A Review of Scotland's National Programme for Improving Mental Health and Wellbeing

2003 – 2006

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A Review of Scotland's National Programme for Improving Mental Health and Wellbeing

2003–2006

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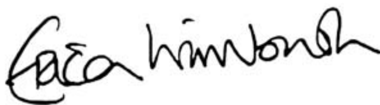
Foreword

Since *Improving Scotland's Health: The Challenge* (2003), Health Scotland was tasked with coordinating the evaluation of health improvement policy in Scotland. In taking this forward, the policy review series was launched as a key driver to support an evidence-based contribution to the development of existing health improvement policies and engage influential and respected experts from outside Scotland in the process of improving Scotland's health.

The policy review process is in itself innovative and a relatively new approach to policy evaluation in Scotland. The Scottish Diet Action Plan review (2006) was the first such review coordinated by a secretariat in Health Scotland. The National Programme for improving Mental Health and Wellbeing was launched in 2001, and since then, has been working locally and nationally to raise the profile and support further action in mental health improvement in Scotland. Its first action plan came to an end in 2006, and this provided an important opportunity for the second review.

There are several features of the policy review process that we regard as centrally important. Firstly, that the reviews are timely and achieve good fit with the policy decision making timetable. Secondly, that the reviews combine both formal evaluative evidence and information but also provide a space for reflection and learning for those involved in the policy implementation process. In this way, the review process becomes part of the evolution of the next phase of policy.

Throughout the past months, many people working directly with the National Programme or who were aware and interested in the Programme's work have given their time to participate in the review process. We would like to extend our thanks to everyone who has taken part and hope that this report will prove to be a useful and interesting reflection of their contribution. Finally, we would like to give our sincerest thanks to the review panel, Professor David Hunter (chair), Professor Margaret Barry and Dr Andrew McCulloch and also Annabelle May (writer to the panel) whose hard work and expertise went into producing this report.



Dr Erica Wimbush

Head of Policy Evaluation and Appraisal, Health Scotland
and Editor of the Policy Review Series

Executive summary

Scotland's National Programme for Improving Mental Health and Wellbeing was launched in 2001 and forms part of the Scottish Government's wider policy on improving Scotland's health and reducing health inequalities. The National Programme was the first step towards trying to change Scotland's record of mental health problems at a time when Scotland's suicide rate was on the rise and depression and anxiety were (and remain) the third and fourth most common conditions reported in GP consultations.

The vision of the National Programme is to improve the mental health and wellbeing of people living in Scotland and to improve the quality of life and social inclusion of those who experience mental health problems. The Action Plan for the first phase (2003–2006) set out four main aims and six priority areas which have been implemented via a number of major national initiatives and a range of support activities as well as by seeding many other smaller projects, posts and ideas.

The purpose of this independent review of the National Programme was to examine progress in achieving the aims set out in the Action Plan (between 2003–2006), to assess its influence and impacts, and to arrive at conclusions that could inform the future direction of policy on mental health improvement in Scotland.

The review was conducted by an independent expert panel comprising

- Professor David Hunter (chair), Professor of Health Policy and Management, Durham University
- Professor Margaret Barry, Professor of Health Promotion and Public Health, Department of Health Promotion, National University of Ireland, Galway
- Dr Andrew McCulloch, Chief Executive, Mental Health Foundation

Progress, influence and impacts

A key feature of the National Programme was its perceived success in attracting a significant level of new investment into the field of mental health and wellbeing. The panel was struck not only by the range and diversity of the work, but also the energy, enthusiasm, imagination and creativity shown. It was also acutely aware that the National Programme was complex in respect of its ambition and goals and that the period under review was comparatively short. It will take many years for the Programme's aims to be fully achieved.

Raising awareness and promoting mental health and wellbeing

Raising awareness of the need for good mental health and wellbeing among the general public was a key aim of the National Programme. Its main communications vehicles for achieving this were: a website developed as an online public resource, the *Well?* magazine as a forum for debate on mental health issues, developing media relations, and delivering Scotland's Mental Health First Aid, a mental health literacy training programme available to the general public, workplaces and others.

The anti-stigma campaign See Me has also been striving to change public and media awareness and attitudes to mental health and illness.

The panel concludes that the National Programme has not only raised awareness within government, but also served to inform MSPs and the service community. Despite these positive impacts, there remains much work to be done in relation to the issues of inequalities and diversity.

Eliminating stigma and discrimination

The See Me campaign is the National Programme's main way of tackling the stigma about mental illness evident in media reporting, public attitudes, the workplace and among service users, patients and their families. Over 1,000 people have signed up to its Stigma Stop Watch and many local organisations and groups now use See Me as an umbrella for their own stigma work. The panel considered that positive shifts in attitudes may represent an improvement in public perception and that See Me could have helped to reduce stigma. Choose Life developed a practical guide for journalists on the reporting of mental health and suicide by the media. Findings from the national public attitudes survey have shown a significant rise in public awareness of media reports and advertisements relating to mental health.

The panel's assessment of the anti-stigma campaign is that it was well run and might have contributed to positive trends in public attitudes but that it now needs to be woven into the other activities that are in hand.

Preventing suicide

Choose Life was established in 2002 within the Scottish Government as a key vehicle for addressing the rising suicide rate with an ambitious national target set by the Cabinet to reduce the rate by 20 per cent by 2013. Echoing the findings of the evaluation of its first phase, the panel concludes that while there has been a great deal of learning about how to develop the infrastructure it is not possible to attribute the current decline in the suicide rate since 2002 to a single initiative.

While not dedicated to suicide prevention, Breathing Space contributes to this goal and was funded by the National Programme in 2002 to provide a free, confidential listening service for people to call when they are anxious or depressed. It is now an integral part of NHS24. While evaluated as a much-needed and good quality service, its impact is unclear due to the lack of follow-up of referrals.

Promoting and supporting recovery

The Scottish Recovery Network is a loose network of organisations and individuals who are promoting, supporting and interpreting recovery from long-term mental health problems. The Network includes people who have experience of long-term mental health problems, their families, friends and carers, and those involved in providing services.

The panel felt that the work on recovery had been taken forward intelligently and had 'struck a chord', giving the service sector a new sense of direction.

Children and young people

The National Programme has had a positive influence in the education sector, raising awareness of the importance of mental health and making mental health improvement a more explicit part of work with children and young people. Key actions include promoting emotional wellbeing in the school setting through the Scottish Health Promoting Schools Unit, providing stimulus via HeadsUp Scotland which was seen as a catalyst for integrating and supporting the mainstreaming of local work on children's and young people's mental health, and engaging with the Further Education Unit on the increasingly pressurised student environment.

A clearer lead on mental health in infancy, early years and parenting is suggested by the panel. A stronger focus on building the confidence and capacity of frontline workers is also recommended, including those working with marginalised young people and those with special needs.

Employment and working life

The National Programme provided an important impetus for a wide range of new work on improving mental health and wellbeing in employment and work settings. The emphasis has been on promoting mental health at work, enabling and supporting people to remain in work, and helping to improve the employment opportunities for people with mental health problems. The principal delivery vehicle for this work has been the Scottish Centre for Healthy Working Lives.

The panel concluded that the National Programme had brought a renewed sense of purpose to this area, in particular the focus on early intervention to help people stay in work rather than to help people get back to work.

Community health and wellbeing

The National Programme has spawned an extensive programme of work on community wellbeing and has had influence over the Scottish Government's work on culture and arts through projects like Artfull. The main challenges for this area of work were seen as the issue of cultural diversity in Scotland, developing leadership in the area of ethnic minority mental health, and embedding user involvement in service design and delivery.

Later life

The National Programme's work on later life issues was reported to be minimal and relied mainly on Health Scotland's later life programme. The need for greater focus on older people, and a more integrated and intergenerational approach across initiatives was strongly expressed, especially in the areas of suicide prevention and mental health promotion. The panel recommends that a future priority for the National Programme should be a more inclusive approach in respect of an ageing population.

Public services

The National Programme has been working to change service provider mind sets. This work is mainly focused on community health and primary care services through

the work on Doing Well by People with Depression. Service issues in primary care were a key area for future action identified via the online survey of stakeholders.

Outside of Choose Life, less progress has been made with changing local government services despite their centrality to the effective mainstreaming of mental health improvement. It was presented to the panel that local and national decision makers still tend to regard mental health as primarily relating to psychiatric and/or mental illness services. This remained the case despite the influence the National Programme had on legislation introduced in 2003 which placed a duty on local authorities and their partners to provide services designed to promote the wellbeing and social development of those with a mental disorder.

Broader public policy and mental health

The impact of social policies relating to social exclusion, housing, employment, education and welfare benefits on people with mental illness and on the practice of health promotion is probably far greater than the impact of health policy. The National Programme has made important inroads into influencing policy across government and outside of health. The panel recognises the huge challenges faced in achieving coherent, cross-government policies on mental health improvement.

Key issues arising

The panel concludes that the prioritisation of, and investment in mental health improvement in Scotland through the National Programme has brought about a number of important changes including the following:

- Scotland is now known in WHO and the European Union as an exemplar of policy development and implementation in public mental health and has influenced policies in other countries
- mental health improvement is no longer viewed as a marginal aspect of health policy and services
- the National Programme has helped inject new energy into mental health policy, releasing a considerable amount of creativity, commitment and enthusiasm; mental health improvement is now seen as an area of innovation and as fostering new possibilities for change
- the National Programme has provided an important focal point within the Scottish Government in terms of its role as a source of help, support and information on mental health improvement
- the National Programme has demonstrated a commitment to developing an evidence-based approach to mental health improvement through its portfolio of research and evaluation, the development of new indicators, communications work, training and capacity-building workshops.

Areas where the National Programme is facing challenges were identified by the panel as follows:

- a powerful guiding coalition is needed to replace the National Advisory Group and to communicate the vision to frontline staff and empower others to act on the vision
- weaknesses related to cross-government working that have created problems for the frontline agencies charged with policy delivery and implementation
- the location of the National Programme within the Scottish Government, and within the Mental Health Division, may pose problems in terms of mainstreaming the programme
- the integration of National Programme initiatives with existing programmes and organisations to avoid overlap and add value, and greater collaboration and cross-fertilisation between initiatives
- further application of the existing evidence base and implementing more of the lessons and models of best practice currently available
- ensuring that in future evaluation (which has generally focused on individual initiatives) is part of continuous quality assessment
- a greater emphasis on user/consumer involvement
- development of a sustainable workforce development strategy
- addressing important gaps, notably inequalities, cultural diversity and gender issues.

Key priorities for phase 2

The panel believes that the National Programme remains necessary but that it needs to become more embedded in policy and practice at national and local levels. In particular, a shift of emphasis is needed from the 'broad-brush' approach of phase one to a more prioritised approach focused on a few priorities.

The panel's key priorities for the next phase of the National Programme are:

- *model of change.* The panel supports the proposed shift from transformational to transactional change
- *a powerful guiding coalition.* To sustain wide support for the National Programme, a high level guiding coalition needs to be put in place which would bring together key stakeholders
- *a shared vision of positive mental health.* The model of positive mental health adopted needs to be systematically refined, shared and developed with the key stakeholder groups; a clear and adequately resourced national communications strategy is an essential component of embedding the vision in the next phase
- *developing a common language.* The National Programme should facilitate multidisciplinary discussion and experiential learning to develop a common language and common understanding of mental health and wellbeing; the process needs to be embedded in the National Programme's training and learning experiences

- *joining up the agendas of mental health improvement and service development.* While Scotland is now a world leader in the development of mental health improvement policy, its mental health services are relatively institutional in comparison with a number of other countries. The need is to align the service improvement agenda with the mental health improvement programme
- *evidence-based practice* should continue to play a critical role in demonstrating the outcomes and added value of mental health promotion. The National Programme has an important role to play in advancing the implementation of best practice in local settings
- *strategic planning of priority actions employing an evidence based approach.* Strategic planning for the next phase needs to be based on findings from existing evaluations, systematic application of the international evidence base, consultation with stakeholders, local needs assessment, and the knowledge of practitioners and implementers
- *building workforce capacity.* A public health workforce 'fit for purpose' is critical in the next phase of the National Programme if the focus is to be on implementation and delivery. The technical skills and competencies required to support programme activities need to be put in place in order to build capacity for effective delivery into the future
- *leadership and management.* The leadership challenge in mental health is a complex one and demands a sound grasp of change management principles and skills. Initiatives like the leadership for health improvement programme launched by Health Scotland in March 2007 with support from NHS Education for Scotland are therefore welcomed
- *health inequalities.* This demands much greater attention. They are a 'wicked problem' in all aspects of health policy, including mental health. Poor mental health is both a cause and a consequence of social, economic and environmental inequalities. Multi-level intersectoral action is required that will address the structural determinants of mental health.

Health Scotland coordinated this policy review and provided the professional secretariat for the panel, gathering together new and existing information and evidence and organising meetings with stakeholders. The full report, along with details of the policy review programme and summaries of the evidence collected are available on the Health Scotland website:

http://www.healthscotland.com/scotlands-health/evaluation/policy-reviews/review-national-programme.aspx.

Further information about Health Scotland's other policy evaluation work is also available via these pages.

Acknowledgments

The compilation of this report would not have been possible without the cooperation and support from a large number of people working in a wide range of mental health services and organisations related to mental health improvement in Scotland. The panel therefore wishes to extend its sincere thanks to all of these individuals and organisations. The list embraces everyone who responded to the call for written and oral evidence; those who attended the panel hearings and gave so generously of their time sometimes on more than one occasion; and all those who took part in the stakeholder event in Edinburgh held towards the end of the evidence gathering stage of the review. We were struck by the desire and enthusiasm among many people and organisations to contribute to the review. Their efforts have been greatly appreciated and have contributed considerably to the panel's thinking and final conclusions.

In particular, the panel wishes to offer its sincere thanks to Jill Muirie, Emma Halliday and Erica Wimbush, and to Jenny Shiell. They comprised the secretariat at Health Scotland who served and supported us so ably throughout the review, ensuring that we saw everyone we needed to see and had access to every key document. Our deep thanks also go to Annabelle May, writer to the panel, who had the unenviable task of marshalling a huge amount of material into a manageable and, we hope, readable report. All of these individuals have made a significant contribution to the panel's deliberations and final report. But, as ever, final responsibility for the report remains ours and no-one else's.

Finally, we must thank all those active in the National Programme for Improving Mental Health and Wellbeing for their cooperation throughout the review. It takes courage and confidence to open up and expose an area of policy to outside scrutiny especially when the future status of an important initiative in a sensitive area of policy may be uncertain. This is especially the case in a country whose political structures are still new and evolving. However, such a context offers great opportunities and we regard the timeliness of the review as a major factor in offering hope for a sound future for mental health improvement.

The panel hopes that its report will be of assistance to those charting the next phase of mental health improvement work in Scotland. Our conclusions and priorities for the future are intended to be used in the journey ahead.

David J Hunter
Margaret Barry
Andrew McCulloch

January 2008

Acronyms

ADHD	Attention-Deficit Hyperactivity Disorder
ASIST	Applied Suicide Intervention Skills Training
BME	Black and Minority Ethnic
CBI	Confederation of British Industry
CHP	Community Health Partnership
COSLA	Convention of Scottish Local Authorities
CPP	Community Planning Partnership
DWBPWD	Doing Well By People With Depression
ESRC	Economic and Social Research Council
FE	Further Education
HE	Higher Education
GHQ12	General Health Questionnaire
GP	General Practitioner
GROS	General Register Office for Scotland
HEBS	Health Education Board for Scotland
HI	Health Improvement
IB	Incapacity Benefit
MSP	Members of the Scottish Parliament
NAG	National Advisory Group
NES	NHS Education for Scotland
NHS	National Health Service
NIST	National Implementation Support Team
NRCEMH	National Resource Centre for Ethnic Minority Health
PHIS	Public Health Institute of Scotland
SAMH	Scottish Association for Mental Health
SEHD	Scottish Executive Health Department
SHAW	Scotland's Health at Work
SIREN	Suicide Information Research and Evidence Network
SME	Small and Medium-Sized Enterprises
SMHFA	Scotland's Mental Health First Aid
SNP	Scottish National Party
SRN	Scottish Recovery Network
STUC	Scottish Trades Union Congress
UK	United Kingdom
WEMWBS	Warwick-Edinburgh Mental Wellbeing Scale
WHO	World Health Organization

1 Introduction and background

1.1 Why a review?

Launched in October 2001, the National Programme for Improving Mental Health and Wellbeing (the National Programme) forms a key part of the then Scottish Executive's wider policy agenda to improve Scotland's health, address inequalities and achieve social justice[1].

