland were available.

A report from the Health Foundation has used epidemiological evidence and morbidity data obtained from linking primary care data in England to secondary health care records and mortality data, to model expected levels of ill health up to 2040. It reports that the number of people in England living with a major illness is projected to increase by more than a third by 2040, with most of this increase a result of an aging population and seen among those aged 70 years and over. Greatest increases are likely to be in conditions managed largely in primary care including an estimated 16% increase in those aged 30 years and older with diagnosed anxiety or depression. The report authors note the need therefore for investment in primary care and community based services (42).

In terms of service provision, PHS have developed a trajectory tool for Child and Mental Health Services (CAMHS) and psychological therapies (43) which allows NHS Boards to consider their numbers of referrals and staff availability and predict the future resourcing required to meet 18 week targets. Again, beyond this no further projections specific to Scotland were identified.

Discussion of future workforce requirements are contained within the recently published government health and care workforce strategy (44).

3.4 Determinants of mental health and wellbeing

The influences upon individual and population mental health and wellbeing and the interplay between these has been extensively researched. Various theories (including socioecological models and resilience based models) have been put forward to explain the mechanisms by which these factors operate, and corresponding frameworks developed to illustrate the processes (45-47). This is complemented by ongoing research that is throwing light on the biological mechanisms by which external influences enact changes to individual's health (48).

Central to all theories and frameworks are similar principles, namely that economic (eg governmental policy, poverty), social (non-medical factors such as education, food security, family dynamics) and environmental (eg pollution, access to natural space) factors, in addition to our individual biology and healthcare provision and access, both influence and in turn are shaped by our mental health and wellbeing (49). Factors interact in many and complex ways; they can increase risk or be protective, and their impacts are cumulative across the life course of an individual. They can also be transferred between individuals within a household or family (50).

This can be illustrated by considering a few examples. Firstly thinking of employment. Employment can be both a risk and protective factor for good mental health and wellbeing, and is widely influenced by and influential of other factors. Job insecurity, poor working conditions and low job satisfaction can all be detrimental to wellbeing, whereas aspects such as positive relationships with colleagues and autonomy can be protective. Opportunities for employment can be influenced by government policies, by economic conditions, exposure to discrimination and stigma, physical health, and trauma experienced. In turn employment can impact upon factors including access to housing, education, managing caring responsibilities, and ability to access and benefit from health and social care services.

Taking a further example, this time relating to children, there is evidence to show that children who live in poverty are at higher risk of experiencing poor mental health. The Scottish Health Survey results from 2016 showed that children aged 4–14 years in the lowest income households were four times as likely to have poorer mental wellbeing as those in the highest income households (13% compared to 3%). They are exposed to a range of risks that can have a serious impact on their mental health, including debt, poor housing, and low income. Children living in poverty are more likely to feel like a failure, useless and hopeless about their future than their more affluent peers (51).

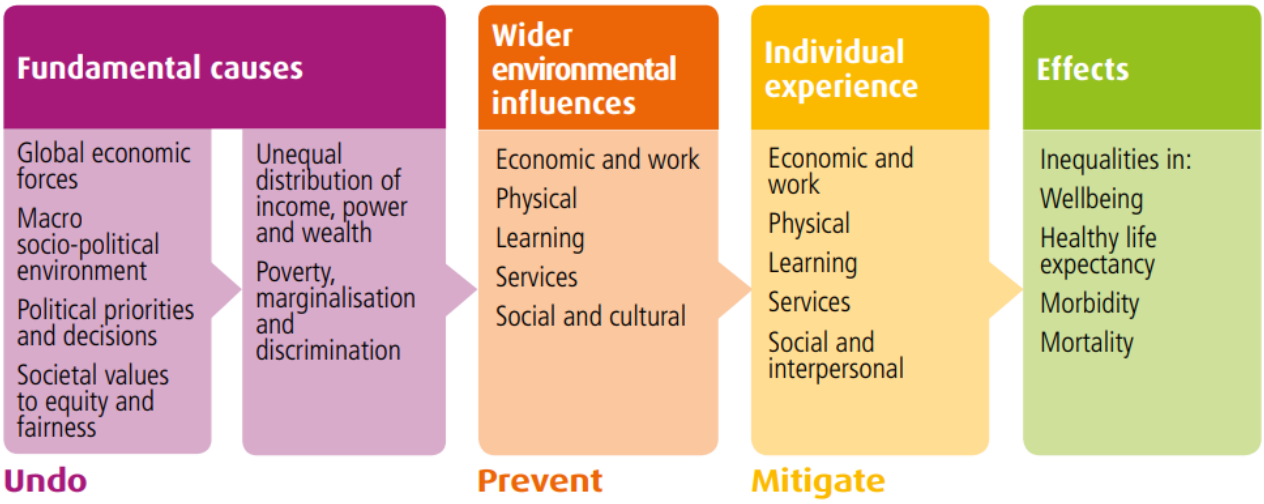
The theory of Fundamental Causes (52) has gained traction in Scotland, informing approaches within PHS. This theory proposes that unequal distributions of power, income and wealth are key drivers of other influences on health. It is supported by findings such as unequal societies being seen to experience poorer health overall than those where resources are more evenly distributed (49). Poverty limits individuals' ability to access the resources necessary for good health, to adopt and maintain healthy behaviours, and to avoid stress and feel in control and supported (53).

3.4.1 Examples of visual frameworks used to illustrate the determinants of mental health and addressing these

Numerous frameworks have been developed that attempt to explain and visually depict the determinants of mental health and how these may be addressed. These date back to the work of Dahlgren and Whitehead in the early 1990s (54) and subsequently Michael Marmot's conceptual framework illustrating policy objectives to tackle the determinants (55). Some frameworks relate specifically to public mental health, while others consider health in general. While differing in appearance, the content within them is broadly similar.

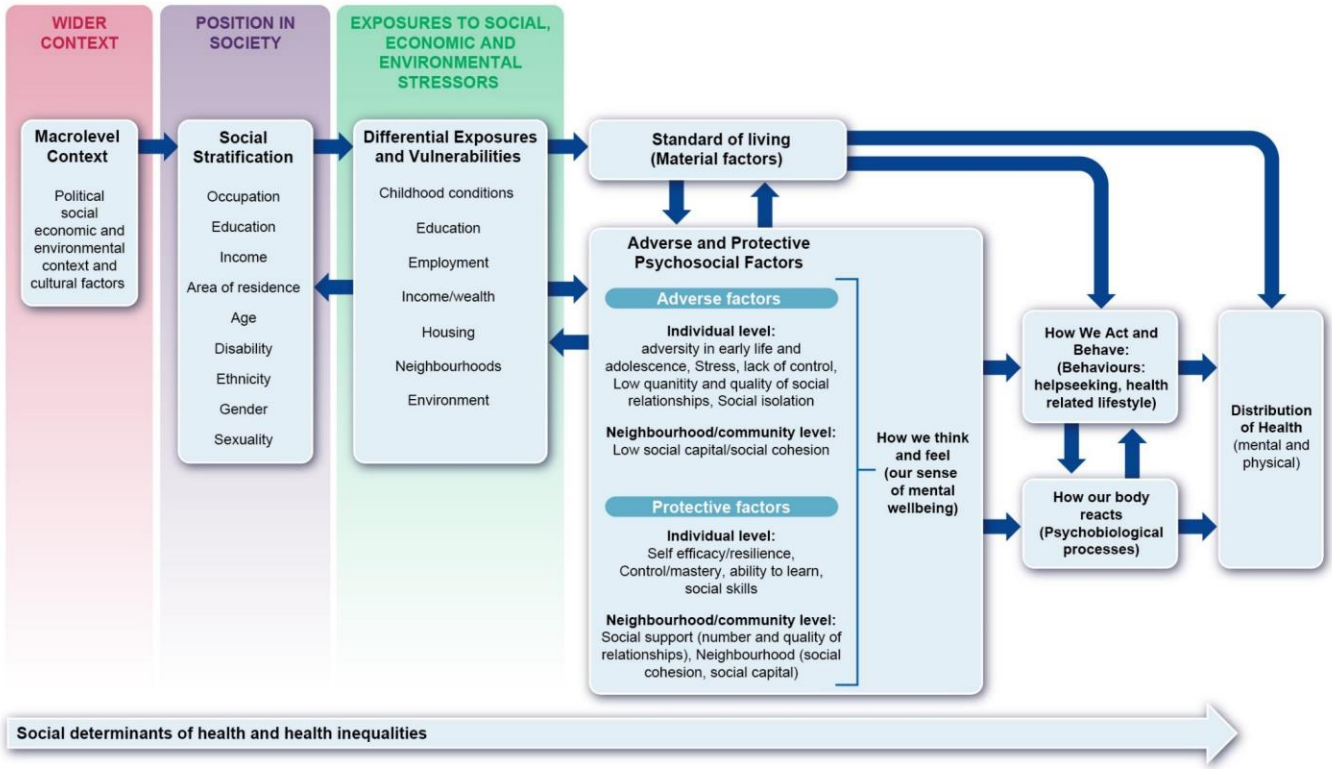
A PHS graphic, Figure 1, illustrates their organisational thinking around the fundamental causes theory in relation to health in general and the three approaches (undo, prevent, mitigate) required to address the effects of the determinants (56):

Figure 1: Public Health Scotland Framework depicting the Fundamental Causes theory



Public Health England developed a pathway that covers the similar influences but depicted in a slightly different way and with some additional details (57). This is shown in Figure 2:

Figure 2: Public Health England Framework illustrating the social determinants of health



A model by Compton and Shim (45) focussed on mental health, illustrates the interaction of genetic and environmental factors alongside social determinants, and the drivers between them. Although developed in a US context, the model is relevant to other 'western style' countries.

Based upon a comprehensive and systematic literature review, stakeholder engagement and consultation involving both experts with lived experience and those from public health practice, the National Institute for Health Research (NIHR) created a framework setting out different drivers of public mental health and their relationships. NIHR are using this framework as a model to summarise the different strands of research and types of evidence around the determinants of mental health. The robust processes to design the framework and its aim to be clear and accessible, mean that it provides one of the most comprehensive attempts to bring together the disparate data on public mental health determinants (58).

It presents 55 determinants of mental health, grouped into four broad categories. These are: Structural; Community; Family and Individual. For each category, determinants are further grouped under sub categories. This is set out in Figure 3. The NIHR framework does not currently depict a hierarchy in influences, but rather describes in accompanying text the differing implications of each of the determinants and the many bi-directional relationships among them.

Figure 3: NIHR framework depicting the determinants of public mental health

Individual	Family	Community	Structural
Trauma & adversity	Family dynamics	Systems & services	Broad factors
Adverse childhood experiences	Attachment	Health & social care	(In)equality & (in)equity
Adulthood trauma	Parenting	Public & community services	Climate change
Bullying	Family connectivity	Criminal justice system	Displacement
Physical & psychological health	Extended family relationships	Social environment	Industry
Genetics & biological factors	Discord & conflict	Social support & networks	Commercial factors
Prenatal & perinatal factors	Family structure	Social inclusion & cohesion	Media & advertising
Physical health	Caring responsibilities	Civic engagement	Government & political
Health behaviours	Intergenerational (dis)advantage	Mental health awareness	Economic conditions
Life experiences & opportunities	Household composition	Geographic & physical environment	Government policies & legislation
Life transitions	Marriage, civil & domestic partnerships	North–South divide	The welfare system
Migration		Built & natural environment	Political structures & climate
Hobbies & leisure time		Urban/ rural/ remote differences	Global politics & events
Identity		Neighbourhood deprivation	Norms & rights
Ethnicity & culture		Community safety	Discrimination & stigma
Gender, sex, gender identity & sexual orientation			Social & cultural norms
Religion, spirituality & faith			Human rights & social justice

Individual	Family	Community	Structural
Personal traits			
Resilience			
Sense of self			
Personal aspirations & ambitions			
Individual autonomy			
Sociodemographic			
Income			
Housing			
Education			
Employment			

3.5 Impacts across the life course

Over the course of their lives, from birth, through childhood and adolescence, into further study, jobs and careers, forming relationships, parenthood, and in older age and retirement, people have different experiences with their mental health and wellbeing. The World Health Organisation promotes a life-course approach to mental health, with a need for policies, plans and services to be designed to address the differing needs of all age groups (59).

Some stages of life are considered particularly important for determining future mental health. Early life and childhood is a key time since most mental health conditions arise before adulthood, and childhood mental ill health is also a risk factor for adult mental ill health (60). Protecting mental health is essential even before birth (49, 61). Maternal health is important, and poor environmental conditions, poor health and nutrition, tobacco use, alcohol and drug misuse, stress, and highly demanding physical labour can all negatively affect the development of the foetus and later life outcomes (62, 63). Increased rates of mental health conditions are commonly reported in individuals with Foetal Alcohol Syndrome (64). There is also a period of increased vulnerability to mental ill health in the transition to parenthood. Poor mental health in parents in the perinatal period, particularly in the context of adverse social and economic circumstances, may be associated with poorer developmental outcomes for infants growing up (65) (66).

The prevalence of mental ill health in infancy is thought to be similar to that of older children, with estimates ranging from 10-22% (67, 68). Good infant mental health is nurtured when babies

receive secure, warm and predictable care and experience positive relationships with their carers. When this is not present, babies' development is significantly affected and they are more likely to experience mental distress and ill health (66). In childhood, factors such as physical activity and healthy eating are important for healthy growth and development, and ensuring that children are able to access these is important. Children can struggle with the transition to secondary school and some are impacted by exposure to trauma, poverty and discrimination (59, 69).

Adolescence and young adulthood is also a sensitive time for a person's mental health. Most mental health conditions in adults have their onset by this stage of life (70). During adolescence, young people experience significant physical, psychological and behavioural changes and transitions which can impact on their mental health positively or negatively dependent on their life circumstances. Many risk behaviours, such as use of substances, start during adolescence, and for some individuals can be particularly detrimental to mental health. The Transdisciplinary Research for the Improvement of Youth Mental Public Health (TRIUMPH) network conducted a workshop with 60 young people aged 12 to 25 from across the UK to gather their perspectives on what would contribute to a mentally healthy society for young people. Five key components were identified: a compassionate government; celebrating different paths in life; equity between affluent and deprived areas; inclusive access to services; and a society that does not focus on work and productivity (71).

Children and adolescents experiencing mental ill health are at a greater risk of self-harm and suicide, have poorer general health and increased mortality. They experience poorer educational outcomes, and are more likely to be isolated socially and be involved in antisocial and offending behaviour. The effects for these individuals are seen to continue into adulthood with an increased risk of mental ill health, a higher prevalence of health risk behaviours, premature mortality, lower earning and poorer employment prospects, and a higher likelihood experiencing violence and being involved in crime as adults. All of these in turn impact on wider society (60). Research on the mental health of students in Scotland found levels of wellbeing to be below national figures for their age group. Lowest levels were found among the youngest students (16 to 20 years old) (72).

In adulthood, employment is one of the main determinants of mental health. Unemployment and insecure work have negative effects on mental health, and are particularly damaging for men (50, 73). Negative working environments are also associated with a greater risk of developing depression, anxiety and work-related stress (74). Care provision may impact on this age group as they look after children and older relatives and the availability of health and support services becomes important as challenges arise for example in physical health, housing and relationships. Mental health conditions can also develop during and after maternity (66).

Mental health conditions in adulthood are associated with giving birth prematurely, increased health risk behaviours, increased suicide and self-harm, reduced life expectancy and higher mortality. Mental ill health increases the risk of physical ill health for both communicable and non-communicable diseases. The impact goes beyond health, to poorer educational outcomes, reduced employment prospects, a greater risk of debt and homelessness, experiencing violence, stigma and discrimination. Effects are also seen to be transferred across generations, with presence of parental mental health conditions being associated with an increased risk of mental ill health in children (60, 75).

Generally, survey findings suggest that older adults (65+) experience better wellbeing and are less likely to have a mental health condition than the rest of the population (18). However, as older people get older (i.e. 75+), their wellbeing decreases and they become more likely to report poor mental health. A systematic review and meta-analysis found that 1 in 4 adults over 60 in high-income countries are lonely at least some of the time (76). Insights from older people suggests that accessing mental health services can be challenging for them, particularly if they are doing so for the first time. In addition, stigma around mental health is a barrier for older people who are less likely to seek help because they may view doing so as self-indulgent or damaging to their self-esteem (77).

Dementia is a disorder of the brain that is not a mental health condition, but that can adversely impact upon people's mental health and wellbeing (78). People with mental health conditions may also be at greater risk of developing dementia (79). Although it is not exclusively an older people's disease, an ageing population is likely to see a higher prevalence with consequent burden on individuals and their carers, and pressure on health and social care services.

3.6 Poor mental health, and access to and care received from services, are not experienced equally

Experiences of mental health and wellbeing and of related services are not the same for everyone across Scotland. Some groups have poorer mental health than others and some groups face barriers in accessing and taking up help for their mental health (80). For others their specific needs are not properly understood or taken into account by those providing care. Often these are the same groups in the population that are systematically disadvantaged in many different aspects of their lives. This topic is explored more fully in the accompanying evidence review on inequalities (3), but a brief overview is given here.

Differences in experiences are most often considered in terms of 'protected characteristics' such as gender, age, race, sexual orientation and disability (81). There can also be variance by socio-economic status, by geography, for example those living in remote and rural areas compared with urban areas (82), and in certain groups such as those in prison (83), students (84), armed forces veterans (85), and neurodiverse individuals (86, 87). However, it is important that inequality is not only considered in terms of single characteristics. In reality, people's lives are multi-dimensional and complex. Everyone has distinct experiences of inequality that need to be understood. This is known as "intersectionality". For example, for groups determined by race (88, 89), gender (90), or sexuality(91), mental health effects may be exacerbated by prejudice and discrimination (92). People with co-occurring substance use and mental health concerns can experience barriers in accessing mental health services. These can include a requirement for abstinence, a lack of integrated services, and stigma (93).

Understanding of intersectional inequalities for mental health is limited. The evidence base for such intersectionality is often restricted to small cross-sectional studies due to persistent data availability issues. Often administrative health data sources do not record data categories such ethnicity or gender transition status. If they do, this is not done in a consistent way, and this restricts research on these topics (94). It is clear however more needs to be done to understand and improve experiences to meet the needs of all people.

3.7 Economic cost of mental health conditions

The Scottish Government has an economic focus upon delivering improved health and wellbeing in accordance with a vision of a wellbeing economy where everyone can thrive (37). The 2023-24 Scottish Budget assigned £290.2 million to the mental health directorate, more than double that of £117 million available in 2020/21 (95).

Spending on mental health services continues to grow. Scottish Health Service Costs estimated the total mental health service spend (comprises general psychiatry services as well as services aimed at children, adolescents and the elderly) to be approximately £1,298 million in 2021/22 (8.78% of total NHS expenditure) and £1,247 million in 2020/21 (8.76% of total NHS expenditure). This is an increase from nearly £1,077 million in 2019/20 (8.5% of total NHS expenditure) (96).

It is widely acknowledged however that the true cost of mental health conditions reaches far wider than providing services. There are substantial costs associated with lost employment, reduced productivity, the impact on families and caregivers, levels of crime and public safety, the negative impact of premature mortality, and the negative impact of stigma and discrimination or lost opportunity costs to individuals and families (60, 97). There have been attempts to estimate the full costs of mental health conditions in Scotland. Most recently, the Mental Health Foundation and London School of Economics estimated these to be £8.8 billion. This included the lost productivity of people living with mental health conditions and costs incurred by unpaid informal carers (46).

A report by Deloitte examined the impact that the Covid-19 pandemic has had on mental health in the workplace. It found that the costs to employers of poor mental health from absenteeism, presenteeism and labour turnover increased by 25% since the start of the pandemic, up to £53-56 billion in 2020-21. This equates to over 2.6% of the UK's annual GDP. The annual cost of poor mental health per employee in Scotland was found by Deloitte to be £2,140, with costs to employers in Scotland as a percentage of earnings being amongst the highest in the UK (98). As productivity falls, there is an overall impact on the economy and for individuals unemployment and income reduction are key drivers of poor wellbeing (99, 100).

3.8 Mental health services

The current system of support, services, therapy and treatment available for people experiencing mental health problems in Scotland, spans a range of settings, across sectors and many different inputs. These progress from self-management interventions through community supports to primary and community care to secondary mental health services and highly specialist services. Following various policy and legislative decisions, mental healthcare and support in Scotland, similarly to healthcare in general and in common with many other countries (101, 102) has increasingly been delivered in the community, with a focus on user rights and involvement (103).

The World Health Organisation recently published its “World mental health report: transforming mental health for all”. This includes an exploration of delivering services with a chapter exploring the restructuring and scaling up required in most countries to transform mental health care services (104). It suggests that care of people living with severe mental health conditions should shift from institutions towards communities and community-based healthcare. The report also argues that there is a “vast care gap for common mental health conditions such as depression and anxiety”. The authors suggest that countries need to diversify and scale up care, for example by expanding into primary health care settings, enabling non-specialist psychological counselling or digital self-help.

WHO describe community-based mental health care as a network of interconnected services that include: mental health services integrated in general health care; community mental health services; and services that deliver mental health care in non-health settings and support access to key social services. WHO notes that the evidence does not point to one model that works best, instead it is up to individual countries to determine what would work for them.

There is a wealth of evidence considering different models of mental health services. This includes research which focuses on models of integrated care, or care for specific conditions or comorbidities, or within specific settings. The Scottish Government published a review of primary care mental health models currently in operation in Scotland which identified the factors that are likely to produce desirable outcomes (105). These include having regular reflective practice or other wellbeing support among staff, integration with digital services and taking a multi-disciplinary team approach. The Kings Fund worked in partnership with the Royal College of Psychiatrists to evaluate various new care models supporting integration of mental health care into the wider health care system introduced at Vanguard sites across NHS England. They found that the adoption of new models of care to remove barriers between mental health care and other aspects of healthcare delivery, was considered by those working in the system to have improved care for patients and service users. It also noted however that there is still much work to be done to fully embed mental health care across all the different NHS systems and in broader work on population health (106). As noted in a feature in the BMJ, the covid pandemic provided an impetus for rapid development of new models of delivering mental healthcare including more online delivery of services, enhanced integration, and greater incorporation of expertise by experience (107).

Some specialist secondary mental health services operate to national access standards and report data about their performance. PHS released data in April 2023 covering the currently defined quality indicators to inform the Quality Indicator Profile for Mental Health, as set out in Action 38 of the Scottish Government Mental Health Strategy 2017-2027 (29). A mental health inpatient census is undertaken yearly by Scottish Government and this provides data on the number of individuals from Scotland and their demographics, receiving inpatient mental health care on a particular date (108). Many other services however do not collect or publish information about the people they support. Those that provide mental health and wellbeing support indirectly through provision of another service such as sport or education may not have capacity or immediate need or incentive to collect this type of data. All this means that currently only a partial picture of the services offered in Scotland, and the people receiving support from them, is available. The Scottish Government has recently published core standards for mental health care provision for those with mental health conditions (109) and these in time will be used to audit provision and performance, initially within a secondary care setting.