Most people will experience mental ill health during their lifetime whether diagnosed or not, and everyone's life will be affected by mental illness. However, mental health problems disproportionately affect the most disadvantaged groups in the community (Scottish Executive 2003a). The vision of the National Programme is to improve the mental health and wellbeing of people living in Scotland and to improve the quality of life and social inclusion of those who experience mental health problems. By pursuing this vision and by working to mainstream mental health into core health improvement work, the National Programme aims to improve the mental health of all in Scotland.

Four main aims and six priority areas for activity for the first phase were set out in detail in the National Programme Action Plan (2003–2006) published in 2003 (Scottish Executive 2003b); see the Key Initiatives section of this report. As well as aiming to evaluate individually the range of actions and initiatives making up the Programme, the Action Plan contained a commitment to evaluate the National Programme as a whole as part of Scotland's broader work on its health improvement policy.

The purpose of this review of the first phase of the National Programme was to examine progress in achieving the aims set out in its Action Plan, and on the basis of the wide range of evidence reviewed, to arrive at conclusions that could usefully inform both the future strategic direction of mental health improvement policy in Scotland and its impact on practice and on public mental health as a whole.

1.2 Terms of reference

These were agreed by the panel and secretariat as follows:

- to review progress in the implementation of mental health improvement policy between 2003 and 2006 – the review will consider whether the implementation of the National Programme locally and nationally has been carried out as planned and what factors have helped/hindered this

[1] During the period of taking evidence for this review, the government of Scotland was known as the Scottish Executive, and to avoid confusion it is accordingly characterised as such in Sections 1–4 of this report. Following the elections of May 2007, it was renamed the Scottish Government. When future directions for the National Programme are discussed in Section 5, it is referred to by the current name.

- to review the impacts and outcomes of current Programme influence and implementation – to what extent has the National Programme and a range of linked delivery agencies and initiatives been effective in raising the profile of mental health and wellbeing in Scotland? To what extent have they influenced the agenda of other organisations?
- to identify the strategic areas of action required to continue and strengthen the policy goal of improving Scotland's mental health and wellbeing and reducing mental health inequalities.

1.3 Approach to the review

This is the second in a series of reviews of health improvement policy in Scotland coordinated by Health Scotland. In common with the first, *A Review of the Scottish Diet Action Plan* (Lang *et al* 2006), the approach adopted was based on the methodology used in the evaluation of Australia's National Mental Health Strategy published by the Australian government in 1997 (National Mental Health Strategy Evaluation Steering Committee 1997). In the present review, the process was adapted both to the demands of the timescale and to the particular circumstances in Scotland.

Any review of Scotland's policy on improving mental health and wellbeing could potentially cover a wide range of issues related to a number of areas of government apart from health: housing, employment, crime, transport and education, for example. The post-devolution document, *Our National Health: A Plan for Action, A Plan for Change,* identified poverty, poor housing, homelessness and '*the lack of educational and economic opportunities [as] the root cause of high inequalities in health in Scotland'* and stressed that it would be necessary *'to fight the causes of illness as well as illness itself'* (Scottish Executive 2001). But as it was important that the conclusions of the present review should usefully inform strategic decisions about future policy on mental health improvement in Scotland, clear boundaries were set at the outset and the terms of reference were agreed accordingly.

Collecting evidence and information in this area can be challenging, as it is acknowledged that there are significant gaps in knowledge and understanding. As Wanless notes in respect of the wider public health field, much of the evidence is weak, especially effectiveness evidence, and this is an area where investment in further research is needed (Wanless 2004). However, Platt *et al* (2005) have offered a list of effective interventions under different 'categories' such as social support, the family, housing, and education. There is also a growing international knowledge base on effective mental health promotion interventions that can be successfully implemented with diverse population groups across a range of settings (WHO 2004a, 2004b; Herrman *et al* 2005; Jané-Llopis *et al* 2005; Hosman and Jané-Llopis 2006; Barry and Jenkins 2007). Commissioning a research programme and developing an evidence base have been an important part of the National Programme's agenda for support activities, although many of these projects are still in their early stages.

A further challenge in conducting the review was a lack of explicit outcomes set for the National Programme in phase 1 against which to assess success (see also 4.1).

1.4 Summary of the review process

Involving key stakeholders

Key stakeholders were involved from the outset. In August 2006 the Secretariat began a series of meetings to discuss the approach, to identify relevant sources of existing information, and to explore views and experiences prior to the first meeting of the review panel itself in November 2006. These opinions and experiences were vitally important in helping to understand the work in this area since 2001, and put it into context, particularly in the areas of implementation and impact.

Online survey

In November and December 2006 a brief online survey was circulated in order to explore perceptions about change and to gauge views on future priorities. This went out to a range of local and national stakeholder organisations including local and national government, especially social work and education; health promotion and healthcare services; voluntary organisations; user and carer groups; National Programme staff; and staff from related initiatives (the proforma is reproduced at Appendix E). A total of 522 responses were received and analysed.

Existing information and evidence

National policy documents, data on population trends and evaluation reports were collected together and reviewed, using advice from experts in Health Scotland, the Analytical Services Division of the Scottish Executive and the Scottish Development Centre for Mental Health.

Evaluation reports

Details of evaluations of individual components of the National Programme, local evaluation reports and other relevant research, either completed or in progress, were collated by Health Scotland and made available to the panel.

Focus groups

A series of in-depth focus groups were commissioned and conducted in March and April 2007 to explore with local planning partners how policy was implemented at a local level, the challenges they faced in doing this, and their views on the future direction of policy in this area. These took place in the NHS Board areas of Highland, Greater Glasgow and Clyde and the Borders. The majority of participants came from a range of professional settings and had a mix of different professional remits and backgrounds including health promotion, clinical services, and research and evaluation. Other participants included those working in the community, voluntary agencies, social work, education, and in mental health charities. A further six focus groups took place with representatives from networks linked to the National Programme's priority areas. These examined the extent to which the importance of promoting good mental health and preventing mental ill health in relevant settings and communities in which participants live and work was now understood and their views on the future direction of policy in this area.

International perspectives

In the context of international shifts in mental health policy it was important that the review should be informed by an international perspective. The aim was to understand how the work to improve mental health and wellbeing in Scotland is viewed by others working in this field internationally; and which aspects of Scotland's National Programme had been influential on work elsewhere in the UK and internationally. Six telephone interviews were carried out with key informants in March and April 2007. A subsequent brief electronic survey yielded eight further responses (See Appendix F). Overall, these included responses from the European Commission, WHO, Finland, Norway, the UK, Italy, Lithuania, Hungary, the US, Australia and New Zealand.

Review panel meetings

In addition to the sources of evidence described above, a number of key stakeholders were identified and invited to meet with the review panel to discuss their experiences and perceptions in more detail. Many other individuals and organisations sent written submissions (see Appendix G). In some cases, people asked to meet and speak with the panel, and these requests were accommodated as far as possible. Between November 2006 and April 2007, the panel met with 80 people over 11 days of hearings. These hearings – themed sessions on policy context, public health evidence, life stages, communities and services – formed part of the review panel meetings, and added depth and context to all the other information gathered. All the organisations and agencies that contributed to the review are listed at Appendix C.

Stakeholder engagement event

In May 2007, 84 people (61 stakeholders, plus facilitators, the panel, organisers and scribes) attended an all-day event at Our Dynamic Earth in Edinburgh, where the panel presented their emerging findings to stakeholders from all sectors who had contributed in various ways to the review process. The presentation was followed by a general discussion on the issues raised, and views were sought on the way forward for mental health improvement policies and practice in Scotland. The feedback from this event was taken into consideration in writing this report.

1.5 The structure of the report

The report is divided into five further sections. Section 2 looks at the policy background in post-devolution Scotland, and at how the National Programme was developed as part of a wider health improvement strategy. Section 3 describes the progress made in implementing the National Programme's first phase aims and priorities, while Section 4 focuses on its overall impact. Section 5 summarises the panel's views on the current findings and suggests some areas for future action. The panel's overall concluding reflections and priorities for the next phase of the National Programme can be found in Section 6.

The report does not attempt to summarise the wide range of evidence considered as part of the review. Instead, it presents the panel's findings and observations on the issues described in the Terms of Reference, informed by the review process described above. Anonymised summaries of the following can be found on the Health Scotland website at

http://www.healthscotland.com/scotlands-health/evaluation/policy-reviews/review-national-programme.aspx

- the online survey of stakeholders
- written submissions
- the international interviews and survey
- focus groups held with NHS Board areas and National Programme networks
- the May 2007 stakeholder engagement event.

2 The policy context

2.1 Introduction

This section outlines the policy background in the light of the health improvement challenges facing post-devolution Scotland, and describes how and why the National Programme was developed as part of Scotland's wider health improvement strategy. It briefly reviews the changes in the structure of government introduced following the Parliamentary elections in May 2007. While these occurred after the panel had stopped formally taking evidence, they are highly relevant to the future of the National Programme. Finally, it considers how Scotland's approach to improving mental health and wellbeing aligns with international thinking in the field.

2.2 Devolution and the health challenge

The 1998 Scotland Act established the Scottish Parliament, and transferred responsibility for 'devolved matters' including health, education, environment, agriculture, justice, local government and housing to Edinburgh. Other areas, including defence, foreign affairs and national security, employment, social security and drug issues remain 'reserved matters', and are dealt with by the UK Parliament.

In 1999, the Scottish Executive replaced the Scottish Office as the devolved government of Scotland. At the time of this review, the Scottish Executive was made up of nine departments, and contained 17 Executive agencies. Following the May 2007 election, which resulted in a new government led by the Scottish National Party (SNP), a number of significant changes have been introduced affecting the organisation of the Scottish Executive.

In 2005, Scotland's then First Minister, Jack McConnell, wrote that devolution and the creation of a Scottish Parliament had given the country and its people a reinvigorated voice. It had enabled the devolved government to reflect the ideas and aspirations of all citizens, and allowed Scotland to deliver distinctive solutions to its own problems (Scottish Executive 2005a).

The opportunity for Scotland to set its own direction also presented what the Executive described as the 'health challenge'. A series of research reports that aimed to interpret Scotland's health in an international context shows that Scotland had poor health by both UK and European standards. They also revealed high levels of health inequality between deprived and affluent areas, and significant differences between urban and rural communities (Levin and Leyland 2006). If the countries of the United Kingdom were regarded as separate entities, then life expectancy in Scotland would, for women, be the lowest in the European Union, and for men, the second lowest after Portugal (Leon *et al* 2003).

Further investigation of these figures revealed that Scotland's overall poor position was driven to a considerable extent by the very high mortality among adults of working age. The effects of tobacco smoke (through passive and active smoking), alcohol and the Scottish diet were identified among the priority areas for intervention. Public health policy in Scotland had already identified mental health as an integral part of the wider agenda for health improvement set out in *Towards a Healthier Scotland* (Scottish Executive 1999; see Table 1, pp 25–26). Mental ill health is both a direct cause of mortality and morbidity and an intermediate determinant of much physical morbidity and mortality, for example, in heart disease, diabetes and cancer.

2.3 Mental health in Scotland

In 2006, a statistical summary of population trends in mental health records depression and anxiety as the third and fourth most common conditions reported in GP consultations in 2003–2004. The number of prescriptions for antidepressants had increased from 1.16 million in 1992–1993 to 3.48 million in 2004–2005, with the estimated daily use of these drugs in the population aged 15 to 90 increasing in the same period from 1.9 per cent to 8.3 per cent. The Scottish Health Survey includes use of the General Health Questionnaire (GHQ12), which contains 12 questions relating to psychosocial health, the standard measure of mental distress and psychological ill-health, where scores are ranked from 0–12 and a score of four or more indicates the possible presence of psychiatric disorder whereas in contrast zero could be considered an indicator of psychological wellbeing. While the proportion of men with high scores remained constant over time at 13 per cent, women's scores showed a slight decline: from 19 per cent in 1995 to 17 per cent in 2003. There has, however, been a marked increase in those with zero scores, with men increasing from 60 per cent to 68 per cent in 2003, and women increasing from 55 per cent to 61 per cent in the same period (Scottish Executive Statistics, 2006).

The *Well? What Do You Think?* survey in 2006 included the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) that is designed to measure positive mental wellbeing. On the basis of responses to WEMWBS, 14 per cent of respondents were classified as having 'good' mental wellbeing, 73 per cent as having 'average' mental wellbeing, and 14 per cent as having 'poor' mental wellbeing (Braunholtz *et al* 2007). The survey reinforces the importance of strong social networks in promoting positive mental health and reports an association between high WEMWBS scores and both low deprivation and satisfaction with neighbourhoods (see also 3.10 for detail of the *Well? What Do You Think?* survey).

Scotland has a higher rate of suicide than the other UK countries, with rates in the deprived areas double those in more affluent communities. In 1995 Scotland's suicide rate was over 50 per cent higher than the UK as a whole, and in 2001 it was twice that of England (quoted in Levin and Leyland, 2005; 2877). Suicide in Scotland was on an upward trend from 1995 to 2002 but since then the figures have dropped from 899 in 2002 to 763 in 2005, with three times more men in the age range 25–44 taking their own lives than women (ibid 2006).

The Scottish Association for Mental Health (SAMH) has shown that apart from the wider implications for society, the impact of mental health problems on Scotland's economy is considerable. Their analysis estimates the social and economic costs of mental health problems at £8.6 billion, nine per cent of Scotland's GDP: and more than the total amount spent by the NHS in Scotland on all health conditions combined (SAMH 2006). In 2002, for example, 40 per cent more per head was spent on antidepressant prescriptions than in England (Levin and Leyland 2005). In addition, a recent report on trends in incapacity benefit (IB) in Glasgow found that mental health problems accounted for 50 per cent of the 61,850 people claiming IB, while 16.4 per cent of these claimants were of working age (Glasgow Centre for Population Health 2007).

2.4 Scotland's population

During the 1980s, Scotland's population experienced a small but steady decline. At the time of writing, the most recent projections from the Government Actuary's Department estimate that the population of Scotland will increase until 2019 but then fall below 5 million in 2036. This contrasts with projections for the UK as a whole, where the population is expected to increase (GROS 2006).

Recent figures from the Scottish Executive confirm that the population is ageing: between 2004–2031 the average age in Scotland will increase from 40 to 45. The percentage of children and young adults is projected to decrease, while the number of males over 65 will increase by 70 per cent.

Ethnic minorities currently make up 2 per cent of the population. Between 1991–2001, while the total population increased by 1.3 per cent, Scotland's ethnic minority population increased by 62.3 per cent (Scottish Executive 2007).

2.5 The development of Scotland's health improvement policy

The devolved responsibility for health offered an opportunity to develop approaches to health care and public health appropriate to the Scottish situation. Since 1999, the Scottish Executive has committed itself to a 'whole government' approach to health improvement, and mental health policy must be viewed in this wider context (Scottish Executive 2006a).

In a series of policy documents, the Executive has made a clear commitment to improving health and to shifting the emphasis away from ill health towards an approach that focuses more on prevention and health improvement (see Table 1 opposite). As part of that commitment, and aligned with the Executive's strategies for promoting social justice and closing the opportunity gap, there is a particular emphasis on tackling health inequalities as the 'overarching aim' of the health improvement agenda.

Table 1: The development of health improvement policy (1999–2006)

Year	Policy
1999	*Towards a Healthier Scotland* Marked the first cross-government commitment to health improvement and remains Scotland's public health strategy.
1999	*Social Justice: A Scotland Where Everyone Matters* Recognised the close links between poor health and disadvantage and set out long-term plans to address poverty and promote social inclusion.
1999	*Tackling Drugs in Scotland: Action in Partnership*
2000	*Our National Health: A Plan for Action, A Plan for Change* Included a commitment to a national anti-stigma campaign; pledged to address 'unacceptably high' suicide rates through a national framework; established a mental health and wellbeing support group.
2002	*Plan for Action on Alcohol Problems*
2002	*Fair for All* Report of an audit of health boards' and trusts' policies and practices towards black and minority ethnic groups. The National Resource Centre for Ethnic Minority Health (NRCEMH) founded by the Scottish Executive to support NHS Scotland and NHS Boards in providing culturally competent services, promoting race equality and delivering the minority health agenda. NRCEMH is hosted by Health Scotland.
2003	*Health Improvement: The Challenge* launched Included work on stigma, suicide and mental health promotion and announced that a three year action plan would be launched later in the year on mental health improvement.
2003	*The National Programme to Improve the Mental Health and Well Being of the Scottish Population: Action Plan 2003–2006.*
2003	*Partnership for Care: Scotland's Health White Paper* Set out vision for Scotland in 2020. Four cross-cutting priority areas identified for action: early years, teenage transitions, employment and working life, and communities. Included mental health and wellbeing as a special focus programme.