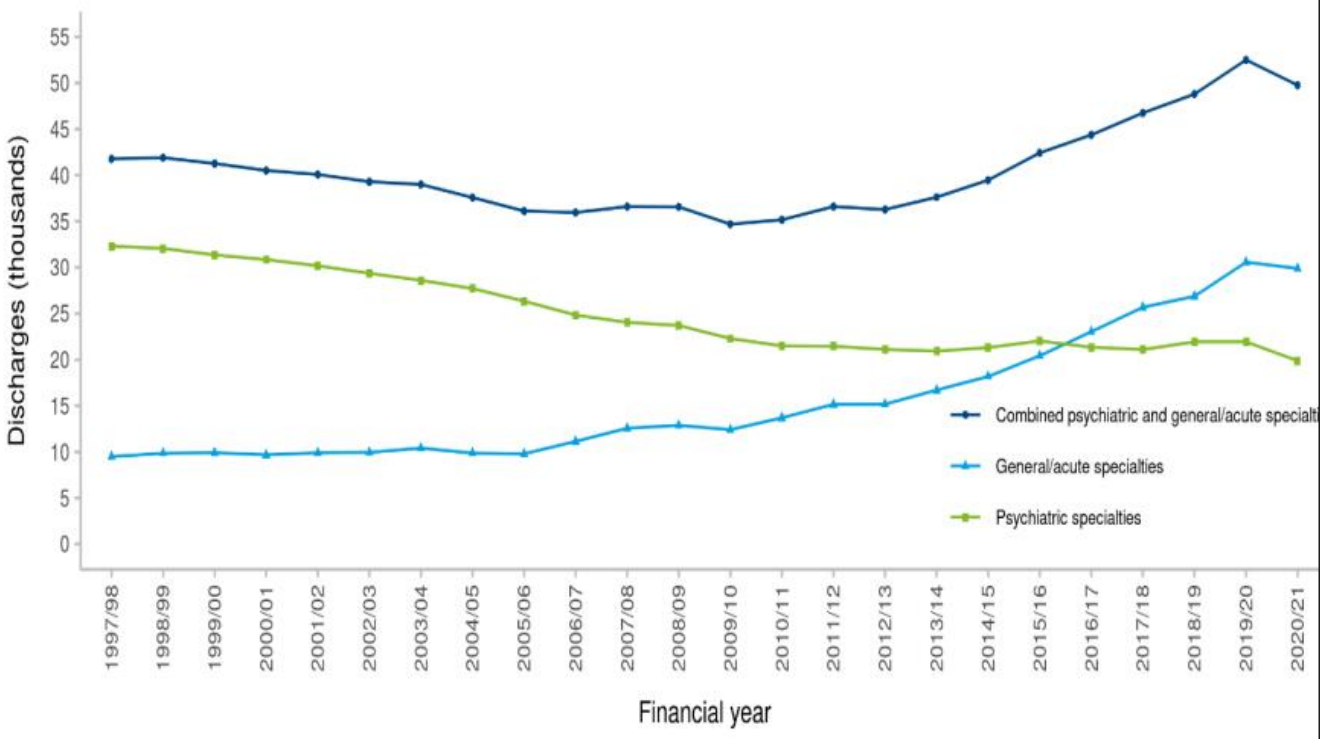
3.8.1 Inpatient care

Despite the move towards community based approaches, there will always be a need to provide inpatient care for those who have complex needs, are acutely unwell or have ongoing issues which mean that they are unable to manage within the community. In the period 2021/2022, there were 3,511 beds available for the mental health grouping. This comprised: 60 for child and adolescent psychiatry; 336 for forensic psychiatry; 1,650 for general psychiatry; and 1465 for psychiatry of old age. The number of available beds has however been dropping year on year, with the figure in 2012/13, 4,630 beds (110).

While the number of available mental health grouping beds has been reducing steadily, the number of patients discharged with a recorded mental health diagnosis has not. As such, more of these patients are discharged from general or acute beds.

There were 49,770 discharges with a mental health diagnosis from general/acute and psychiatric specialties combined in 2020/21. This is the second-highest number of discharges for mental health diagnoses recorded since 1997/98 and a small decrease from the 52,510 discharges recorded in 2019/20. Generally, the number of discharges for mental health diagnoses from psychiatric specialties has decreased over the last 24 years, while discharges related to mental health from general/acute specialties have been increasing. In 2016/2017, the number of discharges for mental health diagnoses was higher from general/acute specialties than for psychiatric specialties for the first time. This trend has continued since and is illustrated in figure 4. This shows the number of discharges with a mental health diagnosis from psychiatric specialties, general/acute specialties, and psychiatric and general/acute specialties combined for Scotland from 1997/98 to 2020/21 (110).

Figure 4: Number of discharges[1] with a mental-health diagnosis from psychiatric, general/acute, and psychiatric and general/acute specialties combined for Scotland[2], 1997/98–2019/2020



Sources: SMR01 dataset (acute hospital activity), SMR04 dataset (psychiatric hospital activity).

1. Excludes discharges from the Learning Disability Specialty
2. The data includes people from outside Scotland, who have been treated in Scotland, including those treated at the State Hospital

Looking at all the mental health discharges whether from specialist or general/acute beds, it is clear that there are ongoing delays in being able to discharge patients from hospital care. This suggests potential challenges in organising post hospital care and support.

There were 98,716 delayed discharge bed days occupied in mental health specialties in 2021/22. This is an increase from 79,650 bed days in 2020/21, however discharge rates were affected in 2020/21 by covid measures. The delayed discharge rate in the year ending 31 March 2022 returned to a similar level to that of the year ending 31 March 2020 (100,746 bed days in 2019/20, a rate of 22.7 per 1,000 among the 18+ population).

The Mental Health & Learning Disability Inpatient Census and Out of Scotland NHS Placements Census provides very detailed information on all patients receiving inpatient care in mental health, addiction and learning disability beds funded by NHS Scotland on the day of the census. The most recent census (11/04/22) found:

- There were 2,876 mental health, addiction and learning disability inpatients in NHS Scotland facilities
- Bed occupancy in NHS Scotland was 85%, though this ranged from 67 - 97% across individual NHS Boards

- The proportion of patients whose discharge from hospital was delayed was 10%, with an average (median) length of delay of just over 2 months
- 76% of adult patients had one mental health condition while 53% of patients also had a long-term physical health condition
- 89% of adult patients in the 2022 Census received some form of physical health check
- 46 patients in the 2022 Census were aged under 18 and 45 of 46 patients aged under 18 were in either a Children's Unit or Young Person's unit

3.9 Mental health workforce

Defining the mental health workforce and compiling how many people are working in specific mental health and the many related roles, across multiple sectors, is challenging. Even within the NHS itself, it is not straightforward to arrive at this workforce total. Official workforce statistics are however available for those working in NHSScotland Child and Adolescent Mental Health Services (CAMHS) and Psychology Services, and also nursing and psychiatry (111).

At 30 June 2023 the CAMHS workforce was 1,359.5 Whole Time Equivalents[1] (WTE). This represents an increase of 108% since 2006, 36.8% since 31 March 2016, 10.4% since June 2022 and 2.9% since last quarterly census. There were 145.4 WTE vacancies advertised. The WTE of vacancies decreased by 8.7% since the last quarterly census and 1.4% since the June 2022 census. (112)

Within Psychology Services in NHSScotland as at 30 June 2023, there were 1,610 WTE clinical staff in post. This is 8.9% (132 WTE) higher than reported 12 months previously. Since the last quarterly census, the WTE of staff in post has increased by 4.7% (71.9 WTE). There were 173.6 WTE advertised vacancies, which is -20.2% lower than 30 June 2022 and 10.4% higher than 31 March 2023. (113)

In June 2023, the WTE number of mental health nursing staff in post was 9,888.2. This represents a slight decrease over the last quarter from 9,923.2, and an increase from 9,739.2 in 2016 .The vacancy rate was 8.4% (906.8 WTE), compared to 8.0 % in the previous quarter, and 3.4 % in June 2016. (114)

The Nursing and Midwifery Council keep a register of all nurses eligible to practice in the UK and broken down by nation. However this gives an indication of potential staff numbers only as not all of these staff will currently be working in the UK, or working in the professional area in which they are registered. The latest annual register report (March 2023) indicated a slight increase in the number of mental health nurses registered with a Scottish address, by 0.9% percent to a total of 10,846 professionals (115).

[1] WTE for each person is based on their hours worked as a proportion of the contracted hours normally worked by a full-time employee in the post. For example, a person working standard hours each day, but only 3 days out of 5, would count as 0.6 WTE

Turning to NHSScotland psychiatrists, at the end of June 2023, there were 773 WTE general psychiatry consultants, 117.6 WTE old age psychiatry consultants, and 72.5 learning disability psychiatry consultants in post. For general psychiatry this represents a decrease from 794.2 in the last quarter and from 810.6 in the June 2016. The vacancy rate for general psychiatrists was 16.4% (60.5 WTE).

The Royal College of Psychiatrists conducts a biennial census to establish numbers of consultant and specialty doctor psychiatrist posts across the UK for both NHS organisations and independent healthcare providers. The latest census was conducted between March and September 2021, and received responses from 84 out of 99 (84%) NHS organisations and 8 independent healthcare providers. This recorded 834 substantive full time and less than full time consultant posts in Scotland and 186 locum consultant posts. There were 63 vacant posts (116).

In general therefore the CAMHS and Psychology workforce has increased over recent years, with vacancy levels going down very slightly. This suggests that more recruits are coming through training to fill posts. In contrast the numbers of mental health nurses and psychiatrists have remained broadly similar. This may reflect an increase in the types of conditions amenable to treatement by pscyhology such as anxiety and less complex depression, and also increasing mental health and wellbeing issues among younger people. Whether the levels are appropriately balanced and will ensure reduction in current waiting lists requires modelling and analysis as part of wider workforce planning.

In the absence of an agreed standardised definition of the mental health workforce, NHS Digital in 2018 attempted to produce a definition for those employed by the NHS, based upon the data fields and lists of values already present within the National Workforce Data set. This has been further worked on over time (117). It aims to cover the majority of registered and support staff but acknowledges that some staff groups outside of core mental health areas are not captured.

A report by the World Health Organisation provides an international perspective on the mental health workforce. This illustrates that no workforce composition emerges as standard, and the particular professionals providing support vary across and within countries according to differing population needs, delivery systems and resources (118).

Local government has a key role to play in delivering wellbeing and mental health care and shortfall in numbers in this area have been widely acknowledged. In 2020, there were 134,540 people employed in adult social care in Scotland (119). Many of them will have a role indirectly, or in some cases directly, supporting wellbeing and mental health care. A group for which there have been particular recruitment challenges is Mental Health Officers. In 2022 there were 707 filled MHO posts which is 13 more than in 2021. This was in turn ten fewer than 2020. There was a reported shortfall of approximately 72 WTE MHO posts. This is slightly down from 2021, but higher than the years preceding then (120) (121).

Mental health care and support is also provided by the private sector, covering primary and secondary care, care at home and long stay provision. There is no overall quantification of this workforce available. The police, education services, and charities while not specifically providing care, will often provide mental health support. Likewise, there are numerous volunteers, unpaid carers, family and friends that all provide mental wellbeing support and services.

A report compiled by the UK All-Party Parliamentary Group on Global health considered the developments needed within mental health workforces globally to meet the needs of the population in the post-pandemic era. It sets out a requirement for large scale change to create a workforce which as well as offering specialist care, can support individuals, and communities to promote good mental wellbeing and health and provide appropriate support. Increased investment in, and prioritisation of the mental health workforce, is needed. Specialists, generalists, the third sector and non-professionals must be integrated and work together, developing new ways of working with people and communities, with a preventive focus. All those involved need to be appropriately trained and supported for them to make these changes and to support improvements in mental health across society (122).

4.0 Challenges to achieving good mental health and wellbeing

There are a number of challenges to achieving good mental wellbeing and mental health for the population of Scotland.

As discussed in the previous section, there are many determinants of mental health and wellbeing, which are wide ranging and varying in their impacts, and which interact in complex and multi-directional ways. This in itself presents a key challenge for policy making and practice, and points to the need for cross-government, multi-agency working (123). There are also specific determinants of mental health that are considered by individuals and organisations in Scotland with professional and lived experience to present long standing enduring concerns or particular challenges at this time. These challenges are discussed in this section.

Also given specific consideration within this section of the narrative are the issues around the provision and staffing of support and services to promote and provide good mental health and wellbeing.

4.1 Global health, economic and political issues

Scotland, like much of the rest of the world, faces a number of pressing issues. The cost of living increased markedly during 2021 and 2022 with inflation reaching its highest level since 1981 in October 2022. It has since eased slightly but remains high. Recovery from the Coronavirus pandemic, and adapting to the changes resulting from leaving the European Union continue to impact on the economy, society and individuals and are likely to do so for years to come. Conflict in Ukraine presents a humanitarian crises and its economic and social repercussions are felt globally. Increasingly the extent of climate change becomes apparent and the serious consequences of this for countries, particularly low income countries, and their populations manifests for example in terms of lowered biodiversity, severe weather events and reduced agricultural production.

There is a well-developed evidence base showing how global environmental, social and political issues can impact on wellbeing and mental health. For example, as climate change occurs, there is an increased frequency of extreme weather events and these events are associated with severe mental distress (124). Also, people who have mental health conditions are more vulnerable to the effects of climate change (125). Natural disasters, such as floods and wildfires, now occurring more frequently as a result of climate change, are known to significantly increase the number of people experiencing mental health problems, including post-traumatic stress disorder, depression and addiction issues. Women, children, those living in poverty, and those living in low- and middle-income countries are most exposed to these events and their mental health consequences (126, 127).