2003	Directorate for Health Improvement set up within the Scottish Executive Health Department (SEHD) to coordinate policies across government as well as coordinating the delivery of national strategies on diet, physical activity and mental health. Through merger of the Health Education Board for Scotland (HEBS) and the Public Health Institute Scotland (PHIS), NHS Health Scotland was established as a new national NHS board responsible for health improvement and public health.
2003	*Let's Make Scotland More Active. A Strategy for Physical Activity.*
2004	*Closing the Opportunity Gap* Sets out detailed objectives and 10 headline targets for addressing poverty, disadvantage and health inequalities.
2004	*Eating for Health: Meeting the Challenge*
2005	*Building a Health Service Fit for the Future (the Kerr Report)* Professor David Kerr's report, backed by MSPs and unions, focused on the need to separate planned and unscheduled care, shifting the balance of care away from hospitals and advocating new ways of working in child and maternal health.
2005	*Delivering for Health* In response to the Kerr Report, advocated a more proactive approach in the form of anticipatory care and prevention and a wider effort to improve health and wellbeing, through support for self care, greater targeting of resources on those at greatest risk, and joint working between the NHS and the new Community Health Partnerships (CHPs) and Community Planning Partnerships (CPPs).
2006	*Delivering a Healthy Scotland: Meeting the Challenge* Health Improvement in Scotland Annual Report.
2006	*Delivering for Mental Health*

All the above documents can be found on the Scottish Government website at www.scotland.gov.uk

2.6 Scottish policy on mental health and the emergence of the National Programme

A landmark in the early development of Scotland's policy on mental health improvement was a major conference held in November 1999 on 'The Sorrows of Young Men' (Morton and Francis 2000). It was designed to raise awareness among policy-makers and practitioners and generated considerable media interest. Suicide emerged as a priority public health and public policy issue, with the trends among young to middle-aged adult men arousing particular concern.

In April 2000, during a debate in the Scottish Parliament, the then Deputy Minister for Community Care expressed his determination to take measures to tackle the issue. The Executive felt that action was needed across government. The start of the formal developmental process began in November 2000 with a consultative seminar and continued through 2001 (Platt *et al* 2006).

Our National Health (2000) endorsed the principles of the Framework for Mental Health Services in Scotland (1997) as a framework for multi-agency planning, involving health, social work, housing agencies and voluntary sector partners to provide a modern comprehensive range of mental health services. The Framework is regarded as a 'live' document, and it is updated in response to latest thinking and policy advances. Our National Health was the first time that Scottish health policy stated that it would look at positive mental health addressing stigma and suicide.

The Scottish Executive Public Health Policy Division secured £2.1 million for public mental health for 2001–2003. Scotland's Health White Paper, Partnerships for Care (2003), and the subsequent framework for action on health improvement, *Improving Health in Scotland: The Challenge* (2003) both included a commitment to establishing a three-year action plan for the National Programme in 2003–2006.

The National Programme itself was launched in October 2001. Minutes documenting meetings held in the early days of the National Programme indicate that the Public Health Division of the Scottish Executive held a meeting to discuss the promotion of mental health and wellbeing, including *'a proposal for a national development process'.* Draft proposals for a national campaign emerged. It was also suggested that a national steering group should be established with a wide range of membership. In October 2001, Malcolm Chisholm, the then Minister for Health and Community Care, announced plans to set up a National Advisory Group (NAG) that would bring together key interests from a range of organisations with a part to play in mental health improvement. Funding was made available, and a small project team was formed to take the work forward. Policy responsibility was located in the Scottish Executive Health Department's Public Health Policy Division which was also leading on the development of new mental health act legislation.

In addition to the National Programme, the Scottish Parliament passed legislation to reform mental health law. The Mental Health (Care and Treatment) (Scotland) Act

2003 came into effect in October 2005. (The law is based on a set of principles that should be taken into account by anyone involved in a person's care and treatment). Influenced by the National Programme, Sections 25, 26 and 27 place a duty on local authorities and their partners to provide services designed to promote the wellbeing and social development of those who have or have had a mental disorder, giving people the opportunity to live lives that are as normal as possible.

Since April 2003, there have been various changes in the arrangements for the organisation and management of the National Programme though it is not deemed necessary to document these here. Moreover, they do not appear to have had a direct bearing on the evidence and views presented to the panel either written or oral.

2.7 Health improvement and the cross-cutting agenda in the Scottish Executive

In keeping with the rest of the UK, Scotland has put health improvement and a narrowing of health inequalities at the heart of its policy-making and of government. Scotland's 2003 Health White Paper (see Table 1) places the health improvement focus on four pillars: early years; teenage transition; workplace health; and community development.

The intention is to work across Scottish Executive departments to achieve these objectives. *'We are taking a cross-cutting and whole-government approach to health improvement – putting health improvement in all our policies, and seeking to support all our policies by improving health'* (Scottish Executive 2006a: 5). But making a reality of joined-up policy and management continues to pose major challenges for governments everywhere, both horizontally across departments and vertically in respect of different levels of government. For instance, the Department of Health in England was criticised in a recent *Cabinet Office Capability Review* for too often operating '*as a collection of silos focused on individual activities*' (Cabinet Office 2007: 19).

Following the Scottish Parliamentary elections in May 2007 the SNP emerged as the majority party in Parliament, and it was keen to develop a new style of government. The arrival of a new incoming administration was timely with proposals set out previously in the Taking Stock review resonating with the new government's desire to adopt changes in the way policy was devised in areas like health (Scottish Executive 2006b). The review had identified areas where changes were required, including in relation to cross-cutting issues. In the new government formed in the aftermath of the May election, the Scottish Executive was restructured so that the Cabinet comprised the First Minister and five Cabinet Secretaries, one of whom (in this case also the Deputy First Minister) is responsible for health and wellbeing. She is supported by two Ministers: one for Public Health, the other for Communities and Sport. The Executive has subsequently been renamed the Scottish Government.

Since the arrangements and changes reported above were introduced after the panel had stopped taking evidence, we are unable to assess their likely impact on mental health improvement policy. In any case, it is far too early to make a judgement. However, the changes appear to address some of the concerns expressed to us by a number of witnesses who gave evidence in the course of our review (see Sections 3 and 4), as well as being in tune with much of the literature on joined-up government.

We further note that a report from the Institute for Public Policy Research on innovations in government claims that Scotland now has much to offer other countries, including England, in respect of how to transform the way government does its business in the twenty-first century (Lodge and Kalitowski 2007).

2.8 The international context

Scotland's approach to mental health issues is now well aligned with current thinking in the international field. At this wider level, there is increasing recognition of the need to address mental health as an integral part of improving overall health and wellbeing. It is acknowledged that treatment strategies alone are not enough and that improving mental health and wellbeing should be part of a comprehensive public mental health policy approach (WHO 2001, 2002a, 2002b). The WHO Mental Health Declaration and Action Plan for Europe (WHO 2005; see Table 2, pp 30), the European Commission Mental Health green paper, and forthcoming strategy (European Commission 2006) all highlight the importance of mental health and wellbeing to the human, social and economic capital of nations and underscore the need for population level mental health promotion. The National Programme has been in the vanguard of international policy development in mental health improvement and has influenced developments in WHO, Europe and the European Union.

Many international experts who responded to the international interviews/survey provided examples of how it was thought that the National Programme had been effective in its first phase or had influenced or informed work in other countries.

This included for example:

- visibility of work of National Programme internationally
- the leadership role of the National Programme and initiatives
- acting as a model for national mental health improvement policy development in other countries (particularly new EU countries)
- work on stigma and awareness raising had been influential
- work on recovery was recognised by those working in other countries.

Table 2: The WHO mental health action plan for Europe

	Five priorities
1	Foster awareness of the importance of mental wellbeing
2	Collectively tackle stigma, discrimination and inequality and empower and support people with mental health problems and their families to be actively engaged in this process
3	Design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery
4	Address the need for a competent workforce, effective in all those areas
5	Recognise the experience and knowledge of service users and carers as an important basis for planning and developing services
	Twelve areas for action
1	Promote mental wellbeing for all
2	Demonstrate the centrality of mental health
3	Tackle stigma and discrimination
4	Promote activities sensitive to vulnerable life stages
5	Prevent mental health problems and suicides
6	Ensure access to good primary care for mental health problems
7	Offer effective care in community-based services for people with severe mental health problems
8	Establish partnerships across sectors
9	Create a sufficient and competent workforce
10	Establish good mental health information
11	Provide fair and adequate funding
12	Evaluate effectiveness and generate new evidence

Source: WHO 2005

3 Progress with implementation in phase 1

3.1 Introduction

This section outlines the steps taken to implement the National Programme's first phase aims and priorities as set out in the Action Plan 2003–2006, and considers the agencies and initiatives established to achieve the Programme's objectives. A list of the key dates and events is set out in Table 3. More detailed information can be found in the evaluations and annual reports of individual initiatives.

Table 3: Selected key events for the National Programme

Date	Event
2000	Establishment of Scottish Public Mental Health Alliance.
2001	Scottish Executive announced the Launch of the National Programme for Improving Mental Health and Wellbeing by the Health Minister (Malcolm Chisholm).
2002	First National Advisory Group (NAG) chaired by Minister for Health.
	Breathing Space introduced as a pilot in Greater Glasgow and Clyde.
	First edition of National Programme's *Well?* magazine.
	Launch of See Me.
	Launch of Choose Life.
2003	Establishment of Scottish Executive Mental Health Division.
	Full time appointment of National Programme Director.
	Launch of National Programme three-year Action Plan.
	Scotland's Mental Health First Aid (SMHFA) pilot programme announced.
2004	Breathing Space extended across Scotland.
	Scottish Recovery Network formally launched.
2005	Launch of Scotland's Mental Health First Aid course across Scotland.
	Launch of WellScotland website.
2006	End of phase one of Choose Life.
	Positive Vision for Scotland National Programme event.
	NAG bought to conclusion.

3.2 The National Advisory Group

The following section is based on early documentation of the National Programme, (e.g. minutes of meetings). The role of the National Advisory Group (NAG) was to advise Scottish Ministers on the development and implementation of the National Programme's action plan (known at that stage as The National Programme to Improve the Mental Health and Wellbeing of the Scottish Population), to help provide leadership, encourage commitment and promote coordination with its other work, nationally and locally.

Chaired by the Minister, the Group attracted a wide range of membership, including representatives from local authorities, the voluntary sector, the Scottish TUC, the teaching profession, community organisations, social work, nursing, universities, the medical Royal Colleges, business and the Scottish CBI, as well as from several departments of the Scottish Executive apart from Health.

Among the cross-cutting issues raised by the NAG were the connections between mental and physical health; the need to include older people; how to share best practice and develop a shared language; the need to tackle negative attitudes in a positive way; and how to embed mental health issues into the Executive's Health Improvement Action Plan and its four key themes: early years, teenage transitions, workplace, and community. This included for example, the importance of working with social justice and area regeneration but also engendering significant improvements in services. All of these issues were raised by participants in the panel hearings conducted for the review, and were perceived by them as just as salient today.

3.3 The transformational approach to change

From an early stage, the change model that informed the approach taken by the National Programme Director and project team was the eight-point framework advocated by Kotter (1995). Kotter argues that successful transformation processes go through eight stages and that these stages should be worked through in sequence as critical errors at any stage can have a 'devastating impact' (see Table 4). The panel assesses whether the Kotter principles were put into practice and achieved in Section 5.

Table 4: Eight steps to transforming your organisation

1	Establishing a sense of urgency
2	Forming a powerful guiding coalition
3	Creating a vision
4	Communicating the vision
5	Empowering others to act on the vision
6	Planning for and creating short-term wins
7	Consolidating improvements and producing still more change
8	Institutionalising new approaches

Source: Kotter 1995

The Kotter framework follows familiar change management principles. However, in their discussion of the literature on the concepts of 'transactional' and 'transformative' leadership, Beinecke and Spencer (2007) note that Kotter makes a distinction between leadership and management with which they disagree. They argue that both are needed and claim that 'leadership behaviour' enriches the management role. The panel shares this view and agrees with these, and other, writers who regard leadership and management as integrated activities (see Section 5.9 Leadership and management).

3.4 Key aims and priority areas

Four key aims, and six priority areas emerged from project group discussions and NAG workshops. These were subsequently set out in the National Programme's Action Plan (2003–2006), published in September 2003. They are shown in Table 5.

Table 5: Key aims and priority areas

The four key aims for National Programme action
• Raising awareness and promoting mental health and wellbeing • Eliminating stigma and discrimination • Preventing suicide • Promoting and supporting recovery
The six priority areas that National Programme aimed to work 'with and through' to achieve these aims
• Improving infant mental health (the early years) • Improving the mental health of children and young people • Improving health and wellbeing in employment and working life • Improving mental health and wellbeing in later life • Improving community health and wellbeing • Improving the ability of public services to act in support of the promotion of mental health and the prevention of mental illness

Source: Scottish Executive 2003b

3.5 The key initiatives

A number of programme initiatives and agencies were established to deliver the Action Plan. While these all shared the common aims, they differed in their focus and scope and in their levels of funding. The Action Plan identified implementing the first phase of Choose Life, the work of Breathing Space and See Me as initial priorities. Each adopted different infrastructure models for implementation. The Plan also included a commitment to evaluate these initiatives.

It is recognised that in addition to funding the key National Programme initiatives – Choose Life, Breathing Space, Recovery Network, See Me and Scotland's Mental Health First Aid – significant funding was allocated to support local projects and national agencies to influence and develop their role in mental health improvement. It has not been possible for the panel to comment on each of these individual projects or organisations in the scope of this report. A summary of National Programme funding allocation is provided in Table 6 and key issues and developments under each of the key aims and priority areas are included in the remainder of Section 3.

3.6 Raising awareness and promoting mental health and wellbeing

With political support, the NAG had already raised awareness and generated support across a broad spectrum of organisations and agencies with a part to play in improving mental health. The National Programme itself, with its wide-ranging aims and priority areas, not only raised awareness within central government but also served to inform MSPs and the service community. It is perceived to have attracted a significant level of investment to mental health and wellbeing (see Tables 6 and 7).

Table 6: National Programme funding – Budget allocations (2003–2007)*

	2003–2004	2004–2005	2005–2006	2007–2007
Mental health awareness raising/mental health literacy	350,000	350,000	350,000	350,000
Stigma and discrimination	650,000	750,000	800,000	810,000
Suicide prevention (national implementation support)	750,000	850,000	950,000	1,000,000
Breathing Space telephone advice line	550,000	600,000	650,000	650,000
Promoting and supporting recovery	–	250,000	250,000	260,000
Priority areas and exemplar projects funding (see Table 7)	550,000	750,000	1,400,000	1,400,000
Evidence into practice	100,000	200,000	200,000	100,000
Research and evaluation (includes surveys)	500,000	550,000	670,000	720,000
National indicators	120,000	150,000	170,000	150,000
Communications, website and publications	100,000	200,000	330,000	330,000
Organisation and management	130,000	150,000	150,000	150,000
Local suicide prevention support funds	3.2 million	3.2 million	3.2 million	3.2 million
Total funding available (Mental wellbeing funds as one part of health improvement funds)	7.0 million	8.0 million	9.12 million	9.12 million

* Note: These figures represent annual budget allocations and provide only indicative allocations made for each of the aims, priority areas and support activities. To demonstrate how funds have been allocated across priority areas of the National Programme, a breakdown is provided for 2006–2007 in Table 7.

Table 7: Indicative allocation of National Programme funding across priority areas (2006–2007)

Priority area	£
Early years, children and young people, further and higher education	490,000
Employment and working life	250,000
Later life	200,000
Community wellbeing (Including arts and culture)	310,000
Promotion, prevention and inclusion in services	150,000
Total	**1,400,000**

The first key aim of the National Programme was to raise awareness of the need for good mental health and wellbeing among the general public. This involved improving understanding of positive mental health, of how to promote mental health, and improving awareness of mental health and mental illness[2].

The Scottish Executive's communications strategy involves both external and internal initiatives, including developing the National Programme website as an online public resource, publishing *Well?* magazine as a forum for debate on mental health issues, and developing a media relations plan involving the use of key contacts to get the messages across.

Located in Health Scotland, Scotland's Mental Health First Aid (SMHFA) is a training programme designed to increase mental health literacy, available to the general public, workplaces and wider communities. SMHFA is part of an overall approach to improving literacy around mental health, mental health problems and mental illness. Based on a training model pioneered by the Australian National University's Centre for Mental Health Research, SMHFA is primarily concerned with raising awareness of the importance of mental health and promoting recovery of those who might be experiencing mental ill health. It takes the form of a two-day 12-hour course, and is intended to teach people how to recognise symptoms and provide initial help, and how to guide someone towards the appropriate professional help.

[2] A briefing paper for the NAG on concepts and definitions defines mental health improvement as *'any action taken to increase mental health among populations and individuals'*. (Friedli 2006; see discussion on pp 10–11) .

The aims of the training are described as to:

- preserve life where a person may be danger to themselves or others
- provide help to prevent the mental health problem developing into a more serious state
- promote recovery of good mental health
- provide comfort to a person suffering mental illness (Scottish Executive 2004).

Training for SMHFA instructors involves a seven-day course that aims in addition to provide deeper insight into mental health issues and offer a peer support forum. As at July 2007, 649 courses had been delivered, 6,888 people had attended courses, and 196 instructors had been trained. The target is for 300 instructors to be trained by the end of March 2008 and 13,900 people to have participated by March 2008.

The third wave of the *Well? What Do You Think?* survey in 2007 has shown that public awareness of mental health and wellbeing and attitudes to people with mental health problems are continuing to improve, with most of the gains noted in the 2004 public attitudes survey consolidated. In addition, the first independent evaluation of SMHFA found that the training had been well received across all sectors and had impacted positively on participant learning (Stevenson and Elvy 2007). However, both reports reflect some of the concerns raised in panel hearings about equalities and cultural diversity. The panel heard, for example, that the SMHFA pack failed to address cultural diversity. The evaluation finds that many participants already had higher levels of prior knowledge than the general population, also that men, black and minority ethnic communities and older people generally were under-represented. When the question of suicide was addressed, some felt that the training duplicated the training offered by the Applied Suicide Intervention Skills Training (ASIST) (see Choose Life, page 39) and thought that more links should be made. We return to training issues in more detail in Sections 4 and 5.

The evaluation includes recommendations that the structure and content of the course should be revised in consultation with employers and professional organisations, and suggests that the SMHFA training should aim for a better 'fit' with the priorities and targets of the 2006 Mental Health Delivery Plan. It also recommends introducing a system of quality assurance for instructors, and random inspections of the courses they are delivering. It is clear that SMHFA will need to take a more strategic approach to future recruitment, and it should ensure that effective linkages are made to other training initiatives, and to primary care and mental health services.

Each of the key initiatives we consider overleaf has also involved raising awareness and promoting mental health and wellbeing within the context of their own programmes.

3.7 Eliminating stigma and discrimination

The See Me campaign set out to address the lack of awareness and ignorance about mental health identified in media reporting, in public attitudes, in the workplace and among service users, patients and their families. See Me is widely viewed as a pioneer since no previous mental health anti-stigma work had taken place at a national level in Scotland. The campaign's primary audience is the general public, with the Scottish media as an important target because of its influence on public attitudes (See Me 2006).

The task of implementing the campaign is carried out by a voluntary sector alliance comprising five partners (National Schizophrenia Fellowship (Scotland), Penumbra, the Royal College of Psychiatrists, the Scottish Association for Mental Health and the Highland Users Group) with agreed joint principles and priorities. The alliance is led by a campaign director, supported by a See Me team and media volunteers.

See Me emphasises that it is not a ready-made, one-size-fits-all campaign, and that it is committed to ensuring participation and listening to local views. The panel heard that placing the campaign in the voluntary sector was thought to have helped break down any initial public distrust that might have been felt towards a central government initiative.

In developing See Me, the organising alliance drew on experience of existing anti-stigma campaigns such as 'Like Minds Like Mine' in New Zealand, 'Mind Out for Mental Health' in England and the World Psychiatric Association's 'Open the Doors' campaign. Focus groups have been an important feature of the campaign's development, testing and evaluating See Me with communities across Scotland, including people with experience of mental health problems, rural and urban communities, and people from disadvantaged and excluded minority groups.

The See Me media campaign used radio, television and posters to reach its target audiences. It has attracted support from local organisations and groups, and over 100 of these now use it as an umbrella for their own local stigma work. This support is seen as important for future sustainability; and also as a possible indication that a lasting process of culture change has started. This optimism appears to be confirmed by national surveys that report positive shifts in public attitudes towards mental health problems (See Me 2007).

See Me claims that involving people with experience of stigma has given the campaign a strong first-person voice that has had an impact on the media and the general public. Individuals have been trained and supported to become media volunteers, speaking out about issues such as suicide, depression and recovery. (The media volunteers programme is funded in See Me but run on behalf of the whole National Programme.) Before each campaign launch, the media are also fully briefed to ensure coverage is handled sensitively and the message conveyed appropriately. We heard that See Me had also been a good model for pushing inequalities up the political agenda.

By 2004, over 1,100 members of the public had signed up to Stigma Stop Watch, which seeks out and challenges specific instances of stigmatisation. Using the See Me website and email alerts as an information resource, individuals are encouraged to respond directly to offending editors, journalists or service providers. As well as offering constructive criticism, the press is monitored to see whether the campaign is making a difference and an award is given for balanced coverage of mental health issues.

The second *Well?* survey found that 72 per cent of respondents had seen, read or heard an advertisement or promotion relating to mental health compared to 43 per cent two years earlier (Braunholtz *et al* 2004). While direct links to policy initiatives are difficult to establish, the panel consider that positive shifts in attitudes may represent an improvement in public perceptions and suggest that See Me could have helped to reduce some of the stigma surrounding mental ill health.

While the majority of reactions to See Me were positive, one concern that emerged related to employers. The panel heard that 70 per cent of employment in Scotland was in small and medium-sized enterprises (SMEs) and that SMEs were difficult to reach. It was suggested that SMEs could well find programmes such as See Me daunting, and needed to be convinced that their businesses could benefit from it.

See Me was often seen as a model for other developing anti-stigma campaigns. In this respect, closer collaboration and links with the Scottish Executive Equalities Unit were welcomed. The See Me initiative is clearly very well regarded, and we heard that the See Me team has regular visits from international delegates and that requests for materials come from around the UK and abroad. The first independent evaluation of See Me is due to report in November 2007.

3.8 Preventing suicide

Choose Life

Suicide prevention is seen as a key challenge for a number of government departments. The National Programme established Choose Life in 2002 as its main vehicle for tackling the then rising suicide rate in Scotland. It combines a broader population health and community development approach with a focus on vulnerable high-risk groups. The at-risk groups identified for Choose Life include:

- children (especially looked-after children)
- young people (especially young men)
- people with mental health problems (particularly service users and people with severe mental illness)
- people who attempt suicide
- people affected by the aftermath of suicidal behaviour
- people who abuse substances
- people in prison
- people who are recently bereaved
- people who have recently lost employment or who have been unemployed for a period of time
- people in isolated or rural communities
- people who are homeless.

An independent evaluation of the first phase of Choose Life was commissioned by the Scottish Executive in 2004 in order to '*assess…infrastructure and early impacts*' during the first phase of the strategy. The following section draws on findings from this evaluation report (Platt *et al* 2006).

The Cabinet has set a national target of a 20 per cent reduction in suicide by 2013. While targets are understood to be helpful in 'concentrating the mind' and stimulating action, the independent evaluation also notes their pitfalls: ambitious targets can unintentionally demotivate national and local stakeholders; and at local level they are seen as inappropriate. Local areas were encouraged to innovate in developing community and voluntary initiatives for local suicide prevention work (Platt *et al* 2006).

In contrast to See Me, the Choose Life national implementation support team (NIST) was placed inside the Scottish Executive, where the Mental Health Division was both the policy and the delivery home for suicide prevention. While this delivery location was unusual (as Scottish Executive agencies, local authorities and other outside bodies more usually deliver policy), the panel heard that the perceived advantages of this location were the commitment to integrating suicide prevention across broader policy goals and the facilitation of links to other national organisations. Some of those who gave evidence felt that there had been an under use of national bodies and organisations that, given their expertise in particular areas, could contribute to driving suicide prevention. Others drew the panel's attention to the disadvantages of this model: the lack of lead-in time for the strategy, and operational difficulties encountered in dealing with what were described as lengthy bureaucratic procedures. National Choose Life coordinators were also funded in Childline, the Scottish Prison Service and the Samaritans.

Locally, Choose Life has been delivered through community planning partnerships (CPPs) and the majority of funding has been devolved to local decision-making (see Platt *et al* 2006) for further details, including examples of local initiatives). In addition, the 32 CPPs had local suicide prevention action plans in place and there were Suicide Prevention Coordinators in each local authority area (Scottish Executive 2006d).The variable effectiveness of local CPPs has been critical in influencing progress of local suicide prevention work. For example, stakeholders told the panel that one limitation of the CPP model was that CPPs had been less effective in engaging proactively with clinical services and planning structures, particularly drug and alcohol and mental health services. Nevertheless, those involved in the National Programme argued that CPPs remained the most appropriate vehicle for overseeing Choose Life delivery at local level.

The broad range of priorities in the Choose Life strategy allowed local areas a high degree of flexibility in agreeing a local focus, and the panel heard that some priority groups had been targeted more frequently (e.g. children and young people) than others (e.g. prisoners). There had also been variability in the approaches used to address similar issues or target similar groups.

Support activities

The first phase evaluation of Choose Life (Platt *et al* 2006) describes the infrastructure of mechanisms and activities set up by NIST designed to encourage and support the exchange of information. These included the Choose Life website, annual summits and a resource database. The Suicide Information, Research and Evidence Network (SIREN) is intended to increase access to research, while the main training programme, ASIST, is seen nationally as a vehicle for raising awareness, building capacity and widening ownership of suicide prevention. By March 2006 there were 168 ASIST trainers working across Scotland, and over 7,000 people had been trained in the programme. An independent evaluation of ASIST is due to report shortly.

Choose Life and the National Programme have worked with the National Union of Journalists to develop a practical guide for journalists on the reporting of mental health and suicide by the media (see Platt *et al* (ibid) for further details).

The NIST had signalled a commitment to evaluation, but as a result of the lengthy process of setting it up and the subsequent recognition of limited capacity within the team, a national framework for evaluation remains to be completed. The need to generate evidence of impact at the local level was underscored. Platt *et al* (ibid) recommended adopting a more rigorous approach to evaluating the effectiveness of local suicide prevention interventions, including testing the transferability of interventions to the Scottish context and evaluating promising innovative practice.

Breathing Space

Launched in April 2002 in pilot form, Breathing Space provides a free, confidential listening service for people to call when they are anxious or depressed. While it is available to anyone, the service set out to target men in the age group 16–40. An independent evaluation was commissioned in 2005. Its aim was to assess the development of the service in terms of inputs, processes and outputs and to evaluate its effectiveness. From data available in 2001–2002, the independent evaluation estimated that around 159,000 men in Scotland in the age group 16–44 showed signs of mental distress (according to the GHQ12; see Section 2.3 Mental Health in Scotland), and therefore could be considered as potential users of the service (Sheehy *et al* 2006).

The service is located within NHS 24, but staffed by advisers who only answer calls specific to Breathing Space. At the time of the evaluation, the service coordinators were line-managed by the Director of Operations for NHS 24. This service is now provided nationally across Scotland. Key coordination roles include: establishing and maintaining contact with health boards, social work departments, and the voluntary sector; advising professionals about what Breathing Space is for and what it can provide; and liaising with local organisations to ensure that they are properly positioned to deal with people signposted on by Breathing Space advisers.

For Breathing Space, like See Me, the panel was told that branding was seen as a key issue. No central government or NHS logos were used, as it was felt that these might deter vulnerable people from using the service.

The independent evaluation found that Breathing Space seemed to be offering a much-needed, good quality service (Sheehy *et al* 2006). It was also critical of the initiative on some counts, finding for example that while callers were given contact details of other services, few followed these up. Furthermore, when signposted providers were located, much of the contact information was found to be incorrect or out-of-date. Although about two-thirds of service providers interviewed were aware of Breathing Space, many were not clear about what the service provided and some organisations working in the field had not heard of it.

The evaluation also found that many of the callers came from outside the target group, drawn instead from both sexes and a wide spectrum of ages, thus raising the question of whether its remit should be reviewed. The panel wondered why the evaluation had not addressed the question of how the Breathing Space service compared with other providers of similar services, such as helplines, in terms of volume of calls, types of caller and so on, and would urge that such comparisons should be made. For the future sustainability of this initiative, it will be important to track referral data and to establish operational linkages with mental health services.

3.9 Promoting and supporting recovery

Launched in 2004, the Scottish Recovery Network (SRN) is made up of a loose network of organisations and individuals across Scotland including people who have experience of long-term mental health problems, their families, friends and carers, and those involved in providing services.

The SRN is moving towards a shared understanding of how to promote, support and interpret recovery for long-term mental health problems. It aims to learn 'what helps' and to share that information, as well as working with partner agencies to help services realise the values and principles of recovery in the way they provide treatment and support.

The SRN defines its approach as follows:

- people can and do recover from even the most severe mental health problems and mental illnesses
- recovery is best described as a journey that may have ups and downs – it is not necessarily an end point
- no two people's recovery journey will be the same – people need different things to help them recover
- people need understanding and support from others to recover and stay well.

(www.scottishrecovery.net)

The need for a recovery programme is underlined by Schinkel and Dorrer (2006:73) when they identify concerns about implementing recovery competencies due to *'some characteristics of the Scottish mentality'.* They argue that due to lack of a culture of self-determination and choice, people are not yet comfortable with critiquing professionals and demanding their rights. However, *'service users and carers, as well as professionals in less powerful positions, need to be empowered to challenge existing modes of practice and be open to initiatives relatively new to Scotland such as peer support'.*

Based on a pilot developed in New York, the SRN is developing a practice tool, looking at what helps or hinders the recovery process and at involving peer support. Findings from 67 in-depth interviews based on personal stories of recovery by individuals who had experienced long-term mental health problems are being published. Such personal narratives could usefully inform local recovery programmes.

While the SRN had been one of the last vehicles to be delivered as part of the National Programme, stakeholders told the panel that it had 'struck a chord', and given the service sector a new sense of direction. We found that the recovery work had been taken forward intelligently. It also has the potential to become embedded to good effect, because work on vision and values has been shown to be important in transforming front-line practice (e.g. Colombo *et al* 2003). The panel also heard that the SRN was becoming known as a resource, and that the development of peer support workers was viewed as a very positive initiative by those working in the area.

The panel was told that the Recovery concept had been challenging, both for the medical establishment (fear of raising false hopes) and for carers (fear of relatives coming off drugs). It was also challenging for providers, whose services have not been cited as aiding recovery. For example, in the Australian evaluation of mental health strategy referred to in Section 1.3 (1997 op cit;13), consumers identified mental health professionals as the main source of the stigma and discrimination that they experienced, describing them as *'insensitive, poorly skilled and unable to deliver the new models of care'.* The same report noted that for consumers, the manner in which services were delivered was just as important as the type of service received and recommended that training in core competencies, particularly values and attitudes, should be developed in collaboration with consumers and carers (pp 27; see also Schinkel and Dorrer, ibid).

The panel agrees with Berzins (2006) view that the SRN will have a key role to play in the future of mental health improvement in Scotland, both through continuing to promote recovery-orientated approaches, and in using its awareness-raising capacity to influence training and research: *'bringing recovery-orientated practice to service planners and providers.'*

3.10 Support activities

The National Programme supports a wide range of agencies, programmes and projects. (A list of the key national programme initiatives, including their website addresses, can be found in Appendix D while detailed descriptions of their activities can be found elsewhere). Therefore we have confined ourselves to commenting briefly on some of the initiatives and partnerships below, under the headings identified as priority areas, based on the oral and written evidence acquired by the panel in the course of this review.

A key support activity of the National Programme is the ongoing collection and dissemination of the evidence base for mental health improvement and the production of helpful guidance and support to assist in the use of the evidence base in local practice. As described earlier, national evaluations of key initiatives have been commissioned as part of this strategic programme of research and evaluation.

Health Scotland continues to support an *Evidence for Action* programme that collects and disseminates the evidence base in mental health improvement and supports practice development. The overall aim of the programme is to establish a framework for developing and disseminating the best available information and evidence relevant to mental health improvement to inform future policy, practice and research in Scotland.

This programme has produced a number of outputs, including:

- research assessing information needs regarding mental health and wellbeing
- evidence into practice workshops, designed to introduce participants to evidence-based mental health improvement, and to develop the knowledge and skills to apply this in their own work
- evidence into practice training for trainers, a course that built on the workshops by building local capacity
- developing and disseminating a series of case studies and evaluation guides
- mental health improvement evaluation training, delivered locally in Health Board areas, for people from a wide range of professional and organisational backgrounds (written submission).

A national research survey on information sources about evidence-based practice led to the publication of a Mental Health Information Strategy for Scotland, and benchmarking indicators were developed to accompany the Mental Health Delivery Plan (McLean *et al* 2001; Philp *et al* 2002; Scottish Executive 2006c). Baseline data relating to mental health demand, capacity and utilisation were reviewed to establish their *'relevance, reliability, completeness, accuracy and validity'* so that trend data could be provided to assist the formulation of local plans for delivering change.