The well-recognised strong link between poverty and mental health (128) indicates that the current cost of living crisis will have a negative impact on people's mental health (129-131). Clinical outcomes will take time to manifest and be measured, but extensive qualitative research exploring people's perceptions of the impact of the crisis on their health and their changing behaviours is already available. For example, an opinion poll commissioned by the Scottish Government of a demographically and geographically representative sample of just over 1,000 adults living in Scotland, undertaken in June 2023, found that 49% of respondents considered that their mental health had been impacted negatively by the rising cost of living. This impact was more prevalent in the lower socio-economic groups, those in the 18 to 54 year old age group, and women (132). A survey of 1,000 adults in Scotland by the Mental Health Foundation in November 2022 found that 33% of adults experienced stress, 40% experienced anxiety and 13% said they felt hopeless due to financial worries over the previous month (133). The Royal College of Physicians surveyed 2,001 UK adults in Apr/May 2022 about the impact of the crisis on their health. Fifty-five percent (1,110) reported a negative impact on their health. Of these, 84% attributed this to increased heating costs, 78% to the rising cost of food, and 46% said rising transport costs had contributed. A quarter of those who said that their health had been negatively affected by the rising cost of living had also been told this by a doctor or other medical professional (134).

One consequence of poverty in Scotland is people's inability to adequately heat their homes. The adverse impact of cold homes on mental health is illustrated by data from the UK Household Longitudinal study. Modelling based on this data suggests that moving into an insufficiently warm home is associated with double the odds of developing severe mental distress in individuals who were not previously experiencing this, and three times the odds for those already on the brink of distress (135).

Evidence also highlights indirect effects of the increased cost of living on mental health through the detrimental impact of the crisis on services providing mental health and wellbeing support. The Scottish Third Sector Tracker wave 3 survey found that 93% of organisations reported rising costs since April 2022, with the most commonly reported rises being in: material and supplies (84%); transport costs (86%); staffing costs (47%) and energy costs (76%). Of organisations seeing rising costs of any kind, 43% felt this affected their ability to deliver their core services or activities (136).

Published evidence suggests that welfare reform (including the introduction of Universal Credit) (137) and Brexit have been contributors to observed increases in psychological distress (138). Earlier evidence of how the 2008 recession and subsequent austerity policies adversely affected mental health in England (139) adds weight to this suggestion.

4.2 Stigma

Many people who have experienced poor mental health have also experienced prejudice, stigmatisation and social exclusion. A recent Lancet commission on ending stigma and discrimination in mental health describes the 'double jeopardy' faced by people with mental health conditions where the impact of the primary condition is compounded by the consequences of stigma. In an extensive review of the literature to complement their work, the Lancet commission describes four different types of stigma people may experience: self-stigma; stigma by association; public and interpersonal stigma; and structural stigma (140).

In Scotland, there is some evidence to suggest that certain aspects of the stigma surrounding mental health conditions may be decreasing. A poll conducted by See Me and Censuswide found that 96% of the people in Scotland surveyed would support someone struggling with their mental health (141). Also, over the last 20 years, there has been a 60 percentage point increase in the proportion of people who say that they would have the confidence to start a conversation with someone about their mental health (from 24% to 84%) (141). Survey research found in 2019 that just over three-quarters (76%) of the British public think mental illness is an illness like any other – which is higher than in other countries (142). In contrast, however, negative attitudes and discrimination towards people with mental health conditions can still be seen among the population in Scotland. For example:

- 34% would be unwilling to have someone with schizophrenia marry into their family (143)
- 47% would not want people to know if they were experiencing mental health problems (143)
- 51% of young people agreed that they would not tell someone if they were having difficulties with how they were feeling (144)
- 33% have experienced being treated differently or unfairly because of their mental health problem (145)
- 69% have witnessed people being treated differently or unfairly because of their mental health problem (145)

The Scottish Mental Illness Stigma Survey provides insight into the views and experiences of adults with self-reported complex, severe and enduring mental health illnesses in Scotland (146). This research project (led by See Me in partnership with the Mental Health Foundation and Glasgow Caledonian University) found that stigma impacted on people's relationships, work and healthcare:

- 82% expected others would not want to be their friend due to their mental illness
- 85% have not taken up opportunities to apply for employment due to stigma or discrimination about their illness

- 87% have experienced unfair treatment when trying to get help for mental health problems

Talking safely about mental health conditions has been shown to lead to improved wellbeing (147) and tackling stigma is essential to remove this barrier to people sharing experiences about their mental health (148).

Stigma can also be a concern in perinatal and infant mental health (149). Addressing perinatal and infant mental health stigma is a core commitment within the Scottish Government Perinatal Mental Health Peer Support Action Plan (150) and a part of the Coronavirus (COVID-19) Mental Health Transition and Recovery Plan (151).

4.3. Adverse childhood experiences and trauma

Since the original study (152) demonstrating that adverse childhood experiences (ACEs), including growing up in a household where adults are experiencing mental health issues, could negatively affect health in adulthood, a wealth of evidence has been developed indicating that ACEs increase the risk of experiencing poorer mental health (and other worse outcomes over the life course). For example, the 2017 Welsh ACEs survey (153) found that compared to people with no ACEs, those with four or more ACEs were statistically:

- 3.7 times more likely to currently be receiving treatment for mental illness
- 6.1 times more likely to have ever received treatment for mental illness
- 9.5 times more likely to have ever felt suicidal or self-harmed.

Thirty-seven individual studies looking at the impact of ACEs are summarised in a systematic review undertaken in 2017, and overall a strong association between multiple ACES and mental ill health was identified (154). ACEs can interact with other determinants of health, such as socio-economic factors, compounding the effects of each alone. ACEs should not be conflated with poverty, however, children living in poverty are more likely to experience ACEs, thus compounding the mental health effects of the poverty (155).

The 2019 Scottish Health Survey (18) included questions asking adults about whether they experienced adversity in their childhood and how this relates to their current health. It found that substantial proportions of the Scottish adult population suffered some form of abuse, neglect or other adverse experiences during their childhood, with 71% reporting having experienced at least one ACE and 15% experiencing four or more ACEs.

Experiencing trauma can impact on a person's inter-personal, emotional and cognitive functioning and skills development. This has implications for relationship stability, social functioning, educational attainment, parenting and employment, all of which can compromise life choices and opportunities. Trauma puts people at higher risk of suffering from a range of mental health conditions. There is also the potential for trauma to be associated with increased risk of a range of physical health diagnoses including, but not limited to: cardiovascular disease, stroke, diabetes, headaches, and complex interactions between poor physical health and mental health (156).

People affected by trauma may not seek or receive the care and support they need as they may find it difficult to feel safe within services and to develop trusting relationships with service

providers. They may also be penalised by services for the normal coping behaviours associated with experiencing ACEs and trauma, such as avoidance, dissociation or the use of substances (157, 158).

There is growing evidence that 'trauma-informed' systems and practice, where staff understand the impact of trauma on those affected by it, can result in better outcomes for people affected by trauma. Trauma-informed practice, does not treat trauma related difficulties. Instead, it seeks to address the barriers that those affected by trauma can experience when accessing the care, support and treatment they require (for example in health, education, housing, or employment) for a healthy and fulfilled life (159, 160). As outlined by the National Trauma Training Programme, working in a 'trauma-informed' way means: realising how common the experience of trauma and adversity is; recognising the different ways that trauma can affect people; responding by taking account of the ways that people can be affected by trauma to support recovery, and recognising and supporting people's resilience; looking for opportunities to resist re-traumatisation and offer a greater sense of choice, empowerment, collaboration and safety with everyone they have contact with; and recognising the central importance of relationships (161).

4.4 Supporting those with multiple and more complex needs

While many people are able to manage their own mental health and wellbeing, or need minimal intervention, some people have very complex needs which requires specialist and/or intense care, treatment and support.

People with multiple and complex needs may experience several overlapping problems at the same time. Estimates suggest that, over a year, there are 41,000 people experiencing poor mental health plus one other disadvantage from homelessness, substance dependency, offending or domestic violence/abuse (162).

People with lived experience of such multiple disadvantage describe 'missed opportunities' for early interventions in schools and other education settings which could have prevented escalation (162). They also describe the struggle of local and national service systems to address the needs of people who present with a range of complex and interacting needs. This is especially so if these needs are accompanied by the perceived challenging forms of behaviour that are often present in people coping with the long-term effects of sustained trauma including Adverse Childhood Experiences (163).

One particular group with more complex needs are those individuals experiencing severe and potentially enduring mental illness. Such illnesses include bipolar disorder, schizophrenia, other psychoses, personality disorders, and any other mental health disorder (such as depression or anxiety) of a severe and enduring nature. These illness have been estimated by the Mental Welfare Commission to affect around 40,000 people in Scotland. However as highlighted in earlier sections of this report, determining the true number of people is difficult given that not all will be in contact with mental health services and fear of stigma can prevent people admitting to their condition (164).

Research by the Mental Welfare Commission for Scotland found many positive aspects of care and support for people with severe and enduring mental ill health in Scotland who were in touch with community mental health services (165). However, only three of the 59 people interviewed had jobs, and a significant number experienced some loneliness and isolation. The Commission points to the need for further support within the community and in employment, and for services to have a focus on recovery.

People with severe mental health conditions often have higher rates of physical ill health such as cardiovascular disease, diabetes, obesity and lung conditions, and also their physical problems can be made worse by effects of their mental health problems. People with severe and enduring mental illness may have their lives shortened by 15 to 20 years, a large part of which is because of physical ill-health (166, 167).

A qualitative exploration of the experience of individuals living with a severe mental health condition and a physical health problem illustrates the challenges of their situation. People with severe mental illness can find it extremely difficult to manage their physical health condition, and therefore personalised support taking into account their needs and circumstances is essential (168).

4.5 Increasing demand for mental health care and treatment

Earlier sections of this report have illustrated the rising demand for mental health services over the last decade. For example, between 2015 and 2019, accepted referrals for specialist services increased year-on-year by 4.7% in CAMHS (169) and 7.9% in Psychological Therapies and Services (170).

During the pandemic, administrative data showed rates of anxiety and depression disorder recorded around one third lower than would be expected (171) and referrals to specialist mental health services dropped. However, evidence shows that need did not go away, as seen in an analysis of electronic patient record data from May 2020. This shows that approximately a month after the lockdown restrictions for the COVID-19 pandemic had been enforced, there was a 12% increase in the number of mental health related incidents responded to by the Scottish Ambulance Service, despite a 7.5% reduction in the overall emergency demand (172). More recent data suggests that the numbers of referrals for the quarter ending June 2022, were similar to pre-COVID levels (173), and that they are rising (174, 175). Data for the quarter ending March 2023 indicates a 3.5% increase in referrals to CAMHS from the previous quarter, and an increase of 5.5% from the same quarter in 2022 (175). Psychological Services received 10.8% more referrals in the quarter ending March 2023 than the previous quarter and 2.6% increase from the same quarter in 2022 (174).

Pressure on CAMHS and Psychology Services has been high for a number of years, in some areas leading to long waiting lists. Audit Scotland in 2018 raised concerns about access to children and young people's mental health services (176). Between January and March 2023, 74.2% of children and young people were seen by CAMHS within 18 weeks of referral, which is an increase from the previous year and quarter but still does not reach the Scottish Government standard of 90%. During 2021/22, 38.7% of under 18 year olds requiring psychiatric admissions were admitted to non NHS specialist CAMHS wards, an increase from 29.3% in 2020/21 and 30.7% in

2019/20. An outcome of the previous Scottish Government mental health strategy is the creation of a new dataset which will capture more individual patient data to enable greater knowledge and understanding of patient pathways to and through CAMHS and Psychological Services, and the outcomes for these patients (177).

There is currently no routine data gathering in Scotland that asks service users about their experiences of accessing community or inpatient mental health services. The Community Mental Health Survey gathers this data for community services in England (178). As part of the development of standards for the provision of adult secondary mental health care, the ALLIANCE, in collaboration with VOX Scotland, conducted a survey in early 2022 to gather views of service users in Scotland. The results of this provide some recent evidence on how people experience services, albeit limited to secondary care. Researchers engaged with 177 people with lived experience and nine mental health focused organisations from February 2022 to May 2022 to collect their experiences. Access was the most commonly reported theme. Almost 60% of respondents remarked that they had tried and failed to access mental health services. The importance of 'attitudes of encouragement' among staff was raised, as was the involvement of service users in the care. Participants wanted greater consistency between services, in staff attitudes and behaviours, and in accessibility, and the need for shorter waiting times was highlighted (179).

Some data relating to people's experience of care for their mental health is captured within the Health and Care Experience Survey (180). However this survey only asks about care received from GPs and related community services, and only around 10% of the data comes from patients consulting about mental health issues. Between 53% and 57% of adults with mental health problems supported at home in 2020/21 agreed that their services and support improved or maintained their quality of life, a decrease from around 74% in 2019/20 (181).