A number of other initiatives have sought to strengthen the evidence base underpinning the National Programme. The following merit particular mention:

- the first national Scottish survey of public attitudes to mental health, mental wellbeing and mental health problems (*Well?* survey), was commissioned by the Scottish Executive in 2002 and repeated in 2004 and 2006. The survey was designed to provide baseline data at the beginning of the National Programme and has been repeated in order to track progress (Braunholtz *et al* 2007)
- the Small Research Projects Initiative supports research projects that are able to contribute to advancing the National Programme aims and also works to build social research capacity in Scotland
- Health Scotland was commissioned by the National Programme to establish a national core set of valid, useable and sustainable adult mental health indicators for Scotland. The project is now entering its final phase with the prospect of the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) being adopted as a key high level indicator in the Scottish Government's national outcomes measurement framework, alongside healthy life expectancy.

3.11 Children and young people

Improving the mental health and wellbeing of infants and children and young people are key priority areas for the National Programme. The panel received evidence concerning a number of initiatives which the National Programme was supporting either in part or their entirety.

Key successes in implementation

The panel welcomed adoption of an integrated approach to promoting emotional wellbeing in the school setting through the Scottish Health Promoting Schools intiatives and the provision of national level support by the Scottish Health Promoting Schools Unit. This 'whole school' approach is in keeping with best practice and also presents a useful opportunity to evaluate systematically the process, impact and outcome of this national level initative on the mental health and wellbeing of Scottish students and staff over the coming years.

A national project for children and young people's mental health, HeadsUpScotland funded by the National Programme until 2008, was described as a useful stimulus in regard to improving mental health and wellbeing. It sought to ensure that those in need of support not only have adequate and accessible services but also have their mental health improvement needs attended to. It was acknowledged that the two communities of prevention and services needed to work closely together and exchange information, as both sides could be diminished by poor relationships. The panel's view is that HeadsUpScotland is serving as a catalyst for integrating and supporting the mainstreaming of local work on children's and young people's mental health.

The panel heard that the National Programme has had a positive influence in the education sector. The curriculum was undergoing an overhaul, and teachers were said to be more aware that services needed to work together for health and wellbeing.

In respect of the further education (FE) sector, the panel was informed that the FE Unit had used the National Programme framework to develop work in relation to mental health improvement and that there was a feeling of optimism and enthusiasm arising from the Unit's engagement in this work. A written submission on universities informed the panel that the expanding and increasingly diverse student population, together with the increasingly pressurised student environment, were leading to increased concern about suicide – the opposite of national trends – and producing a wide range of mental health problems, from severe and enduring mental illness to depression.

Limitations and barriers to implementation

Although the National Programme was reported to have had a positive influence on the education sector, it was also reported to the panel that in contrast to the positive developments in the school setting, there appeared to have been limited impact in relation to the integration of mental health improvement within the pre-school and out-of-school settings for young people. Likewise, the need for a clear lead on parenting and targeted early years interventions was communicated to the panel.

While the National Programme was housed in Health, some stakeholders felt that the key focus for children should be in Education. There was a growing awareness of a need to shift thinking and focus on mental health in infancy and early years, with a consensus that it had not been given sufficient emphasis hitherto. However, the panel was told that the production of the Executive's early years policy had been delayed until 2008. The Framework document, *The Mental Health of Children and Young People,* takes a multi-agency approach and articulates a shared vision of mental health and wellbeing that is intended to promote and shape coherent, interagency planning (Scottish Executive 2005b).

The National Programme was perceived as having been influential in raising awareness of the importance of mental health and making mental health improvement a more explicit part of the work with children and young people. However, it was put to the panel that while staff working with young people on the ground may be aware of mental health issues, there needed to be a greater focus on building the confidence and capacity of front line workers effectively to address these issues in the local context. In particular, the need for a strategic approach in addressing the complex needs of marginalised young people and those with special needs was stressed.

Although there was a general welcome for the National Programme's work in the area of further education, apart from localised pockets it was reported to the panel that the National Programme had not hitherto had any significant impact on higher education. It was suggested that despite a long standing concern in higher education about the mental health of students, the National Programme had failed to capitalise on this or engage with the existing expertise available in higher education institutions. However, the representatives who communicated with the panel were keen to stress that the higher education sector shares the vision of the National Programme and is keen to contribute to the work of the National Programme in order to realise that vision.

Priorities for the future

The effective provision of universal and targeted interventions to improve the mental health and wellbeing of children and their families from pre-birth to age five is highlighted as a continuing key priority for the National Programme in its next phase. The roll out of such programmes based on existing evidence-based approaches is identified as a critical area for action.

The need for a specific focus on adolescent mental health and the development of effective youth centred approaches in the out-of-schools setting for 12–25 years olds is also highlighted for action.

While the panel of course accepts that the National Programme cannot be held solely responsible for a failure to tackle health inequalities, it considers that it needs to have a strong inequalities focus and that this has not been evident so far either in respect to the needs of children and young people or elsewhere.

Again, as in other sectors, given the difficulties that had been encountered in articulating what 'mental wellbeing' meant for different sectors, a priority for the future must be combining specific guidance with clear and effective communication. The panel was told that employers and teachers were asking what they should be doing. The panel considers that there is an opportunity here for the National Programme to provide such support.

In the further education sector, a priority identified was the need to work with staff working with vulnerable young men as it was felt that mental health training attracted those who already had a good awareness of mental health issues. The National Programme should also seek to make use of the expertise available within higher education and develop stronger links with the sector.

3.12 Employment and working life

Improving mental health and wellbeing in employment and work is another priority area for the National Programme. The panel heard how the National Programme had provided an important impetus for work in this area with an emphasis on promoting mental health at work, enabling and supporting people to remain in work, and helping to improve the employment opportunities for people with mental health problems. As in other areas, the panel received information on, and heard evidence concerning, a wide range of initiatives in which the National Programme was engaged.

Key successes in implementation

The Scottish Centre for Healthy Working Lives was established to improve the health of working age people by ensuring healthier and safer workplaces, promote healthier lifestyles and to develop the field of employability throughout Scotland. It is the principal delivery vehicle for this part of the National Programme.

The National Programme also funded a dedicated mental health and wellbeing project within the Scotland's Health at Work (SHAW) Programme which was aimed at promoting positive mental health and wellbeing for all staff and removing barriers to employment for people with a history of mental health problems. In 2007, the new Healthy Working Lives Award programme replaced SHAW. The Health Working Lives Mental health and Wellbeing commendation award portfolio forms part of this programme and sets a workplace standard for good practice in promoting positive mental health and wellbeing, supporting staff with mental health problems in the workplace and reducing barriers to recruiting staff with a history of mental health problems. The panel heard that the (former) SHAW programme was successfully integrating mental health and wellbeing within its wider programme in workplaces. A number of national training initiatives in mental health are underway and some 100 organisations throughout Scotland were working towards the (former) SHAW commendation award for mental health and wellbeing. SHAW has also linked with the See Me campaign at a national level in challenging stigma in the workplace. There are clearly opportunities to link current activities to vocational rehabilitation and employability initiatives and it is envisaged that this will be developed further through the Scottish Centre for Healthy Working Lives. Finally, an evaluation of the second year of the project concluded that it was succeeding in becoming embedded and was working effectively in partnership with other agencies (Patterson 2005).

The panel heard evidence suggesting that mental health services had in the past 'removed people from life'. The National Programme had brought a renewed sense of purpose and was working to change service provider mindsets. In particular, the need to intervene early was stressed so that people could be helped to stay in work rather than be helped to get back to work.

Limitations and barriers to implementation

The view was expressed to the panel that the reserved/devolved split on employment issues mean that the policy landscape was complicated and that as a result policies failed to join up. But it was also suggested that such barriers could be overcome and with the right management attitude should not be allowed to act as barriers.

Priorities for the future

In panel hearings, the view was expressed that the public sector should show leadership on mental health and employment practice Local authorities were said to have a better record than the NHS on this, although it was claimed that they were not good at sharing their experience with a national audience. The NHS was viewed as more risk-averse in its employment practices, and it was suggested that it could provide more work along the lines of the Scottish Executive/NHS initiative to increase employment of people with mental health problems.

It was put to the panel that the message that poverty/health/work were all linked should be reinforced and that every manager (especially those in human resources) should be given mental health first aid training.

Given the links across various policy sectors and government departments, there is a need for greater, and closer, intersectoral working.

3.13 Community health and wellbeing

The panel heard that the National Programme had spawned an extensive programme of community wellbeing work as well as having an influence over the Scottish Executive's culture and arts work.

Key successes in implementation

The National Programme is supporting the Scottish Arts Council in an arts and mental health initiative, *Artfull*, that aims to raise awareness, and support people's recovery through engaging with the arts. It aims to develop an evidence base on the benefits of the arts in relation to mental health and wellbeing.

Limitations and barriers to implementation

It was pointed out in hearings that any debate on community health needed to recognise the growing cultural diversity within Scotland's population (see Section 2.4 Scotland's population). The panel heard that research was now needed to identify effective models, and that the National Programme needed to utilise information on black and minority ethnic (BME) issues in a Scottish context. The mental health improvement indicators were seen as being out of context for the BME experience, while the National Programme's advertisements on television and in the mainstream press did not give relevant contact details, and had not included visible BME participants.

The panel heard that strategic leadership was badly needed in the area of ethnic minority mental health as the issue could not be left to individuals and small agencies.

Representatives of BME groupings expressed the view that the National Programme had placed undue emphasis on stigma at the expense of access to services, while recognising that stigma can affect this.

Priorities for the future

This is perhaps the place to raise the issues of service user testimony. The panel heard that it might be accepted at conferences, but was not yet incorporated into local services. Moreover, it was claimed that token user participation was often solicited without understanding the implications for individuals or for processes. Overall, there was not enough service user involvement. It was said that some practice development had not involved service users at all.

With the exceptions of See Me and the SRN, these issues were raised in many settings, and regarding several agencies and initiatives. The survey respondents highlighted more extensive involvement of those with lived experience of mental health problems in service design and delivery and in needs and care assessment as a future priority.

3.14 Later life

Work on later life issues appeared to be minimal. The panel heard evidence about the work of Health Scotland's mental health and wellbeing in later life programme, and received strong messages that there was a need for a greater focus on older people across initiatives such as suicide prevention and mental health promotion, and for a more integrated and intergenerational approach across the board.

Limitations and barriers to implementation

In spite of the implications of Scotland's ageing society (see Section 2.4 Scotland's population) the panel was told that older people were 'fighting for the scraps from the table'. We also heard that older age mental health services remained a Cinderella, although it was argued that there was a 'hard-nosed business case' for anticipatory rather than reactive care as moving 'upstream' could take pressure off the NHS and social services. It was pointed out to the panel that the budget for the National Programme was relatively small when compared to that for community care.

Stakeholders regretted that a proposal to include older people in Choose Life had been unsuccessful, although it was argued that focusing more on this group – older men in particular – could help to bring down the national suicide rate. This neglect was perceived by voluntary sector agencies as an example of structural discrimination.

It was also said that not enough work was being done on end-of-life issues, while other important but neglected later life areas included carers (perceived by some as a late 'add-on'), forces' veterans and older prisoners. There were also issues to be addressed around stigma, rural poverty and isolation (see Levin and Leyland 2006). For example, although the campaign was described to the panel as a good model for pushing inequalities up the political agenda, it was suggested that a different kind of See Me was needed to address stigma and discrimination against older people.

3.15 Public services

Key successes in implementation

The National Programme had been very supportive of the Doing Well by People with Depression Programme (DWBPWD), which was focusing on the community and on primary care, in terms of cultural, attitudinal and behavioural change. It was felt that the DWBPWD evaluation had raised as many questions as it had answered, but a network had emerged for sharing and learning. Pharmacological guidelines were to be developed, and some 'good prescribing' schemes had been adopted (McCollam *et al* 2006).

The panel heard that there had been some initial professional resistance to such initiatives. However, as noted in Section 3.12 Employment and working life, the National Programme was working to change service provider mindsets and this was starting to penetrate into primary care with, for example, projects in GP surgeries.

Limitations and barriers to implementation

While mental illness had been a clinical priority for many years, there had been no mental health targets and the Executive agenda was focused on population-based mental health awareness, not services. As GPs were key to the success of this approach, the Executive was working with them and trying to engage their support as part of a four-year service change improvement programme. While the Quality and Outcomes Framework (QOF) now included some mental health targets, they still remained limited and 'medical' (see Woods and McCollam 2002).

One written submission to the panel argued that current policies left mental health inequalities ill-defined, and claimed that policies lacked a coherent approach to health inequalities. Furthermore, based on ongoing research, it was said that senior experienced practitioners and planners in primary care did not routinely discuss, explore or act on these issues. The submission suggests that the National Programme could be in a position to stimulate and lead debate and new thinking on the links between health and social inequalities in Scotland, and urges that all strands of the Programme should incorporate an inequalities perspective. The panel endorses this view. 'Inequalities' was a recurring theme throughout the oral and written evidence for this review, and we return to it in Sections 4 and 5. Unless policy-making across all departments – from Rural Affairs and Environment, to Justice – is informed by the 'best possible' evidence of health impacts, lack of coherence could undermine the national goals of mental health improvement (Council for Science and Technology 2006).

Local government is one of the areas where less progress has been made, although it is vital for the effective mainstreaming of mental health and wellbeing. Scotland's local authorities can work with their local communities in improving social and living environments, promoting mental health, and meeting the needs of people with mental ill-health in terms of quality housing, recreation facilities, arts and sports activities, building social capital, volunteering and social inclusion initiatives.

Local and national decision makers still tend to regard mental health as relating to psychiatric and/or mental illness services delivery. Community Planning Partnerships (CPPs) are slowly taking up the themes and messages relating to mental health improvement, but progress continues to be patchy.

Priorities for the future

Respondents to the online survey carried out for the review identified service issues in primary care as a key priority. This included early intervention, improving the skills of primary care professionals, better access to counselling and talking therapies, together with the use of social prescribing and community resources as an alternative to antidepressant prescribing.

While useful progress had been made to change provider mindsets, this needed to go much further and should be a priority in future.

3.16 Broader public policy and mental health

While policy on mental health services per se is the primary concern of the Mental Health Division of the Executive, the impact of other areas of public policy, and particularly social policy, both on people with mental ill-health and on the practice of health promotion is probably far greater. People with severe or chronic mental health problems often face social exclusion, and experience difficulties with issues including housing, employment, education and welfare benefits. This was reflected in the written submissions to the panel, and in feedback at the stakeholder meeting.

However, achieving a totally coherent mental health improvement policy over time presents huge challenges:

- the views of different stakeholders and the priorities of many different government departments must be reconciled
- policy must integrate horizontally – across health, education and local government for example, and vertically from small organisations up to government
- the non-measurable side of what is offered is very important to the stakeholders – services, whether generic or specialist, must be responsive, caring, joined up and visible to users, carers and the general public – yet these features of services are hard to influence from central government

- balancing resources across the general public, people with severe illnesses and people with common illnesses such as depression is tricky. So too is achieving the right balance between promotion, prevention and service development, all of which must be linked
- common mental health problems and poor mental health are more costly, but people with severe mental health problems have more complex needs. These, if neglected, will not only affect individuals but also affect the perception of policy as a whole (Muijen and McCulloch, forthcoming).

3.17 Conclusion

In reviewing the various initiatives launched by the National Programme, the panel was struck by their range and diversity and the energy and enthusiasm which lay behind them.

All of the initiatives were in themselves well-intentioned and laudable, and many were imaginative and creative. But within the confines of the limited capacity available to the National Programme, the panel did wonder as a general conclusion if a more focused approach, with the adoption of clear priorities and goals, might not have been a more effective way of proceeding and channelling resources.

Keeping track of progress across a myriad of projects and initiatives is challenging and being able to provide appropriate support where required is therefore unlikely especially with limited capacity.

The issue goes beyond funding. Indeed, in terms of resources, the National Programme has been relatively well-endowed but when it comes to managing progress and securing robust outcomes, the panel takes the view that the capacity available has been thin and uneven. We expand on our thinking in Sections 4 and 5 since we consider such issues to be of the utmost importance in the next phase of the National Programme’s life.

4 Overview of impacts and outcomes

4.1 Introduction

Based on the range of oral and written evidence acquired by the panel, this section considers its findings on the impacts and outcomes of the National Programme as a whole, as at May 2007.

It should be acknowledged at the outset that the period under review is comparatively short, while much of the work undertaken by the National Programme is complex and will take longer than a few years to achieve its aims. Five or six years is not long enough to embed cultural shifts. Measurable outcomes could take even longer to achieve. Moreover, attributing causal relationships in social policy is always problematic because of the number of variables involved and the dynamic, shifting nature of the social and policy contexts.