SAMH conducted surveys in autumn 2021 and spring 2022 to examine how mental health treatment and care had changed for people during the pandemic and their experiences of this. While higher levels of satisfaction than dissatisfaction were expressed, there were concerns about the absence of a post pandemic return to face to face contact (182).

The Scottish Government commissioned YouthLink Scotland to work in partnership with Young Scot, Children's Parliament and Scottish Youth Parliament as part of an engagement activity to gather the views of children and young people on accessing information, support and services for mental health and wellbeing (183). Themes across age groups surveyed (8 to 25 years) include a need for improvement in access, a desire to have someone they can talk to, and to know that support is available when need it.

4.6. Achieving a skilled, supported, sustainable and diverse mental health and wellbeing workforce

The challenges of building a mental health workforce which is fit-for-the-future are widely acknowledged, with the impact of the pandemic and an aging population contributing to pre-existing shortfalls in staff numbers (184). It is recognised that it will be necessary to recruit more staff from more diverse backgrounds, to retain and improve the morale of those already working

in the service, and to broaden the mental health skills and knowledge base across wider professions.

4.6.1 Recruitment

In Scotland, as in other parts of the UK, it has proved difficult to recruit sufficient people into mental health posts to meet the increasing demands, changing roles and address gaps created by an aging workforce retiring and others leaving. Recruitment is an issue across the health, social care and social work sector but there are some unique challenges in mental health. These include retirement from aged 55 for those designated as mental health officers and serving from before 1995, and more limited international recruitment options than other specialties, given fewer specialised mental health training courses available in other countries. The demographic profile of the workforce can also differ from general nursing, for example being older, meaning different priorities for those contemplating future careers (185, 186).

A report commissioned by NHS Employers and led by the Centre for Mental Health, looks at ways of attracting more people to study mental health nursing (187). While focused on England, it draws on UK-wide evidence. The report comprises of a literature review, as well as qualitative research undertaken with students on mental health courses, practicing nurses and career advisors. Based on this evidence gathering, it sets out factors which can encourage or dissuade people from pursuing mental health training.

Personal experience and exposure to health services and staff can have a big influence on people's career choices generally, and the research found that this effect is also seen in mental health nursing. Those who have more understanding of the work and the role are more likely to consider training themselves. Availability of courses locally, and funding for these, is also found to be of importance in attracting students.

The report notes that a lack of understanding of what the role might involve, with limited coverage of mental health nursing in the media, leading to misconceptions about this career. These misconceptions include a view that mental health nursing is less academic than other types of nursing, with nursing generally, in turn, seen as less intellectual or carrying less prestige than other clinical roles. It is also thought that it predominantly involves working with people with serious mental illness in forensic settings, with a consequent perception by students that they may not be able to cope with its stresses and demands. Stigma around mental health in general, also carries across to people's perspectives on seeking a career in this area.

Similar themes are picked out in other recent qualitative research. A report prepared by the Centre for Mental Health, based upon consultation events involving around 100 people, comprising of a mix of service users, informal carers, education and health and care providers, highlights the importance of raising awareness of possible career pathways (188). A focus group study with students taking an A-level course in psychology, and considering applying for psychology courses, reported a desire among them to pursue therapeutic careers. However, this was accompanied by a lack of understanding of the qualifications required to pursue clinical psychology and the competitive entry to these courses, and also of the wider range of alternative career options in mental health that are available (189). In a further study in which 28 individuals who could potentially pursue a career in mental health nursing were interviewed,

enablers to this career were considered to be a desire to help people and a greater awareness of what mental health nursing involves. Barriers were a lack of knowledge about what the role involves, the routes into employment and the qualifications required, and the perceived stressful nature of the work (190).

Mackenzie et al. (190) created a model to identify the factors that would encourage individuals to consider a mental health nursing career. Statistically significant predictors were found to be female sex, having a mental health condition, and possessing a greater knowledge of mental health. Having had experience of working with people with mental health difficulties was, however, a negative predictor. Similar to the other research in this field, facilitators to actually taking up a career were found to be a desire to help others and receiving appropriate training. Off-putting factors included the perceived impact on stress levels and work life balance, and the level of recompense for this, lack of knowledge about roles, and also the time and expense of training.

Turning to psychiatry, many of the factors that attract or prevent students from considering mental health nursing careers, apply also to medical students. The nature of psychiatry, with its differing paradigms and approaches from other more clinical areas of medicine, can be both a barrier and a facilitator to attracting students (191). Efforts have been made to increase the number of psychiatry trainees in the UK, but not all these trainees go on to take up UK psychiatry posts at the end of their training. A mixed methods study combining secondary data analysis of psychiatry trainees' progression into specialist registrar psychiatry posts, and qualitative research with current and former trainees, investigated why this may be the case. Aspects of working in the profession which trainees found to be challenging were different cultural and social norms compared with other clinical areas of medicine, functioning in under-resourced systems, and a perception of risk, with 35% of trainees frequently experiencing verbal and behavioural aggression. Other work conditions, and individual factors, were noted by trainees as impacting on their ability to deal with this risk. More flexible working arrangements, and access to other learning and development beyond their training programme, were noted as aspects which would encourage people to remain in training. The research also suggests that expectations around the time taken for trainees to progress should be adjusted to take into account that most people, for a variety of reasons, including career breaks and pursuing other training, do take longer than specified times to progress through the process (192).

These research studies all point to there being a potential workforce available, but with which greater efforts are required to promote mental health careers. There is a need to highlight the potential rewards of mental health roles in terms of helping others and being able to make a difference. General awareness of the nature of the roles and career pathways needs to be increased, and diverse and financially viable training routes offered. Regarding this latter point, it can be seen that applications and entrants to nursing, midwifery and allied health profession preregistration programs in England declined two years in a row after student loans replaced bursaries in 2017. By contrast, in Scotland and Wales, where the nursing bursary was retained, numbers increased (193).

4.6.2 Retention

There are a number of challenges that people face whilst working in mental health services which can affect their decision to stay in the workforce. An inadequate workforce in itself impacts upon employee's feelings about their job, and their ability to remain in post. A British Medical Association survey (194) of 1,036 mental health professionals in England highlighted that 52% of respondents said they were too busy to provide the care they would like on their last shift worked and 44% of respondents said that their individual workload was either mostly unmanageable or unmanageable. In turn, almost half (49%) of them agreed that they felt upset that they could not provide the level of care they had wanted, and 44% said they felt demoralised, on their last shift worked. This point is also illustrated in a survey of 20,235 self-selected general nursing staff across the UK, undertaken by the Royal College of Nursing. Results are presented separately for respondents from Scotland and are in line with the overall results. Some 68% of nurses in Scotland disagreed with a statement that they had time to provide the level of care that they would like (195).

While there is much research concerning retention of health, social care and social workers in general, evidence on the factors which promote or inhibit retention of the mental health and wellbeing workforce specifically, is more limited.

A systematic review undertaken in 2021 attempted to synthesise the evidence to date relating to retention of mental health nursing staff (196). The review includes 23 studies which were undertaken in a variety of different countries and differing health systems, and over a time period ranging from the early 1990s to 2019. As such, the generalisability of the findings are limited. The themes emerging however do provide an indication of the main issues and align with findings coming from individual UK based studies.

The first theme identified related to individual characteristics of the employee. Evidence within this theme suggests there are potential benefits of recruiting more mature students as they are more likely to remain in subsequent employment than younger nurses, while acknowledging a need to particularly support younger nurses to stay in post. A coherence in values of an individual with their organisation also promotes retention. The second theme concerned working within health services. The unique nature of the role in terms of being rewarding and exciting, but also potentially stressful, with incidences of violence and aggression and with stigma attached, results in a delicate balance of push/pull factors. These can be supported or hindered by some of the characteristics of individuals identified in the first theme, and the general support available within the clinical setting. Under theme three, training and skills, the association between feeling adequately trained and equipped to undertake a role, with opportunities to use one's skills, was seen to be important for both new and more experienced nurses. Lastly theme four, the work environment, noted positive working relationships, good supervisory support and line management, and a culture which appreciates the role of mental health nurses and rewards them accordingly as being conducive to retention.

'Burn-out' and low levels of wellbeing have been identified as issues throughout the healthcare profession, but these can be particularly prevalent among mental healthcare staff. This in turn has implications for the quality of care delivered. In a narrative review on the topic, Johnson et al. identify reasons for this and suggestions for addressing the issue (197). Many of the causes of burn-out in mental health staff are common to other professions, but particular mental health related factors identified in the review align with those set out by Adams et al. (196) as barriers to retention. These include the emotional toll of the job, the risk of violence and underfunding. An additional reason put forward by the authors for further exploration is a tentative link with a

greater proportion of people with mental health issues being drawn to mental health careers than other areas of nursing.

In terms of addressing the challenges, the review authors note that research into effective interventions is still developing, but suggest that job training and education interventions could be helpful for reducing overall burn-out and staff satisfaction, while person-directed interventions may be most effective for reducing emotional exhaustion. They recommend that interventions should be based upon emerging research, with links built between healthcare organisations and university researchers. To encourage uptake, organisations should emphasise the potential positive outcomes of the interventions to staff. They should also look to design interventions that will target burnout and improve patient care simultaneously, building upon the feedback loop between these.

Much of the research on the mental health workforce focuses on general mental health nursing. Forensic mental health can bring additional unique challenges, and these are examined in a review by Oates et al. (198). It illustrates how staff must be adequately supported in an emotionally and ethically charged environment.

Research particular to other professionals is also available. Psychological wellbeing practitioners are a relatively new professional group, and Health Education England commissioned an audit to investigate a particularly high turnover rate in this group, with large variation across England. Career progression to other mental health careers was found to be one of the main reasons for this, illustrating a perhaps unintended consequence of introducing a new role (199).

Issues impacting recruitment and retention of social care staff are similar to those employed in healthcare, and include increasingly unmanageable caseloads, resulting in implications for work quality, a need to work excessive hours and reduced wellbeing (200). The Scottish Government Chief Social Worker's report sets out examples of initiatives in different parts of the country to boost recruitment and retention in the social work profession including a 'grow your own' approach, promoting opportunities for peer support, and practice development and learning (201).

4.6.3 Training and upskilling of the workforce and wider development of mental health care skills and knowledge

Having the right numbers of skilled, trained and supported staff, in the right place, at the right time and in the right roles is essential to providing high quality health and care services (202). Such services are then equipped to address health inequalities and encourage and support people to take more responsibility for their own health and wellbeing (203, 204).

Purposeful training and upskilling helps to refine skills, plug any knowledge gaps, improves quality of support, care and recovery and is essential for patient safety. For example, the Scott Review highlighted gaps in training in relation to equality and diversity training for independent advocacy workers (205). The Early Learning and Childcare workforce responses to a survey by Early Years Scotland noted a need for targeted professional learning opportunities to enable them to specifically support the mental health and wellbeing of children aged 3 to 5 years. While

they had received some training on this topic, their training was mainly directed towards supporting older children (206).

Training and upskilling also opens up pathways to careers progression and potential redirection of someone's career. Approaching the recruitment issues in this way can provide staff with a route into new roles. Giving existing staff members the chance to learn new skills may mean that they can fill available positions or take on a varied post. In line with the Scottish Government's Digital Health and Care Strategy, work is ongoing to develop the digital capabilities of the social care workforce (207). Since 2021, more than 2,500 public and third sector staff in Scotland working in primary mental health care roles or alongside psychological therapists, with no previous training, have accessed an Enhanced Psychological Practice programme that provides them with postgraduate certificate level training (208).

As well as tackling capacity issues within the specialist and core mental health workforce through increasing recruitment, retention and training, research notes the need for a wider distribution of skills and knowledge of how to support those with low levels of wellbeing and poor mental health, and a need for these to be developed throughout the wider health and care community (60). By growing the skills and experience base across the workforce, more individuals can be offered support at an earlier stage, potentially preventing the need for further intervention and hence reducing pressure on the specialist workforce (209, 210). In Scotland, a range of training resources and a knowledge and skills framework have been co-produced by NHS Education for Scotland and PHS to support the implementation of Scotland's Public Health Priorities for Mental Health, Scotland's Mental Health Strategy 2017-2027 and Scotland's Suicide Prevention Action Plan – Every Life Matters (211).

The development of new types of mental health posts working alongside more established professions can also help alleviate pressure and provide better outcomes for individuals through earlier intervention (188, 212). Likewise, greater use of peer support can prove more effective for some individuals, and reduce pressures on the healthcare system downstream (213).

Drawing from all sections of the population to fill future mental health roles not only offers more potential candidates, but ultimately ensures a more person-centred and lived-experience driven service for all (187, 190, 214). Current evidence suggests that students on mental health nursing courses tend to be older than those on general nursing and allied health professional courses (187). They are also more likely to be male (187). Individuals with more limited financial resources may be unable to take up volunteering posts which often constitute a route into a training place or career. Gender stereotyping is also identified as an issue which may be off-putting to some (215). These factors all suggest the need to consider specific support into mental health careers for particular groups within society to create the strong, diverse workforce desired.

5.0 What works to improve wellbeing and mental health, and to manage mental health conditions

The earlier sections of this report have highlighted the multitude of factors contributing to individual and population mental health and wellbeing, including structural, social, community and individual determinants, and the particular challenges being faced by individuals and the health and care system in Scotland at this time.

To identify approaches to addressing these challenges and achieving the outcomes set out in the Mental Health and Wellbeing Strategy for Scotland there is a need to consider the evidence for:

- Promoting good mental health and wellbeing at an individual, community and population level, improving understanding and challenging stigma
- Preventing mental ill health and facilitating early intervention for those who are experiencing problems, and tackling the underlying determinants of mental health and wellbeing
- Providing mental health and wellbeing support and care, ensuring people can access the right support in the right place at the right time

An extensive evidence review published by the Royal Society of Public Health (RSPH) (60) observes that there are many interventions available known to prevent mental ill-health and promote mental wellbeing. For improvements to be seen across the population however, there needs to be high levels of implementation and access to these interventions, informed by comprehensive needs assessment – initially at a national level, and complemented by evaluation of coverage and outcomes.

Other strategic actions which can support population level benefits include: increased visibility of local data on provision of services and unmet need; improved mental health literacy and understanding across the population; providing public mental health training across health and care and other related professional groups; taking targeted settings based approaches, and addressing the wider determinants of health.

The RSPH review sets out the available published evidence on many different public mental health interventions, grouping these according to whether they are relating to prevention, treatment or minimising the impact of mental ill health, or to promoting wellbeing. This review constitutes a very extensive collection of evidence and the full details can be viewed in the RSPH report (60). Summarised information is provided in sections 5.1 to 5.3 of this report.

Based on the RSPH review (60) and additional more recently published literature, the Royal College of Psychiatrists' Public Mental Health Implementation Centre has set out the interventions for which they a) deem there to be the strongest evidence of effectiveness available, b) which have evidence of impact across a wide range of policy areas, and c) show the largest impact on mental health and target groups who could be at higher risk of illness or not

benefiting from public health interventions (216). These interventions fall into seven broad areas, as follows:

1. Interventions during pregnancy and immediately after birth to prevent child mental ill health
2. Interventions to prevent and treat parental mental ill health and problematic parental drug/alcohol use
3. Parenting programmes which prevent child mental ill health, substance use, antisocial behaviours and unintentional injury and improve child behavioural outcomes, parenting and parental mental health
4. Home visiting and parenting programmes to improve child-parent attachment and prevent child adversity
5. School-based interventions to prevent mental ill health and alcohol/tobacco/drug use, reduce child adversity, promote mental wellbeing and resilience, and improve social-emotional skills
6. Workplace-based interventions to reduce employee mental ill health, increase wellbeing and promote recovery from mental ill health
7. Interventions to reduce smoking, alcohol, drug use, physical inactivity, COVID-19 infection and promote appropriate care of physical health conditions.

The report also notes what they designate as "Priority intervention areas", which are approaches with high public health relevance but currently a more limited evidence base. These are:

1. Address socio-economic inequalities to improve outcomes among marginalised groups (eg minoritised racial and ethnic groups, people in poverty or on low incomes, LGBTI+ people)
2. Targeting marginalised and higher risk groups (for example those with special education needs, carers, looked after children, those with long-term health conditions) to improve access to public mental health interventions

These nine intervention areas range across the spectrum of wellbeing promotion, mental health illness prevention, early intervention, and treatment, with a focus on intervening early. PHS's modelling studies indicate the need for interventions to cover all the domains (Promote, Prevent, Provide) to reduce health inequalities in Scotland (217).

Summarised information from the extensive literature review published by the RSPH (60) for each of the three domains are now considered in turn, along with other more recent evidence and data and evidence specific to Scotland. Then consideration is given to how the fundamental determinants of mental health may also be addressed.

5.1 Promoting mental wellbeing

This domain can comprise the promoting of the factors that protect mental wellbeing, intervening early to promote wellbeing in those experiencing an episode of low wellbeing and also interventions to promote wellbeing in those for whom this is chronically poor. Promoting wellbeing can take place at the level of individuals, or around creating healthier, more sustainable communities with environments which support improved health. It may also be at a structural level with policy and legislative changes. Interventions across the life course are needed and these should be targeted at those at greatest risk.

Considering the life course, under the heading of 'Starting well', the RSPH review discusses interventions such as parenting programmes, parental mental and physical health promotion, breastfeeding support and infant attachment programmes. Then for 'developing well' attention moves to pre-school and school-based programmes and support, as well as family based interventions. For adults, interventions can encompass many areas of life and include those to promote social interaction and also physical activity. Financial measures, housing and neighbourhood programmes, interventions promoting positive psychology, and cultural and religious/spiritual activities. Work is also key, and providing increased control, flexible working and adequate training can impact on wellbeing. For older adults, interventions researched include psychosocial programmes, volunteering, physical activity, addressing hearing loss and supporting reminiscing. Many of these interventions to promote mental wellbeing can bring about economic savings (60).

The What Works Wellbeing Centre compiled a 'Knowledge Bank' (218) based upon a series of systematic reviews they undertook between 2016 and 2019, which aims to bring the evidence on what works to improve wellbeing into one searchable spreadsheet. It notes where evidence is strong/promising/unclear or lacking for a large number of evidence statements, a number of which relate to effectiveness of interventions, and provides a helpful starting point to refer to when seeking information on this topic. A more recent systematic review brings together primary studies which all used the same outcome measure to examine the effectiveness of wellbeing promotion interventions, namely the WEMWBS score. This enables some degree of comparison between interventions but the review also served to highlight a frequent concern in this type of intervention research, that most studies did not include a control group. With the caveat that the absence of a control group (64% of studies) means that effects cannot be definitively attributed to the intervention, the authors suggest that psychological interventions can have a strong effect on improving wellbeing, with medium to strong effects for person-centred support/advice, arts-based, parenting, and social prescribing interventions (219).

Turning to recent work conducted in Scotland, an evidence review was published by Scottish Government which specifically considered prison-based wellbeing interventions (220). It points to benefits for yoga, meditation and mindfulness. A rapid evidence review by PHS looking at socioeconomic determinants of mental wellbeing and socioeconomic interventions identified only limited robust evidence of the latter. The review noted that a population-labour market intervention and the provision of welfare advice services in a primary care setting showed some evidence of benefit to mental wellbeing. No evidence was identified that addressed the socioeconomic inequalities in mental wellbeing (47). Lastly to note is some qualitative work which was conducted during the pandemic period, but is of potentially more general relevance. PHS worked with community partners, to produce a series of short films which illustrate what

people and their communities found helpful to maintain and rebuild positive mental wellbeing (221).

5.2 Prevention of mental ill health and early intervention

Addressing the risk factors for developing mental ill health, and intervening early if problems do arise, is a key part of a public health response and can help to avoid the lifelong impacts of mental ill health. Interventions aimed at improving outcomes for children are important here as this is the age when many mental health conditions start to develop. Also, increasingly seen as important are interventions for the perinatal period, aiming to reduce the risk of development of maternal mental illness and to give infants the best start in life. In middle and older life, interventions around addressing violence, abuse and loneliness and dependence patterns are needed, including specific focus on at risk groups. There is inevitably overlap with the interventions that promote wellbeing as poor mental wellbeing is a risk factor for mental ill health and the latter can also result in the former (60)

McDaid and Park considered specific interventions for preventing poor mental health with demonstrated evidence of cost-effectiveness (46). They identified interventions from across the life course and these broadly fit into the areas noted by the Royal College of Psychiatrists and described in section 5.0 of this report as having the strongest evidence base. The interventions identified by McDaid and Park are:

1. Universal health visitor-delivered identification of risk of perinatal depression in women followed by provision of psychological therapies
2. Universal and targeted manualised parenting programmes
3. Anti-bullying programmes as an integral part of the school curriculum
4. Workplace identification of mental health problems plus brief psychological support; actions to change workplace cultures to promote and protect mental health
5. Early identification of risk of poor mental health supplemented by brief psychosocial or psychological therapy support for adults (remote or face-to-face)
6. Different types of exercise opportunity for all children, young people and adults
7. Brief psychological interventions for people living with long term health conditions
8. Investing in measures to promote opportunities for older people to continue to engage in activities that reduce the risk of social isolation (potentially through mechanisms such as social prescribing)

9. Suicide prevention: In addition to restricting access to means; early identification of risks of future self-harm, for instance in hospitals and in primary care, followed by appropriate ongoing mental health support

A further report from the Mental Health Foundation looked specifically at the mental health effects of a Universal Basic Income (222). While there was insufficient evidence to draw conclusions on an implementation of such a scheme, the evidence did show the potential implications of conditionality of such schemes and suggests that removal of such barriers in welfare benefits could be explored to enhance the beneficial effect for mental wellbeing. This point is also included in one of the recommendations coming from a report comprising research by the University of Glasgow and also the expertise of 28 stakeholders to consider the provision of social security and employment support in Scotland in relation to mental health (223).

5.3 Providing safe, effective treatment and care for people living with mental health conditions

People who live with mental health conditions need to be able to access safe, effective treatment and care. Many treatments and therapies are available which can aid recovery or make it easier to live with symptoms, and that have well-developed evidence bases assessing their efficacy and effectiveness. Access to these is often limited however, and people who could benefit from treatment do not always receive it (224).

The RSPH evidence report (60) covers early identification, treatment and prevention of relapse of mental health conditions, providing detailed evidence on the treatment and care for specific mental health conditions. Much of the content is drawn from UK NICE (National Institute of Health and Care Excellence) guidance (225), but other high quality evidence reviews are also highlighted. SIGN (Scottish Intercollegiate Guidelines Network) clinical guidelines specific to Scotland are also available for some conditions such as eating disorders (226). A systematic review published after the RSPH review, focuses particularly on non-pharmaceutical interventions and how they can be used to reduce inequalities. There is currently insufficient robust evidence for the authors to draw strong conclusions, but they do note potential benefits in the use of interventions such as social prescribing and collaborative care, and their use in socio-economically disadvantaged groups (227). For both care and treatment, evidence is widely available which shows that a life course approach is needed which responds to the different needs of children, young people and adults (228).

Evidence reviews highlight the need to better consider the physical health of individuals with mental health conditions, ensuring appropriate investigations and treatment, if maximal improvements in quality of life and life expectancy are to be realised (229). The reverse is true for people whose primary presentation is one of physical health (230). ‘Diagnostic overshadowing’ can be a particular issue for certain population groups such as those with learning difficulties (231, 232). The evidence points to the strong need for better integrated working between mental and physical health services to create positive change (233).

Another aspect to consider around care and treatment is the workforce. In July 2021, the report ‘New Directions for the Mental Health Workforce Globally: Summary and Recommendations’

(122) prepared by a UK All-Party Parliamentary Group on Global Health, made a range of recommended changes for global mental health provision. The main focus was that mental health prioritisation and funding needs to be brought up to a similar level with that of physical health in terms of pay, investment, and attention to workforce wellbeing.

Some key recommendations from the report include:

1. A need to increase the specialist workforce to support those with chronic and severe conditions, as well as a need to widen the mental health workforce to integrate non-professionals fully and engage primary care and general health services.

2. Incorporation of people with lived experience when designing mental health education, in planning future systems and services, and in service delivery.

3. The mental health workforce needs to be empowered such that they can take on enhanced roles as leaders, enablers and agents of change to help people, communities, and organisations in all sectors, to provide care, prevent mental illness, create health, and tackle stigma and discrimination.

As service models develop and change, public awareness needs to be raised of the mechanisms and routes by which individuals can access support. A survey in early 2022 of the public's perceptions of primary care conducted with a nationally representative sample of 1,136 adults living in Scotland, indicated only around half (53% of respondents) were aware that they could access an appointment with a mental health professional in primary care. Awareness was higher among younger than older individuals. Respondents also reported that their levels of trust in different primary care health professionals were lowest for mental health, and again this was most pronounced in older individuals (234).