The suicide reduction target merits comment at the outset as this is the sole national level outcome for mental health specified by the government. The panel has noted the downward trend in suicide rates since 2002 but establishing a causal relationship between this trend and the existence of the National Programme, and in particular Choose Life, is not possible. The panel suspects there is little relationship given the wealth of other external factors influencing suicide rates and the current lack of evaluative evidence on the impacts of Choose Life. Downward trends are evident in England in the absence of a national initiative of this type. Overall, therefore, a falling rate of suicides is a weak success measure for the National Programme, although it is essential that suicide is tracked as part of the government's public reporting on Scotland's health. It is in any case too early to tell if the downward trend will continue and become significant. There is also a sharp inequalities dimension to suicides with those living in the most deprived areas of Scotland having a risk double that of the Scottish average.

4.2 Successes and highlights

The prioritisation of, and investment in, mental health improvement in Scotland through the National Programme is viewed as being a leading exemplar in Europe of policy development and implementation in public mental health. At the stakeholder meeting in May 2007, the panel heard that, prior to the National Programme, mental health improvement had been marginal in Scotland. There had been ambivalence and fear, so that people came to services too late. Initially the then Scottish Executive had perceived mental health largely in clinical or forensic terms, and understanding of the mental health improvement contribution to other policy objectives had been weak. On another occasion, the Scottish mental health services were described as having been 'hope-*less* rather than hope-*full*'. Through

its wide range of activities, the National Programme has released a considerable degree of energy, commitment, creativity and enthusiasm and is successfully bringing positive mental heath and wellbeing onto the policy and public agendas.

The National Programme was widely welcomed by virtually everyone the panel saw, notwithstanding a few dissenting voices. The Programme has served as a catalyst, not only putting mental health on the wider policy agenda – it was suggested that its greatest benefit had been bringing awareness of mental health and wellbeing issues into education, policing and social services through CPPs – but injecting new energy into mental health policy. The raised awareness referred to here was reflected in the written evidence the panel received.

Many informants perceived the Programme as an important focal point for cross-cutting issues. Now that the Taking Stock review has given added impetus to a whole systems approach at the centre, the panel believes that the National Programme has begun to make inroads into complex cross-cutting issues within the Scottish Executive (see Section 2.7).

Evidence of progress and achievements is shown by a number of new initiatives that would not otherwise have taken root. For example, the National Programme funded a three-year research project at Glasgow University to examine the relationship between modern consumerist culture and health and wellbeing in Scotland. Seven working papers have been produced so far and some fieldwork is in progress, including a series of structured focus groups termed 'learning journeys.' The panel believes that this type of exploratory research, which often fails to get funded through orthodox routes, is a good example of where the National Programme has been innovative and helped to contribute new knowledge. The Programme has demonstrated its commitment to developing an evidence-based approach to mental health improvement through research, evaluation, the development of indicators, communications, training and capacity-building workshops. The National Programme has also developed its role as a source of help, support and information. It has enjoyed a high political profile, and has been well funded.

Scotland has acquired a mental health promotion profile internationally as a consequence of the National Programme and this, in turn, has fed back into the domestic arena and boosted confidence. Many of those involved in National Programme initiatives told the panel that being part of it had given them a national champion at the policy-making centre and a higher profile, as well as the benefits of the shared aims and vision emerging across a wide spectrum of campaigns. Moreover, being seen as part of a national agenda had often 'opened doors'. This visibility had also brought sustained funding for a reasonable period of time and the supportive infrastructure, including research and evaluation, referred to above.

The panel's overseas informants said that the National Programme's work was well known in WHO and in the European Union and confirmed that Scotland had taken a leading role in this field. Scotland was also thought to have influenced policies in other countries, and this had brought the benefits of knowledge transfer. For example, NHS Health Scotland is designated as a WHO Collaborating Centre for

Health Promotion and Public Health Development which includes responsibility for the coordination of work to address stigma and discrimination in relation to mental health, one of the priorities of the Helsinki declaration. Scotland is one of 18 countries involved in a European Alliance Against Depression, part-funded by the European Commission, which is exploring a public health approach to depression and suicide awareness.

The message conveyed to the panel from many quarters was that the National Programme was still needed for 'a period of time' in order to provide a 'secure space' and offer a focus for consolidation. However, there was also a consensus from those at the hearings and those at the stakeholder feedback meeting that it was now time for a shift of emphasis. Rather than continuing with what was referred to as a 'broad-brush' approach, it was strongly felt that future actions should be prioritised with the focus on a few key issues. These issues are discussed further below, and in the following sections.

4.3 Challenges and limitations

As mentioned in Section 3, the change management model for the National Programme is based on Kotter's eight-step framework (see Table 4 on pp 32). Measured against these eight steps, and taking into account the evidence submitted to the panel, both written and oral, we consider that the Programme has only been partially successful in fully implementing the framework. In particular, step 2 – forming a powerful guiding coalition – has not been fully achieved and needs to be further addressed in phase 2.

The makings of such a coalition may have existed in the early days of the National Programme when the National Advisory Group was actively engaged, but the panel heard that it had now been bought to an end and had not been replaced by any equivalent grouping of broad stakeholder interests to guide the programme and its future development. The National Programme also needs to continue focusing on Kotter's step 4 – communicating the vision – as this does not seem to have been fully achieved, especially at the level of frontline activity.

The same applies to step 5 – empowering others to act on the vision. Although there has been some progress, there needs to be further development in nurturing the general advocates for the National Programme on the frontline. Finally, steps 7 and 8 – consolidating improvements and producing still more change, and institutionalising new approaches, respectively – have not yet been fully realised either, and require further work. Those close to the National Programme acknowledge that these issues will need to be addressed in phase 2.

In the period under review, it was clear to the panel that difficulties in achieving collaboration between departments at the centre had created problems for the front-line agencies charged with policy delivery and implementation. Community Planning Partnerships appeared to be hampered by having to respond to too many targets and policy objectives set by the centre. Multiple reporting arrangements and funding streams had caused difficulties in delivering objectives and service improvements.

For instance, in its review of CPPs, Audit Scotland points out that 'the lack of integration and prioritisation of the large number of national policy initiatives, and the fragmented nature of funding arrangements to support these, making it difficult for CPPs to achieve their potential in meeting objectives and create a further administrative burden' (Audit Scotland 2006: 3). From the evidence the panel received regarding the implementation of the National Programme's key initiatives, it was clear that the same problems were being experienced for largely similar reasons.

While funded by Health Improvement (HI), the mental health improvement programme was not part of mainstream HI. At the time of the panel hearings, there was no joined-up approach and no sense of links between directorates, divisions and external agencies. While some saw structures as irrelevant or as challenges to be overcome, others felt that mainstream infrastructure was important for developing a mainstream programme for the second stage.

There was a degree of consensus about the difficulties, and about current challenges. At the outset, for example, time pressures had forced roll-out before a strategy had been developed, raising concerns about sustainability. Having to cope with bureaucratic procedures was also perceived as a disadvantage in terms of time and process.

At one hearing, it was put to the panel that clinicians had taken the Programme less seriously because the Executive was leading it. We do not have the evidence to corroborate this claim, but if true it is an area that should be urgently addressed as actively engaging clinical services in supporting National Programme initiatives has to be a key objective of the second phase.

The panel was told in hearings that the then Executive Health Department lacked a high-level cross-cutting group that was able to take a strategic overview and to consolidate the concept of 'mental wellbeing'. While the strong emphasis on messages and branding had been effective in phase 1 (agenda-setting), a coordinating group or body was now needed for phase 2. As noted in Section 2, the Taking Stock review had identified areas relating to cross cutting issues where changes were required and, following the May 2007 Parliamentary election the Scottish Executive, has restructured, reduced the number of its departments, and renamed its ministerial portfolios in order to give more prominence to cross-cutting issues.

Some interviewees identified a gap emerging between policy and practice, attributing this to a lack of capacity and know-how on the ground. It was also pointed out to the panel that raising awareness had raised expectations, so if these issues were not addressed in the second phase of the National Programme, then frustration and disenchantment could well be the result. This is discussed further in Section 5.

Since the launch of the National Programme the Scottish landscape has continued to change, and there are now so many overlapping initiatives that priorities and links are needed to pull strategies together and give the Programme's work greater coherence and focus. The panel heard that questions were being asked as to who was doing what; whether similar goals were being pursued; and whether the initiatives were adding value in relation to existing agencies in the field (i.e. Breathing Space and existing telephone helplines; Choose Life and existing drugs/alcohol projects). Similar messages emerged from the stakeholder meeting in May 2007.

It was also put to the panel that opportunities for collaboration and cross-fertilisation between initiatives needed to be expanded further. There is an identified need for a greater strategic link, as it was said that in some cases competition had been emerging between initiatives. So far, evaluation had focused on individual projects and initiatives; in future, it was felt that this should be part of continuous quality assessment. In the panel's view, the National Programme could play a valuable integrating role by identifying priorities and disseminating the best evidence-based practice. This activity has been largely lacking to date.

The panel felt that Scotland could do more on implementing some of the lessons and models of best practice described in existing evidence, particularly in relation to disadvantaged populations and communities (i.e. low income groups, BME people, victims of domestic abuse, isolated and socially marginalised groups). These should be an area of focus in the future, with effective consumer involvement pursued within the overall goal of mental health improvement. The panel's international informants underlined this message.

Rather than commissioning new studies, the panel is not alone in the view that more effort should be put into co-ordinating and applying existing information. The panel heard that some existing information and data sets were not being used: for example, local authorities and COSLA (the Convention of Scottish Local Authorities) did not exchange information with Health Scotland. It was also put to the panel that much work on outcomes and evidence reviews already existed elsewhere, and it was felt that this could be built on rather than reinvented. The panel was also encouraged to learn that the Evidence for Action team in Health Scotland are currently taking forward this work and regards the progression of this work as being of the utmost importance.

Overall, there was a need to pull together existing work and research and to reach agreement on what's 'good enough'. Currently, there was too much of a 'transmit-receive' model with insufficient time or space for reflection or for listening to practitioners.

But while evidence has to be embedded in policy and practice, it was unclear in many quarters whether the skills were in place to achieve this. Capacity and sustainability appear to the panel to be major issues. Workforce development needs a strategic approach, but the National Programme lacks an overall training strategy. Instead of taking a generic approach to training, enabling people to work across

different settings, training was currently carried out within specific initiatives. Issues of duplication, relevance and focus were frequently raised, and we support those who argue that future training courses should be reviewed and coordinated. We return to this issue in more detail in Section 5.

Our *National Health* (Scottish Executive 2001;72) identifies women's mental health as a priority in terms of post-natal depression, sexual abuse and domestic violence, but these issues are barely present in the National Programme. We heard that this area is particularly relevant for the Scottish Prison Service. *Equal Minds* (Scottish Executive 2005c) discusses the importance of gender issues and attitudes in mental health, pointing out that older women encounter the 'double jeopardy' of ageism and sexism.

In view of the varying critiques of Scottish culture alluded to in hearings and elsewhere – see Section 3.9 – there is a need for the National Programme to take account of cultural and gender issues including sexism, discrimination and masculinity.

5 Future directions for phase 2

5.1 Introduction

In the light of an agreed shift of emphasis for the second stage of the National Programme, this section offers the panel's thoughts for the future. We acknowledge that of key importance is the future of mental health improvement work in Scotland. Not all our suggestions are within the exclusive provenance of the National Programme to deliver but even where this is the case we consider that the Programme has an important advocacy and lobbying role so it can bring influence to bear on those stakeholders and/or parts of government and its agents as necessary.

5.2 Model of change

The panel is aware that the Scottish Government[3] is considering proposals for the second stage of the National Programme which would shift its emphasis from 'transformational' to 'transactional' change. The panel wholly supports this shift and hopes it will be adopted. From early 2007, it was proposed that the direction of mental health improvement should focus on four main goals:

- promotion (mental wellbeing for all)
- prevention (preventing mental health problems and illness – suicide and depression in particular)
- support (supporting improvements in the quality of life, social inclusion, equalities and rights for those experiencing mental health problems or illness)
- inequalities (addressing inequalities in mental health).

Set against these goals, the panel offers the following observations.

5.3 A powerful guiding coalition

In order that wide support of the National Programme can be sustained, there needs to be a high level guiding coalition put in place which would bring together key stakeholders across sectors. This would meet the panel's concern that since the demise of the National Advisory Group there has been nothing established to replace it.

5.4 A shared vision of positive mental health

The panel was clear from the outset that the National Programme's fundamental aim was mental health improvement: that is, improving the mental health status of the Scottish population. This entails a positive model of mental health that addresses people with good mental health, those with compromised mental health who may be languishing or vulnerable, those at serious risk of mental illness, self-harm or suicide, and those who are already mentally ill.

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[3] See footnote 1, page 17.

While not impossible, it was always going to be difficult to underpin a disparate set of projects and activities with a clear model of positive mental health, especially when the target groups were different for different work streams (i.e. the general public for See Me, younger men at risk of suicide for Choose Life, people with severe and enduring mental health problems and service providers for the Recovery Network).

Those delivering the national programme have always been clear about the distinction between good mental health and the absence of mental health problems. However, understanding of the model of mental health being used in the National Programme was not always apparent amongst the other stakeholders who gave evidence to this review. Indeed, some did not even see key components of the programme (e.g. suicide) as fundamentally relevant to mental health.

This issue is fundamental to communicating how the programme can add value to progress on other social issues (such as inequalities and crime); how it articulates with mental health and other service development; and why universal approaches are needed for some issues and targeted approaches for others. Without a wider understanding of the model, it will be difficult to get everyone pulling in the right direction.

This issue relates back also to the change model being used to underpin the National Programme. Most change models, including Kotter's, emphasise the importance of a shared vision and of embedding that vision and the related values, aims and rationale with the key stakeholders. As we noted earlier, the National Programme has not fully succeeded on this front so far. However, in the next phase it is important that the model of positive mental health used is systematically refined, shared and developed with the key stakeholder groups. It must also be clear what the practical implications are for the action being taken – the 'how, why, when and what' in terms of concretely improving mental health and addressing inequalities. A clear and adequately resourced national communications strategy for key stakeholders should be an essential component of embedding the vision in phase 2.

5.5 Developing a common language

The issue of a common language to describe both good mental health and mental ill health is closely related to the embedding of a shared vision discussed above. A number of those giving evidence to the panel acknowledged that the lack of a common language was problematic. This is particularly the case with children and young people, where different languages (sometimes overlapping but not coherently so) are used by mental health professionals, education professionals, social care, the general public, the criminal justice system and government. This leads to endless confusion, especially when delivering mental health promotion initiatives and generic or primary care interventions in settings such as schools.

Whilst the National Programme will not – and should not – end debates about psychiatric diagnosis, educational difficulties or labels such as conduct disorder and ADHD, it could facilitate multidisciplinary discussion and experiential learning about language, and a focus on a common concern for mental health and wellbeing. This would be a huge step forward in common understanding. This process needs to be embedded in the training and learning experiences being promoted by the national programme as well as in carefully stratified communications activity.

5.6 Joining up the agendas: mental health improvement and service development

Italian psychiatrists in the forefront of deinstitutionalisation, such as Basaglia and Dell'Acqua, have emphasised the fact that the nature of mental health services affects public attitudes to mental health and mental health improvement because the 'institution' symbolises a negative view of both mental health and mental illness (Dell'Acqua 2005). Some respondents to the panel pointed to the fact that whilst Scotland is a world leader in the development of mental health improvement policy, its mental health services are relatively institutional in comparison with a number of other countries.

This issue is now being addressed in policy, but a clear need emerges to bring the service improvement agenda closer together with the mental health improvement programme both generally and specifically. For example, the SRN, See Me and Choose Life, or any similar activities initiated in the future, should link with the related service improvement domains of crisis intervention, deinstitutionalisation, access to work and access to talking therapies. Public mental health embraces both mental health promotion and service development.

Concretely the National Programme needs to:

- systematically join up with the service development strategy both thematically and in terms of individual projects
- engage clinical opinion formers and service leaders in the thinking behind the programme and on how services can benefit and contribute

- ensure that an overall vision for a mentally healthy Scotland embracing mental health improvement and service development is articulated in policy
- use concepts like recovery and positive mental health to shape service providers' views of how they might enhance people's mental health rather than just reducing psychiatric symptoms
- explain how work around issues like discrimination is complementary to services by removing barriers to access, improving population attitudes to services, users and the workforce and helping tackle issues like recruitment.

5.7 Strategic planning of priority actions employing an evidence-based approach

The identification of priorities for action in phase 2 needs to be guided by strategic planning that is informed by evidence and carried out in consultation with key stakeholders.

The National Programme has shown a clear commitment to evidence-based practice in phase one, and as the programme moves into the next phase there needs to be an increased focus on the systematic use and application of the existing evidence base. This entails at least two elements:

- a critical review of the evaluation findings from initiatives implemented in phase 1 and a plan for scaling up local interventions that have been found to work successfully
- the systematic use and translation of existing international evidence to guide policy and priority action selection, including the transferability of the evidence into culturally appropriate, feasible and sustainable strategies in the Scottish context.

A wide range of innovative interventions and activities were seeded during phase one of the National Programme, and the majority of these have been evaluated to determine their effectiveness in meeting planned objectives. It is now timely to take stock of the findings from the evaluation reports, both in terms of the outcomes of these initiatives and the processes which were deemed to have facilitated or inhibited effective implementation at the local level. In other words, critically review which initiatives are working well and identify the structural, technical and contextual factors that facilitated their positive effects.

In this respect, decisions will need to be made with regard to focusing effort in those areas which are most likely to reap benefits. While it is acknowledged that there needs to be flexibility in designing programmes and initiatives to meet local needs, as opposed to following top-down policy directives, it is appropriate for the next phase of the National Programme to give clear direction on where resources should be invested and about focusing efforts on initiatives that are known to be effective and have been tried and tested.

This does not mean stifling local innovation, but rather balancing creative local practice with a commitment to implementing and scaling up evidence-based programmes that have been clearly shown to have worked across different settings. For example, there is a very robust evidence base concerning the effectiveness of interventions in the early years with families and young children. Serious consideration should be given to adopting and implementing international best practice programmes within the Scottish context, particularly the rolling out of universal programmes, in the next phase.

Evaluation, and the systematic application of the evidence base, could usefully serve as a driving force for planning priority actions and effective local strategies in phase 2. A robust evaluation framework for local initiatives needs to be put in place in order to monitor progress in meeting desirable and measurable processes and outcomes, building up the local evidence base and collecting learning from practice.

In phase 2, more active strategies are required to identify and disseminate models of best practice, based on national and international evidence, that could be applied in the local context, including:

- more strategic targeting of action where there is good evidence of effectiveness
- adopting a structured planning approach to scaling up evidence-based interventions, including the supports required for effective local implementation
- building capacity for local implementation based on what has been achieved to date – identifying gaps in technical and practical skills, workforce development, organisational support and local delivery structures
- developing national guidelines on best practice – ensuring that practitioners have access to information on best practice, including knowing what to do and how to do it in the local context
- providing practitioner skills development opportunities through creating and sustaining networks for knowledge transfer
- establishing mechanisms for eliciting public engagement in the local planning, delivery and evaluation processes.

5.8 Building workforce capacity

Building the capacity of the workforce in implementing evidence-based mental health promotion is fundamental to the successful implementation and sustainability of the next phase of the National Programme.

The development of best practice depends on having a skilled and informed workforce with the necessary competencies to work at the level of population groups, communities and individuals. Partnership working and implementing cross-sectoral strategies at the local level call for high-level expertise in engaging and facilitating the participation of diverse sectors. The expertise required to translate policies and plans into effective action needs to be supported at the national, regional and local levels.

In this respect, mapping the capacity of the mental health promotion workforce in Scotland could usefully inform planning regarding the technical expertise and specific competencies that will be required to guide and direct, and be accountable for, the process of effective implementation into the next phase. At least two different levels of the workforce may be envisaged as necessary:

- dedicated mental health promotion specialists who facilitate and support the development of policy and practice across a range of settings
- the wider workforce drawn from across different sectors such as health, education, employment, community, health services and non-governmental organisations.

While there are skilled and dedicated groups of staff working on specific initiatives, it was clear from the review that the development of more generic competencies in mental health promotion, especially concerning evidence-based planning, implementation and evaluation, needs to be further strengthened. Continuing professional development and training is required to support and enhance the quality of practice and skill set required to work within changing local contexts.

Workforce education and training range from awareness raising, and training about the promotion of mental health for the wider workforce, to skills development needed to support and implement specific initiatives, through to dedicated mental health promotion specialists who facilitate and support the development and implementation of policy and practice across a range of settings. The technical skills required to support programme activities need to be put in place in order to build capacity for effective delivery into the future.

5.9 Leadership and management

As we have remarked upon already, a notable feature of the National Programme has been the energy and drive to get it established and to give it a profile within the then Scottish Executive. These are no mean achievements, especially in such a short period of time. But in much of the written and oral evidence submitted to the panel, it is clear that the National Programme has sometimes been less successful in communicating clear messages to those on the ground charged with implementing the various initiatives it has inspired.

Much of the National Programme's success and strength to date has come from the dedication, commitment and enthusiasm of a handful of individuals, including its director. Such 'product champions' perform a critical role, but the risk is that unless their achievements and ways of working are embedded then when they depart (as they inevitably will) they may not survive the transition.

The leadership challenge in contemporary public health, including mental health, is a complex one. A focus on leadership alone tends to highlight the role of individuals and the part played by heroic leaders in securing change. Given the complexities and interconnectedness of modern public health challenges, a reliance on heroic individuals is therefore neither appropriate nor possible, even if it were

desirable. Effective leadership for health demands a sound grasp of change management principles and skills, and these have not for the most part been well understood or developed in the public health workforce. These deficits are at last being acknowledged and action is being taken to address them. For example, Health Scotland supported by NHS Education for Scotland has recently introduced a pioneering leadership programme targeted at frontline practitioners. The panel welcomes, and fully endorses, such initiatives.

A distinction is often made between leadership and management. Though this has some appeal, we find it unhelpful and agree with those, including management writers such as Henry Mintzberg, who make the point that leadership and management are not mutually exclusive. Like them, we reject the view that leadership is supposed to be something bigger and more important than management. We agree that managers have to lead and leaders have to manage. In Mintzberg's words: *'management without leadership is sterile; leadership without management is disconnected and encourages hubris'* (Mintzberg 2004: 6).

The panel suggests that the National Programme has emphasised a particular form and style of leadership (as described above) and that greater attention could have been given to the change management process including embedding new ways of working and delivering services. In the next phase of the National Programme, based on the evidence reviewed by the panel, we consider that much more attention should be given to how the leadership and management functions can proceed in tandem since many of the weaknesses of the Programme's impact seem to be a result of managerial weaknesses.

The panel subscribes to the principles of a successful leadership for health improvement programme run as a pilot in an English region, the framework for which has been adopted by Health Scotland with support from NHS Education for Scotland for the new leadership programme referred to above (Hannaway, Hunter and Plsek 2007). These principles embrace the Kotter steps that have informed the National Programme from its conception, but are more explicit about the management skills required to secure effective and sustainable change.

5.10 Health inequalities

As we have noted already, reflecting the views expressed to the panel by many of those who gave evidence, health inequalities have not received the attention from the National Programme that they appear to merit. It is a conclusion that is reinforced by the findings from the 2006 *Well? What Do You Think?* survey recently published (Braunholtz *et al* 2007). It reported that *'people on lower incomes, people who experience difficulty managing financially and people who live in more deprived areas are the most likely to rate their general health as poor and to be more susceptible to mental ill-health'.* Attitudes to mental health are also poorer in areas of greater social and economic deprivation. In the light of this and other evidence, a priority in phase two of the National Programme must be that more is done to tackle inequalities issues. Indeed, it was put to the panel by one witness that the National Programme was well-placed to stimulate and lead debate and

new thinking on inequalities in mental health. This might either take the form of creating a strand to focus on inequalities or, preferably, ensuring that current and future strands of work incorporate an inequalities perspective.

The contemporary challenge of health inequalities is considerable, especially when set against a backdrop of a growing health gap between social groups within and between areas, not only in Scotland but also across the UK. Indeed, some of the most dramatic inequalities in health are evident within countries. In 'remote rural' Scotland, for example, health inequalities are greater for both males and females than in urban areas (Levin and Leyland 2006). However, in one of the most deprived areas of Glasgow, the life expectancy of men is 54 years, compared with 82 years in the most affluent (Hanlon, Walsh and Whyte 2006).

The Scottish Government's announcement of a Ministerial Task Force on Health Inequalities that will report to Cabinet by May 2008 is therefore greatly to be welcomed, particularly the emphasis to be placed on addressing the wider health needs of those with physical disabilities and mental health problems (Scottish Executive 2007). Poor mental health is both a cause and a consequence of social, economic and environmental inequalities as mental health problems both reflect deprivation and contribute to it (Social Exclusion Unit 2004). Mental health problems are more common in areas of deprivation and poor mental health is consistently associated with unemployment, less education, low income or material standard of living, in addition to poor physical health and adverse life events (Patel 2005; VicHealth 2005). Recent research also suggests that both the experience of racial harassment and perceptions of racial discrimination contribute independently to mental health problems (Chakraborty and McKenzie 2002; Aspinall and Jacobson 2004). There is evidence, too, to suggest that higher national levels of income inequality are linked to a higher prevalence of mental illness (Pickett *et al* 2006).

These findings suggest that tackling mental health inequalities entails addressing the structural determinants of mental health, including engaging in inter-sectoral action on access to higher levels of education, improved standards of living, freedom from discrimination, coping with adverse life events, and the promotion of physical and positive mental health.

The panel believes that mental health policy has an important role to play in mediating the relationship between inequity and poor health and social outcomes, as, for example, where depression is part of the pathway to cardiovascular disease, or where conduct disorder can lead to poor education and contact with the criminal justice system. In short, mental health is important to tackling poor outcomes as well as important in itself.

The recent changes in the structure of the Scottish Government, following the Taking Stock report (Scottish Executive 2006b) have the potential to achieve more effective cross-government working and inter-sectoral action. Indeed, getting health inequalities into all policies may bring about the greatest gains and help realise government's important stewardship role in respect of promoting health and wellbeing. The Taking Stock report rightly recognises the need *'to continue*

breaking down organisational barriers and encourage working across departmental silos in order to achieve overarching objectives'. The development of a cross-cutting agenda, however, requires committed leadership to work across boundaries, a culture and workforce to support this, and stability in the wider system to ensure that high-trust relationships can form and be sustained. Scotland's poor health status gives added urgency to the task of finding and implementing joined-up solutions to problems that have proved stubbornly persistent over decades. The National Programme has a critical part to play in ensuring that this challenge be effectively met in respect of mental health improvement and wellbeing.

It may be less evident in Scotland than elsewhere, although we cannot be sure, but over the past decade or so there has been a policy shift in regard to health inequalities and their causes (Hunter 2005; Dowler and Spencer 2007). A comparative review of the post-devolution health policies in England, Wales and Scotland, carried out as part of a major ESRC study with research teams in Durham, Aberdeen and Cardiff (Blackman *et al* 2006), bears this out (Smith *et al* 2007), as does a review of the New Labour policy agenda for tackling health inequalities over the past decade (Dowler and Spencer eds 2007).

Prior to 2003, the principal health policy documents were concerned with the structural determinants of health, and the role government had to play in tackling these. But since that time, the Scottish and English documents make far fewer references to any direct health impacts of broader social, material and economic determinants. Instead, they discuss these factors mostly in relation to their impact on lifestyle behaviours accompanied by a greater emphasis on individual responsibility for health. But the paradox here is that changing lifestyle behaviours without addressing the systemic causes of inequality may contribute to widening health inequalities.

In the panel's view, public health policy concerned with health inequalities should not focus only on those who experience the effects of health inequalities, but on the whole of society. As the Commission on Social Determinants of Health in its Interim Statement points out, focusing on the gap between top and bottom fails to draw attention to the social gradient in health (Commission on Social Determinants of Health 2007). It concludes that 'the social gradient in health means that we are all implicated' (ibid: 7). Public policy therefore needs to engage with social justice and sustainable development.

The risk and consequence of locating problems at the individual level is that culpability is located there, too: if poor people's physical and mental health does not improve, then it is their own fault. We eschew such 'victim blaming', and take the view that the vast majority of health inequalities are avoidable. However, regardless of the appeal of drug treatments and other interventions we disagree with those who believe the solution lies within the health sector alone. Multi-level inter-sectoral action for health is required, and the hope must be that Scotland is well placed to move beyond the rhetoric and implement such an approach.

6 Conclusion

Reflecting on the wide-ranging evidence submitted to the panel, we must conclude that during its first phase the National Programme has achieved gains for mental health policy that would otherwise probably not have happened or been possible. But no such initiative could be expected to achieve all it set out to do, and the National Programme is no exception. There are gaps and weaknesses, and areas where progress still needs to be made. The Programme has perhaps been too keen to support innovative initiatives without always going back to see if they are succeeding. But where it has succeeded is in raising awareness of mental health issues among policy-makers, especially at the centre within the then Scottish Executive. Given the powerful lobbies arguing their case and bending the ears of Ministers, that is no mean achievement.

The fact that support for the National Programme remains high across all sectors is testimony to its achievement and to its profile. But while few want it to disappear, many do want it to refresh itself, to revisit its purpose and to review the way it conducts its business in order to meet the new challenges ahead.

The challenges for phase two were summarised to the panel as pragmatism, integration and developing a more inclusive approach. While the 'command and control' model of the first phase achieved policy influence, it was seen to have been less successful in reaching down to community level. However, there is no longer any local forum for bringing programmes together: CHPs have a delivery role; CPPs are in an early stage of development and already have a huge agenda. More robust structures will be needed in future, so that priorities cannot be skewed by individuals or by fall-out from future structural shifts. The initial drive for action on all fronts now needs to give way to a more considered, and focused, strategic approach.

In summary, the panel considers that the following issues need to be addressed in the next phase:

- the National Programme remains fragile and lacks embeddedness in policy and practice at national and local levels – hence the need for its continuation
- while a determination to achieve change on all fronts was necessary in the first phase of a new venture, the panel considers that more attention needs to be given to embedding its work and ensuring that implementation and delivery occur as it enters the next phase
- if wide support for the National Programme is to be sustained there needs to be a high level 'guiding coalition' put in place which would bring together key stakeholders across sectors – this might take the form of a reinstated or renewed NAG, or variant of it, and should have as its chair someone who is seen as credible and able to command widespread respect
- the National Programme's mission, aims and objectives are diffuse and could profitably be reviewed in order to provide greater focus, so that it may do a few things well rather than dissipating its energies across such a wide range of initiatives

- as part of this effort to achieve greater focus, a strong communications strategy is needed since a current weakness is the lack of coherence in respect of what the National Programme is for
- a public health workforce 'fit for purpose' is critical in the next phase of the National Programme if the focus is to be on implementation and delivery, so initiatives like the leadership for health improvement programme launched in March 2007 are to be welcomed
- evidence-based practice plays a critical role in demonstrating the success and added value of mental health promotion and is vital to justifying funding for sustaining initiatives in the longer term. The National Programme has an important role to play in advancing the implementation of best practice in local settings. In going forward, there is a need to focus efforts and resources on interventions and initiatives that are cost effective, feasible and sustainable in local settings
- strategic planning for the next phase needs to be based on findings from evaluations conducted to date, systematic application of the international evidence base, consultation with key stakeholders, local needs assessment, and the knowledge of practitioners and local implementers
- through the National Programme, there is a need for central coordination in guiding the development of best practice through: publishing guidelines for effective implementation of sustainable programmes, setting desirable indicators by which to monitor progress, designing dissemination strategies for sharing best practice, and providing training in evidence-based programme planning, delivery and evaluation
- health inequalities demand much greater attention – which is why we devoted a sub-section to the in Section 5. They are a 'wicked problem' in all aspects of health policy, including mental health, although enough is known about the absence of self-esteem and effective control over people's lives to be able to target efforts on those with poor mental health (Wilkinson 2005).

6.1 The panel's priorities

Against this context, the following priority areas for attention emerged from the review. This summary list is underpinned and supported by the evidence discussed in previous sections:

- *the early years:* infant mental health, families and parenting, child development, the mental wellbeing of young people
- *later life issues:* Scotland is an ageing society, and issues of poverty, rurality and access mean that the National Programme must be more inclusive in its approach
- *achieving a balance between population-wide work and reaching key 'at risk' and disadvantaged minority groups:* including looked-after and accommodated children, people with disabilities, black and minority ethnic communities, prisoners, and survivors of domestic violence or childhood sexual abuse
- *involvement:* more extensive involvement of those with lived experience of mental health problems in service design and delivery, and also in needs and care assessment.

Above all, in order to meet the above challenges, strong leadership and managerial drive is required to support the future of mental health improvement in Scotland. Without this, it is unlikely to survive. But with it, the panel sees no reason why it cannot go on to achieve significant gains for the people of Scotland and perhaps become an exemplar to others both elsewhere in the UK and in the wider world.

Appendix A

References

Aspinall, PJ and Jacobson, B (2004). *Ethnic Disparities in Health and Health Care: A Focused Review of the Evidence and Selected Examples of Good Practice.* London: London Health Observatory.

Audit Scotland (2006). *Community Planning: An Initial Review.* Edinburgh: Audit Scotland.

Barry, MM and Jenkins, R (2007). *Implementing Mental Health Promotion.* Oxford: Churchill Livingstone Elsevier.