5.4 Tackling the determinants of mental health

As previously discussed, it is well established that mental health is influenced by a range of social, economic and environmental factors and that these are experienced unequally across society. Tackling these different factors and addressing inequalities therefore is essential to improving wellbeing and mental health (92). This requires policy and practice interventions that go beyond the health and care context alone.

The active consideration of health consequences in policies not directly focused on health is the key feature of a 'Health in All Policies' (HiAP) approach to government (235). Such an approach has the potential to improve mental health and wellbeing, while simultaneously addressing other policy priorities. For example, in Scotland, policies around the Fair Work Framework, the Young Person's Guarantee, and social security are aimed at addressing the social and economic determinants of mental health. Additionally, social prescribing and school-based interventions may influence levels of social isolation, while planning policies will influence housing conditions. In all cases, the evidence base could be enhanced by rigorous and robust policy evaluation, incorporating methodological innovations when appropriate, such as recent developments in the measurement of health and wellbeing outcomes that enable relative

assessments of cost-effectiveness (236-240). Examples of such cost effectiveness evaluations of interventions addressing social and economic determinants, including use of WELLBYs (Well-Being adjusted life Years) and QALYs (Quality Adjusted Life Years) as wellbeing and mental health outcomes, are available (46, 241). These measures allow direct comparisons of interventions that would otherwise have differently measured outcomes, and enables calculation of relative cost effectiveness of the different interventions.

Estimating the effect on mental health outcomes of specific policies influencing the economic determinants of mental health is challenging because of the interrelationships between characteristics and the complexity of causal pathways. Consequently, current evidence mainly identifies determinants of mental health and how factors influencing these determinants can be modified. The Health Equity and its Economic Determinants project, ongoing at the University of Glasgow, is attempting to model how these complex relationships can be influenced by income, tax, and benefit policies (242).

The following section of this report sets out a selection of evidence relating to some of the economic, social and environmental determinants of health to provide an indication of the types of actions which could have an impact on mental health outcomes. A very large amount of evidence could be discussed here in relation to many determinants of mental health, but in line with the content of this evidence narrative as a whole, the intention is to be illustrative rather than comprehensive. As such, attention is focussed on several areas identified by the Scottish Government MHRAG as of particular interest in Scotland, but these should not be viewed as necessarily being more important or pervasive than other factors.

5.4.1 Economic determinants

Poverty impacts negatively on mental health through many different mechanisms and, consequently, efforts to reduce poverty by increasing incomes and lowering costs can have a large impact upon individual and population health. Interventions to achieve these goals range across policy areas and include increasing social security payments (especially child benefit), increasing the minimum wage, providing financial advice, building more energy efficient homes, providing free childcare and school meals, improving access to public transport and providing better services in areas of greatest need. Tackling the compounding effect of poverty-related stigma is also essential (243, 244).

Recent UK research suggested that employment outcomes may be more important in determining mental health outcome than income or poverty (245). The negative effect of unemployment on mental health has been identified in meta-analysis (246). Employment outcomes are particularly important for the mental health of men (245, 246). Likewise, for young people making the transition from secondary education, evidence consistently shows that preventing individuals becoming NEET (not in education, employment, or training) can improve mental health outcomes (247, 248). An initial attempt to value the negative wellbeing effect of moving from employment to unemployment, using WELLBYs as a measure of benefit, gave an average cost estimate of £5,980 per person affected per year (241, 249). Supported employment schemes for those experiencing mental ill health, such as the Individual Placement and Support programme have been shown to create benefits for individuals wellbeing as well as wider society (250). An OECD report Fit Mind, Fit Job concluded that an integrated government

approach is needed to ensure that people with mental ill health can achieve and sustain employment. In particular, policies must cover and connect health systems, youth support systems, workplaces, and welfare systems. Action across each of these policy areas is vital to improving the health, educational and labour market opportunities and outcomes of people experiencing mental health issues (251).

While employment has consistently been shown to be one of the main determinants of mental health, the benefits of employment on mental health vary depending on the characteristics of the job. Insecure work, such as having a fixed term contract, or volatile hours, has similar negative effects on mental health to becoming unemployed (252). Furthermore, the negative effects of insecure work on mental health are experienced regardless of unemployment fears being realised and throughout the income distribution, from richer to poorer (253). As with unemployment, insecure work is particularly damaging to mental health outcomes for men (253).

Research has also shown that insecure work cannot be defined by contract status alone (253, 254). Employment becomes insecure due to inadequate institutional support (255). In addition to pay and contract status, factors such as career progression, stable hours, and notice of schedule changes can reduce insecurity (256, 257). Improved employability has also been demonstrated to reduce the effects of insecure work (258). Similarly, active labour market policies providing training have been shown to provide greater mental health benefits than employment assistance policies (259).

Mixed evidence exists for the effects of working hours on mental health. Workers transitioning to part-time work while wishing to work more hours, have been shown to suffer mental health declines comparable to that of job loss (260). However, a separate study found this difference was not seen when other aspects of job quality were taken into account (261).

Although the effects of income and poverty appear smaller than those of employment, a recent systematic review identified income changes impacting on both mental health and wellbeing. Changes which moved people across the poverty line (the estimated minimum income to secure the necessities of life) had the greatest impact (100). A further systematic review provides evidence that social security policy reforms can influence people's income and level of wealth to improve mental health (262). Emerging evidence from a meta-analysis focusing on the Coronavirus Job Retention Scheme, which protected both income and employment, indicates that this policy mitigated some of the effects of the COVID-19 crisis on mental health (263).

5.4.2 Social support

Various sources of evidence have demonstrated the importance of relationships to mental health and wellbeing, with the availability of social support (relates to the provision of emotional, informational and other resources), and features of social networks (relates to the number, frequency and duration of social contacts) being protective of mental health (264). While the evidence is broadly consistent across sub-groups, for people with physical disabilities the quality of social relationships and availability of social support are more important in determining mental health outcomes than access to social networks (265).

Loneliness and a lack of social support have been shown to have negative effects on mental health and wellbeing across age groups (266, 267), with some studies focusing on young people (268) or older adults (269). There is also evidence that a lack of social support worsens the outcomes of those with existing mental health conditions (270).

Social support and cohesion may be enhanced by non-medical interventions to tackle loneliness. For example, evidence from a randomised control trial for a community singing group indicates that social prescribing may generate mental health benefits for older adults by increasing social contact (271). Furthermore, evidence provided by Age Scotland as part of the Men's Shed programme highlights that community based support is effective in supporting mental health and wellbeing amongst older adults. Age Scotland found that 79% of users felt their mental health had been improved because of the program, which enables members to be able to socialise, find information about local services, and provides a safe space for men to talk about their mental health and wellbeing (272). The What Works Centre for Wellbeing has published a review of 364 studies on the effectiveness of interventions to address loneliness which highlighted the need for interventions to be tailored to the needs of diverse groups and social contexts (273). The review included leisure activities, educational approaches, befriending, and community interventions. The benefit of moving from moderate to mild loneliness has been valued at £9,100 per year for each affected person using WELLBYs as an outcome measure, with valuations varying between specific groups (241, 274).

The important sources of social support vary across the life course, with adults being more influenced by their spouse or partner, and younger people influenced by parental support (266). Marriages and partnership are known to influence wellbeing, with better quality relationships having a positive effect. The strength of the association is moderated by various factors including gender (275). The breakdown of a marriage or partnership is an example of a stressful life event that can impact mental health and wellbeing. Evidence from the UK has shown that relationship satisfaction influences mental health, but also that mental health may influence relationship satisfaction (265). The implication being that improvements in mental health will contribute to a beneficial cycle of strengthening relationships within households and preventing exposure to relationship breakdowns.

Some policies have focussed on improving the quality of relationship between parents and children, with positive outcomes. The Incredible Years parent programme has addressed child disruptive behavioural problems, and has been found in several trials to be effective and likely to be cost-effective (276). A programme used in the United States to address the adverse childhood experience of parental divorce resulted in health outcomes amongst children within the programme that were better than the control group 15 years later, with the programme likely to be cost effective in the US context (277).

The Solihull Approach, an educational and therapeutic framework to improve relationships between parents, carers and children, has been extensively used in the UK. Its effectiveness has been demonstrated in different settings, with various groups, including in a randomised control trial carried out in 2019 (278). Online Solihull Approach programmes have been made accessible to every parent across Scotland, providing evidence based information on relationships and child development all the way through to 18 years.

An evaluation of the Psychology of Parenting Implementation project, an nationally implemented programme delivered in early years services in Scotland found that it resulted in

clinically significant improvements and, as such, had potential to be cost saving in future years, given the high cost of the impact of conduct disorders (279).

Relationships within school and among their peer group are known to influence the mental health outcomes of children. In particular, children subjected to bullying have poorer mental health outcomes that can persist into adulthood (280, 281). Problematic social media use has also been associated with lower wellbeing amongst adolescents (282). Universal anti-bullying programmes within schools have been found through meta-analysis to be highly effective (283).

The role of peer support in perinatal mental health is explored in a Scottish Government evidence review. It illustrates that this can be an effective intervention and makes suggestions for further development in Scotland (284).

Social support is key for good mental health across different equality groups. Qualitative research has shown that having supportive family and friends is one of the most important factors contributing to good mental health in LGBTI+ people, and is shown to be a predictor of positive mental health outcomes and a protector against depression, substance abuse and suicidality (285). Evidence from Change Mental Health (previous known as Support in Mind Scotland) into rural mental wellbeing also showed that opportunities for increased integration into local communities, as well as opportunities for language learning are good for the mental health of asylum seekers and refugees (286). Furthermore, respondents to the National Rural Mental Health Survey highlighted the importance of mobile and outreach services, particularly on the islands, and recommended that 'low-level', non-clinical support outside of hospitals also be offered within rural communities (82).

5.4.3 Stigma

A recent Lancet Commission set up to support the eradication of stigma around mental health, provides an extensive review of different types of evidence on interventions to address stigma in mental health (140). This includes an 'umbrella review', which is an overview of existing systematic reviews, a review of practical experience in setting up, delivering and evaluating anti-stigma programmes, and a survey of the views and priorities of people with lived experience of stigma and discrimination due to diagnosis of a mental health condition.

The umbrella review of 216 systematic reviews showed that interventions based on the principle of social contact (whether in person, virtual, or indirect) that have been appropriately adapted to different contexts and cultures are the most effective ways to reduce stigmatisation worldwide. The evaluation of ten large-scale anti-stigma programmes around the world found that they are most effective when they involve people with lived experience of mental health conditions as co-producers in all aspects of development, when target groups are consulted on programme content and delivery, and when programmes are sustained over the long term. In a global, multilanguage survey of people with lived experience (PWLE) of mental health conditions, 391 people responded from 45 countries and territories. Most (≥70%) participants agreed that: PWLE of mental health conditions should be treated as equal to people with physical health conditions; stigma and discrimination do negatively affect most PWLE; the media are an important factor in worsening stigma and discrimination; the media could play a crucial part in reducing stigma and discrimination; and stigma and discrimination can be worse

than the impact of the mental health condition itself. The commission noted that PWLE are key agents for change in stigma reduction and need to be strongly supported to lead or co-lead interventions that use social contact.

5.4.4 Housing and neighbourhood

Where people live influences their mental health and wellbeing (287). Across various measures of housing disadvantage (including tenure and physical conditions) a consistent effect on mental health has been found (288). A number of studies have shown that improvements to housing, particularly warmth and energy efficiency interventions, can improve mental health and wellbeing (289).

Housing insecurity, such as being behind on payments or moving multiple times, has been shown to affect the mental health outcomes of children (290). Multiple moves also negatively impact on maternal mental health (291).

The neighbourhoods within which people live also influence their mental health outcomes. Evidence from a meta-analysis of a small number of studies indicated that changes to urban environments, such as land use patterns and architectural features, could improve mental health and wellbeing (292). Similarly, a recent study from New Zealand indicates that neighbourhoods in close proximity to negative health producing sites (such as fast-food outlets) had worse mental health outcomes than neighbourhoods nearer to positive health producing sites (such as green and blue space) (293). The positive relationship between access to green space or nature and mental health has been found in a number of studies (294, 295). Valuations for wellbeing and Quality Adjusted Life Year benefits for various aspects of neighbourhoods have been estimated by the UK Government, although these are often specific to England and Wales (241). The evidence relating to neighbourhoods indicates that a “Health in All Policies” approach to improving mental health and wellbeing would extend to planning policies.

Housing First, which is an internationally recognised approach to tackling homelessness for people who have been unable to sustain long-term accommodation, has a well-developed evidence base that indicates that this approach can be beneficial and cost-effective (296-299).

5.5 Measuring what is working in Scotland

Aiming to support regular measurement within Scotland of what is working to improve wellbeing and mental health, PHS recently put together a first set of indicators which could be used to assess changes in mental health outcomes in adults and also in the individual, community and structural determinants of mental health outcomes. They have able to identify appropriate measures and relevant data sources for the majority of these, but there are a number of indicators, particularly relating to the determinants of mental health, for which data gaps exist. These indicators include: adult drug use disorders (although work is in progress to address this); sleep behaviour; supportive family unit/relationships; use of social media; spirituality; institutional trust; racism; and stigma around mental health (300). There is also a PHS indicator set specifically for children and young people, covering both mental health outcomes and the determinants of mental health (301). While data sources are also available for the majority of these, again there are a number of indicators lacking currently collected robust data. These are: mental wellbeing in children under 11; non-fatal deliberate self-harm in

children and young people aged 17 and under; prevalence of eating disorders in those aged 17 and under; maternal alcohol use in pregnancy; maternal exposure to gender-based violence; opportunities for spontaneous play; parent-infant relationship; parental conflict; parent imprisonment; caring experiences of older children; sense of belonging to their community; perception of mental health stigma; use of green/blue/open space; and optimism in society's future.

6.0 Discussion

6.1 Messages from the published data and evidence

Understanding the current situation in Scotland regarding population and individual mental health and wellbeing, and future challenges, is a necessary starting point to inform and shape strategic direction for policy and practice. This evidence narrative has sought to provide the part of this picture that can be drawn from the published data and evidence.

It highlights that it is important to think of mental health similarly to physical health, varying day to day and over the years. Sometimes people will experience periods of being mentally unwell, and for some, as with physical health conditions, they may experience a long-lasting condition. People also experience varying levels of mental wellbeing, relating to how they are feeling and how they are managing and enjoying their life. Neither mental health nor mental wellbeing has a standard definition, yet most people understand what these mean for them. Mental health and wellbeing relate to one another and interact with individuals' physical health, all contributing to the way people feel, think and function day-to-day, and in the long term.

The evidence clearly illustrates the many, diverse and interacting determinants of mental health and wellbeing, with these being driven by structural factors such as unequal distribution of income, power and wealth, global, national and local economic and political forces and priorities, and societal attitudes. The impact of poverty, along with stigma and the pervasive nature of adverse childhood experiences and trauma are seen to be impacting on wellbeing and mental health at an individual and population level in Scotland, and the evidence of how inequalities are being exacerbated by the ongoing effects of the pandemic and cost of living increases continues to emerge. The wide-ranging nature of the determinants of mental health and the interrelationships between them is widely considered to require cross policy action far beyond health to bring about change.

The narrative highlights the large impact of both poor mental health and low levels of wellbeing on individuals, communities and the nation, and concerning trends in these that have been seen over the last decade. It also notes multiple datasets and publications showing unequal distribution of levels of mental health and wellbeing across population groups, and how the ability of individuals and groups to access the support, care and treatment necessary to manage their mental health and improve wellbeing varies.

Amid this picture of increasing wellbeing concerns and growing demand for mental health care and support, the need to improve population level wellbeing and to create sustainable, efficient and safe services and support to meet current and future requirements is consistently

highlighted in the identified evidence. There is increasing international evidence available of what works to increase and maintain wellbeing and how to improve and better support mental health. Both population level and individual interventions are needed to bring about overall improvements.

Greater recognition of the importance of creating the conditions to prevent reduced wellbeing or mental ill health developing or worsening in the first place is considered to be essential. Strong communities, peer support, and enhancing understanding of the nature of wellbeing and mental health and its influences across society, and particularly within the workforce beyond specialist mental health professionals, all support this. Interventions which have the most evidence of effectiveness for promoting wellbeing are focussed on early life and parenting, workplace support, and supporting reduction of unhealthy behaviours. Similar interventions are also seen to be helpful in the prevention of mental ill health and taking action early when problems arise. While it is difficult to demonstrate the cost-effectiveness of preventive interventions, there have been attempts to do this using new methods and evidence is emerging.

For interventions relating to care and treatment, evidence highlights the need to take a life course approach, and to consider the physical health also of individuals with mental health difficulties. Attention should be paid to meeting the different needs of individuals and groups, and for care and support to be effective, it needs to be accessible in the first place. It is necessary to consider new models of service provision, with a spectrum of levels of support, differing modes of access including a greater digital offering, and more provision within communities. Vital to service provision is boosting the workforce and evidence suggests ways to address current barriers challenges to this. There needs to be a raising of awareness of mental health careers, particularly among currently under-represented groups. New roles should be created to complement current ones, and attention should focus on developing and enhancing the knowledge and understanding of wellbeing and mental health, and how to promote these within the wider workforce, beyond those in specialist mental health roles.

A Lancet report published in August 2023, considered a series of major reports which have examined various aspects of the global mental health crisis. Based upon a syntheses of these, the authors recommend a series of changes in mindset, approach and practice that are required to address this. They then go on to specify four policy actions that they suggest can achieve these, to improve mental health and wellbeing internationally. The themes identified and the suggested policy approach align very closely with those identified in this review and the shape of policy thinking within the current strategy development and delivery process in Scotland (302).

6.2 Gaps in the evidence base

To inform the development of effective mental health and wellbeing policy and practice, and in turn, to monitor and evaluate the impact that this makes and learn from this, comprehensive robust data and evidence is essential.

There are particular areas relating to mental health care and wellbeing in which a considerable amount of routinely collected data is available. This tends to reflects current and previous policy priorities. For example, the detailed workforce statistics for NHS CAMHS and psychology professionals, and activity data related to the services provided by these groups. Extensive data is also available covering inpatient bed occupancy and related lengths of stay and discharges.

Other data however that could help to guide decision making is lacking. Earlier sections of this report highlighted that it is difficult to establish how many people in Scotland are currently experiencing particular mental health conditions, and whether these numbers are changing. This is needed to determine current and projected future needs. Prescribing data in terms of volume of prescriptions is readily available, but actual indications for which dispensing is occurring and appropriateness of the prescribing is not. Despite the considerable detail on numbers accessing services whether inpatient or outpatient, there is a lack of research and data to determine to what extent these numbers reflect actual population need, and what is the impact of these services, support and other interventions on clinical and person-centred outcomes. Ensuring best value care and use of public money requires an understanding of the relative costs and benefits of different approaches and interventions. This is lacking and better data is needed in particular in relation to preventive interventions to enable their true value to be understood.

Data, for a variety of reasons, is often not collected in a way that allows sufficient analysis of the differences between socio-economic, geographic and/or protected characteristics groups, and this could be improved. There is room for much more detailed information gathering when it comes to intersectoral evidence, that considers interactions from belonging to different population groups. It would be helpful to see more recording of data regarding protected characteristics, socioeconomic status, experience of trauma and ACES, and of comorbidities.

More interconnection between data across sectors and systems is also required. The recent Scottish Government Health and Care Data Strategy should help to start addressing this (303). To ensure greater consideration of people's overall health, it is important that data regarding physical health is better connected to mental health data.

As well as directly health-related measures and outcomes, data to better understand the deteminants of mental health and what acts on these, is required. This includes in some cases establishing appropriate measures, in others identifying data sources or undertaking new data gathering. It may also require the defining of research studies to fill gaps. PHS is contributing to this work through its mental health indicators programme and also in a proposed new work programme looking at the wider determinants of mental health.

A significant evidence gap highlighted in this narrative review is people's experiences of and perspectives on the services and support available to them. Lived experience evidence such as this contributes to creating evidence-informed policy alongside data and published research. It helps with determining appropriate outcomes measures for research, considering applicability of research evidence in real life, and identifying gaps for further research. It can also serve to challenge dominant paradigms and perspectives, as illustrated by recent qualitative participatory research with service users of a north Glasgow community organisation (304).

While there is a much greater recognition in research and policymaking than before about the value of considering different types of evidence to inform decision making, improvements still

need to be made. The strengths and weakness of each type of evidence need to be acknowledged and their varying degrees of appropriateness to answer different types of question considered. Robust methods need to be used to combine the different types of evidence, and these are not always employed. There is a need for further development of skills and knowledge among those bringing different evidence together to ensure methodologically robust synthesis. Better understanding is needed of how to ensure the appropriate integration of these different evidence types to best inform policy making (305, 306).

As the impact of COVID-19 continues to be felt, more data and evidence will be needed to understand the ongoing and longer term impacts of the pandemic on mental health. A 'living evidence review' has been published in the BMJ which brings together data from 134 individual studies comparing mental health symptoms before and during the pandemic, and this will be updated as new evidence emerges (34).

The growing impact of other global challenges such as climate change also necessitate a need to better understand their implications for mental health and wellbeing (307). As time goes on, the clinical and longer term impacts of the cost of living crisis will emerge and appropriate data gathering and analysis will be required to understand and respond to this.

More explicit consideration and specification of mental health and wellbeing research requirements could help to direct funding and research resource towards filling the data and evidence gaps necessary for informing future policy and practice development. This could for example be in the form of a mental health research strategy, or through building and/or strengthening appropriate networks and enhancing networking. This research and data could contribute to evaluating the implementation and impact of the new mental health strategy.

Emphasised within the published literature around mental health however, is the point that greater knowledge and awareness of which approaches and interventions have the potential to make a difference is only the first step in creating change. These approaches and interventions also need to be implemented as intended, with appropriate support, and then robustly evaluated in local and national contexts to assess whether the anticipated benefits are being realised. The new mental health strategy for Scotland can help to achieve this by driving forward improvements based upon published data and evidence and also people's lived experienced. Also, a key element of the strategy will be the monitoring and evaluation of its implementation and impact, ensuring that the learning from this is taken onboard on an ongoing basis.

7.0 Conclusions and recommendations

The points emerging from the published evidence and data for consideration in the development of an evidence-informed mental health strategy and delivery plans include:

- Considering mental and physical health as equal parts of our overall health
- The importance of our wellbeing alongside our health in determining how we feel and behave
- Mental health and wellbeing are influenced by a wide range of interacting factors

- Poor mental health and wellbeing creates a huge burden at all levels, for individuals, communities, through to society and the economy, and there are concerning trends seen in these in recent years
- Certain groups in society experience worse mental health and/or lower wellbeing than others, as well as unequal access to care, therapy and support
- It is important to create the conditions to promote good mental health and wellbeing, and if problems develop, to stop them worsening by intervening early
- Individual and population level interventions are needed to bring about change, with a' Health in All Policies approach'
- Greater understanding across society of mental health and wellbeing and what can affect these would be beneficial for everyone.
- A life course approach, taking into account individual need is required in considering interventions
- New service models are required to meet growing demand and to reach all that need support
- Essential to service provision and wider improvements at a population level is a strengthened, supported and more diverse mental health and wellbeing workforce with a broader diffusion of mental health knowledge and awareness throughout the health and social care professions
- Better data and evidence to inform policy and practice is required to guide decision making and establish what is working for whom and why. This ensures that individuals and Scotland's population are best supported to achieve optimal mental health and wellbeing and public money is spent effectively to achieve this. To enable delivery and evaluation for the Scottish Government mental health strategy, as well as more generally for mental health policy and practice in Scotland:
    - There needs to be improvements in data and evidence gathering and analysis. This is particularly the case relating to people's care experiences, also evaluating the effectiveness of interventions being delivered in Scotland, and to support economic evaluations. A new mental health care experience survey could be introduced that complements other current health experience surveys.
    - There should be more explicit specification and prioritisation of research requirements alongside greater networking to help direct mental health and wellbeing research efforts in Scotland and ensure that funders and researchers are aware of the data and evidence gaps which most need to be filled to inform policy and practice.

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REVISIONS TABLE

	Date	Changes
First Published 1.0	07/11/2023	Update 1.0

How to access background or source data

The data collected for this social research publication:

☐ are available in more detail through Scottish Neighbourhood Statistics

☒ are available via socialresearch@scotland.gsi.gov.uk

☐ may be made available on request, subject to consideration of legal and ethical factors. Please contact <email address> for further information.

☐ cannot be made available by Scottish Government for further analysis as Scottish Government is not the data controller.