Beinecke, RH and Spencer, J (2007). *Leadership Training Programs and Competencies for Mental Health, Substance Use, Health and Public Administration in Eight Centres.* In collaboration with the International Initiative for Mental Health Leadership. New Zealand: iimh.com

Berzins, K (2006). *Implementing a Recovery Approach in Policy and Practice: A Review of the Literature.* Scotland's National Programme for Improving Mental Health and Wellbeing: Small Research Projects Initiative 2005–06. University of Glasgow. www.scotland.gov.uk/Publications/2006/06/19103019/1

Blackman, T, Elliott, E, Green, A, Harrington, B, Hunter, DJ, Marks, L, McKee, L and Williams, G (2006). Performance Assessment and Wicked Problems: The Case of Health Inequalities. *Public Policy and Administration* 21(**2**): 66-80).

Braunholtz, S, Davidson, S, and King, S (2004). *Well? What Do You Think? [2004]: The Second National Scottish Survey of Public Attitudes to Mental Health, Mental Wellbeing and Mental Health Problems.* Research Findings No 44. Edinburgh: Scottish Executive Social Research.

Braunholtz, S, Davidson, S, Myant, K, Ipsos MORI and O'Connor, R (2007) *Well? What Do You Think? [2006]: The Second National Scottish Survey of Public Attitudes to Mental Health, Mental Wellbeing and Mental Health Problems.* Research Findings No 58. Edinburgh: Scottish Government Social Research.

Cabinet Office (2007). *Capability Review of the Department of Health.* London: Cabinet Office.

Chakraborty, A and McKenzie, K (2002). Does Racism Cause Mental Illness? *British Journal of Psychiatry* **180**: 475–477.

Colombo, A, Bendelow, G, Fulford, KWM and Williams, S (2003). Evaluating the Influence of Implicit Models of Mental Disorder on Processes of Shared Decision-making within Community-based Multidisciplinary Teams. *Social Science & Medicine,* **56**: 1557–1570.

Commission on Social Determinants of Health (2007). *Achieving Health Equity: From Root Causes to Fair Outcomes.* Interim Statement. Geneva: World Health Organization.

Council for Science and Technology (2006). *Health Impacts: A Strategy Across Government.* London: CST.

Department of Health (2001). *Making It Happen: A Guide to Delivering Mental Health Promotion.* London: Department of Health.

Dell'Acqua,G (2005). Personal Communication with Dr McCulloch. Trieste: Department of Mental Health.

Dowler, E and Spencer, N (eds) (2007). *Challenging Health Inequalities: From Acheson to 'Choosing Health'.* Bristol: The Policy Press.

Durlak, JA, and Wells, AM (1997). Primary Prevention Mental Health Programs for Children and Adolescents: A Meta-analytic Review. *American Journal of Community Psychology,* **25(2)**: 115–152.

European Commission (2005). *Improving the Mental Health of the Population. Towards a Strategy on Mental Health for the European Union.* Green Paper. Luxembourg: European Communities.
http://europa.eu.int/comm/health/ph_determinants/life_style/mental/green_paper/consultation_en.htm

European Commission (2006). *Mental Wellbeing.* Special Eurobarometer 248/Wave 64.4. TNS Opinion & Social. European Commission.

Friedli, L (2006). *Mental Health Improvement 'Concepts and Definitions': Briefing Paper for the National Advisory Group.* Edinburgh: Scottish Executive.

Glasgow Centre for Population Health (2007). *Turning the Tap Off! Incapacity Benefit in Glasgow and Scotland: Trends over the Past Five Years.* Briefing Paper 6. Glasgow, Glasgow Centre for Population Health.

Goodwin, N (2006). *Leadership in Health Care: A European Partnership.* London: Routledge.

GROS (2006). General Register Office for Scotland. www.gro-scotland.gov.uk

Hanlon, P, Walsh, D and Whyte, B (2006). *Let Glasgow Flourish.* Glasgow: Glasgow Centre for Population Health.

Hannaway, C, Hunter, DJ, Plsek, P (2007). Developing Leadership and Management for Health. In: Hunter, DJ (ed) *Managing for Health.* London: Routledge.

Herrman, H, Saxena, S and Moodie, R (eds) (2005). *Promoting Mental Health: Concepts, Emerging Evidence, Practice.* A WHO Report in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne. Geneva: World Health Organization.
http://www.who.int/mental_health/evidence/MH_Promotion_Book.pdf
<http://www.who.int/mental_health/evidence/MH_Promotion_Book.pdf> (2 October 2006)

Hosman, C and Jané-Llopis, E (1999). Political Challenges 2: Mental Health. Chapter 3. In *The Evidence of Health Promotion Effectiveness: Shaping Public Health in a New Europe:* 29–41. A Report for the European Commission. International Union for Health Promotion and Education, IUHPE, Paris: Jouve Composition & Impression.

Hosman, C and Jané-Llopis, E (2005). The Evidence of Effective Interventions for Mental Health Promotion. In Herrman, H, Saxena, S and Moodie, R (eds), *Promoting Mental Health: Concepts, Emerging Evidence, Practice:*169–188. A WHO Report in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne. Geneva: World Health Organization.
http://www.who.int/mental_health/evidence/MH_Promotion_Book.pdf
<http://www.who.int/mental_health/evidence/MH_Promotion_Book.pdf (2 October, 2006).

Hunter, DJ (2005). Choosing or Losing Health? *Journal of Epidemiology & Community Health* **59 (12)**: 1010 -1013.

Jané-Llopis, E, Barry, MM, Hosman, C, and Patel, V (2005). Mental Health Promotion Works: A Review. In Jané-Llopis, E, Barry, MM, Hosman, C and Patel, V (eds), The Evidence of Mental Health Promotion Effectiveness: Strategies for Action. *Promotion and Education,* suppl: 9–25.

Jané-Llopis, E and Barry, MM (2005). What Makes Mental Health Promotion Effective? *Promotion and Education,* suppl 2: 47–55.

Kotter, JP (1995). Leading Change: Why Transformation Efforts Fail. *Harvard Business Review,* March–April 1995: 59–67.

Lang, T, Dowler, E, and Hunter, DJ (2006). *Review of the Scottish Diet Action Plan: Progress and Impacts 1996–2005.* Edinburgh: Health Scotland.

Leon, D, Morton, S, Cannegieter, S, and McKee, M (2003). *Understanding the Health of Scotland's Population in an International Context. A Review of Current*

Approaches, Knowledge and Recommendations for New Research Directions. London: London School of Hygiene and Tropical Medicine.

Levin, KA and Leyland, AH (2005). Urban/Rural Inequalities in Suicide in Scotland, 1981–1999. *Social Science & Medicine* **60 (2005)**: 2877–2890.

Levin, KA and Leyland, AH (2006). A Comparison of Health Inequalities in Urban and Rural Scotland. *Social Science & Medicine* **62 (2006)**: 1457–1464.

Lodge, G and Kalitowski, S (2007). *Innovations in Government: International Perspectives on Civil Service Reform.* London: Institute for Public Policy Research.

McCollam A *et al* (2006). *National Evaluation of the 'Doing Well by People with Depression' Programme.* Edinburgh: Scottish Executive.

McLean, J, McCollam, A, and MacCallum, E (2001). *Information Needs for Mental Health Services in Scotland: Report of a National Research Survey.* Edinburgh: Scottish Development Centre for Mental Health, December 2001.

Mintzberg, H (2004). *Managers Not MBAs: A Hard Look at the Soft Practice of Managing and Management Development.* Harlow: Prentice-Hall.

Morton, A and Francis, J (2000). *The Sorrows of Young Men. Exploring Their Increasing Risk of Suicide,* Edinburgh: Centre for Theology and Public Issues, University of Edinburgh (Occasional Paper No 45).

Mrazek, PJ and Haggerty, RJ (eds) (1994). *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research.* Washington DC: National Academy Press.

Muijen, M and McCulloch, A (2007). Public Policy and Mental Health. In: Gelder, M (ed) *The New Oxford Encyclopaedia of Psychiatry.* Oxford: Oxford University Press. (accepted for publication).

National Mental Health Strategy Evaluation Steering Committee, for the Australian Health Ministers Advisory Council (1997). *Evaluation of the National Mental Health Strategy: Final Report, Mental Health Branch, Commonwealth Department of Health and Family Services.* Canberra Act 2601, December 1997.

Patel, V (2005). Poverty, Gender and Mental Health Promotion in a Global Society. In: Jané-Llopis, E, Barry, MM, Hosman, C, and Patel, V (eds). The Evidence of Mental Health Promotion Effectiveness: Strategies for Action. *Promotion & Education,* suppl **2**: 26–29.

Patterson, N (2005). *Scotland's Health at Work Mental Health & Wellbeing Project.* Evaluation of Year 2. Edinburgh: Scottish Executive.

Philp, AV, Watson, L, and Muir, R (2002). *Mental Health in Scotland: Information Sources and Selected Insights.* Edinburgh, NHS Scotland Information and Statistics Division.

Pickett, KE, James, OW and Wilkinson, RG (2006). Income Inequality and the Prevalence of Mental Illness: A Preliminary International Analysis. *Journal of Epidemiology & Community Health* **60**: 646–647.

Platt, S, Petticrew, M, McCollam, A, Wilson, S, and Thomas, S (2005). *Mental Health Improvement: An Appraisal of Scottish Policy. Part 1: Main Report and Appendices 1–4.* Commissioned by NHS Scotland. Edinburgh: University of Edinburgh: 41–47.

Platt, S, McLean, J, McCollam, A, Blamey, A, Mackenzie, M, McDaid, D, Maxwell, M, Halliday, E, and Woodhouse, A (2006). *Evaluation of the First Phase of Choose Life: The National Strategy and Action Plan to Prevent Suicide in Scotland.* Edinburgh: Scottish Executive Social Research.

Schinkel, M and Dorrer, N (2006). *Towards Recovery Competencies in Scotland: The Views of Key Stakeholder Groups.* Glasgow: Scottish Recovery Network; www.scottishrecovery.net

ScotPHO (2007). *Briefing Notes: The Scotland and European Health for All (HfA) Database 2007.* Edinburgh: Scottish Public Health Observatory, www.scotpho.org.uk

Scottish Association for Mental Health (2006). *What's It Worth? The Social and Economic Costs of Mental Health Problems in Scotland.* Glasgow: SAMH.

Scottish Executive (2001). *Our National Health: A Plan for Action, A Plan for Change.* Edinburgh: Scottish Executive.

Scottish Executive (2003a). *Improving Health in Scotland: The Challenge.* Edinburgh: Scottish Executive.

Scottish Executive (2003b). *National Programme for Improving Mental Health and Wellbeing: Action Plan 2003–2006.* Edinburgh: Scottish Executive.

Scottish Executive (2004). *Evaluation of Mental Health First Aid: Pilot Project in Scotland, January–June 2004.* Executive Summary. Edinburgh: Scottish Executive.

Scottish Executive (2005a). *Devolution Factsheets.* Edinburgh: Scottish Executive, 15 April 2005.

Scottish Executive (2005b). *The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care.* Edinburgh: Scottish Executive.

Scottish Executive (2005c). *Equal Minds.* Edinburgh: Scottish Executive.

Scottish Executive (2006a). *Delivering a Healthy Scotland: Meeting the Challenge.* Annual Report. Edinburgh: Scottish Executive.

Scottish Executive (2006b). *Taking Stock Review: Fit for the Future.* Edinburgh: Scottish Executive.

Scottish Executive (2006c). *Delivering for Mental Health.* Edinburgh: Scottish Executive.

Scottish Executive (2006d). *Scottish Executive Response to the Evaluation of the First Phase of Choose Life.* 29 August 2006.

Scottish Executive (2007). *Better Health, Better Care.* A Discussion Document. Edinburgh: Scottish Executive.

Scottish Executive Statistics (2006). *Health of Scotland's Population – Mental Health. High Level Summary of Statistics Trend Last update Tuesday June 20 2006.* www.scotland.gov.uk/Topics/Statistics/Browse/Health/TrendMentalHealth

See Me (2006) See Me so far. *A Review of the First 4 Years of the Scottish Anti-stigma Campaign.* Edinburgh: See Me.

See Me (2007). *A Fairer Future. Building Understanding. Moving Forward Together.* Edinburgh: See Me.

Sheehy, C, Jones, L, Dobbie, F, Hayes, F, and Platt, S (2006). *Evaluation of the Breathing Space Telephone Advice Line and Signposting Service for People Experiencing Low Mood or Depression.* Edinburgh: Scottish Executive Social Research.

Smith, K, Hunter, DJ, Blackman, T, Williams, G, McKee, L, Harrington, BE, Elliott, E, Marks, L, and Greene, A (2007). *Divergence or Convergence? The Post-Devolution Health Policies of England, Scotland and Wales.* Unpublished paper (under review for publication).

Social Exclusion Unit (2004). *Mental Health and Social Exclusion: Social Exclusion Unit Report.* London: Office of the Deputy Prime Minister.

Stevenson, R and Elvy, N (2007). *Evaluation of Scotland's Mental Health First Aid.* Edinburgh: Hexagon Research and Consulting.

Tilford, S, Delaney, F and Vogels, M (1997). *Effectiveness of Mental Health Promotion Interventions: A Review.* London: Health Education Authority.

VicHealth (2005). *Mental Health and Wellbeing Research Summary Sheets No 1. Burden of Disease due to Mental Illness and Mental Health Problems.* Victoria: The Victoria Health Promotion Foundation, Australia.

Wanless, D (2004). *Securing Good Health for the Whole Population.* London: HM Treasury.

Wells, J, Barlow, J, and Stewart-Brown, S (2003). A Systematic Review of Universal Approaches to Mental Health Promotion in Schools. *Health Education,* **103(4)**: 197–220.

Wilkinson, RG (2005). *The Impact of Inequality: How to Make Sick Societies Healthier.* London: Routledge.

Woods, K and McCollam, A (2002). Progress in the Development of Integrated Mental Health Care in Scotland. *International Journal of Integrated Care,* **2**: 1, June 2002, http://www.ijic.org

World Health Organization (1986). *Ottawa Charter for Health Promotion.* Copenhagen: World Health Organization.

World Health Organization (2001). *Mental Health: New Understanding, New Hope.* The World Health Report. Geneva: WHO.

World Health Organization (2002a). *Prevention and Promotion in Mental Health: Evidence and Research.* Department of Mental Health and Substance Dependence, Geneva: WHO.

World Health Organization (2002b). *Prevention and Promotion in Mental Health.* Geneva: WHO.

World Health Organization (2004a). *Promoting Mental Health: Concepts, Emerging Evidence and Practice.* Summary report. World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne. Geneva: WHO. Available: www.who.int/mental_health/evidence/en/promoting_mhh.pdf

World Health Organization (2004b). *Prevention of Mental Disorders: Effective Interventions and Policy Options.* A report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht. Geneva: WHO. Available: www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf

World Health Organization (2005). *Mental Health Action Plan for Europe: Facing the Challenges, Building Solutions.* Available: www.euro.who.int/document/mnh/edoc07.pdf

Appendix B

Review timeline

Timeline	Mental Health Improvement Policy (MHIP) Review
May 06	Initiation • Meeting with the Secretariat (Health Scotland) and the Scottish Executive
June 06	Review proposal adopted
	• Adoption of the review proposal by the Scottish Executive
July–August 06	Panel Chair appointed
	• Chair of MHIP Review Panel identified/appointed
August 06	Chair briefing
	• Chair of MHIP Review Panel briefed
August–Sept 06	Panel appointed
	• Two further MHIP Review Panel members recruited
Nov 06	Review Panel briefing and hearings (two days)
	• Approach agreed and evidence required outlined
	• MHIP Panel briefed on background to Scottish policy context
	• Panel meetings with representatives from:
	– Scottish Executive
	– Health Scotland
Nov–Dec 06	Evidence gathering
	• Web-based questionnaire
	• New research commissioned
	• Gathering and synthesizing existing evidence

Dec 06	**MHIP Review Panel Hearings (two days)**
	• Panel meetings with representatives from areas of:
	– Public health
	– Research
Jan 07	**MHIP Review Panel Hearings (three days)**
	• Panel meetings with representatives from areas of:
	– Employment and working life
	– Children and young people
	– Later life
March 07	**MHIP Review Panel hearings (two days)**
	• Panel meetings with representatives from areas of:
	– Communities and culture
	– Communications
	Interviews and survey of international experts
	• Small number of telephone interviews and short electronic survey
	• Insight into international perspectives on work that has gone on in Scotland
April 07	**MHIP Review Panel hearings (two days)**
	• Panel meetings with representatives from areas of:
	– Services/infrastructure for delivery
	– Prison service
May 07	**Stakeholder engagement event**
	• Engagement event with stakeholders involved in meetings and consultation to date
May–July 07	**MHIP Review Panel writing sessions**
	• Panel prepare draft report

July 07	Draft report submission
	• Draft report submitted to Health Scotland for editorial revisions
Aug 07	Panel review report revisions
Sept 07	Final report submission
	• Final report submitted by Panel to Health Scotland
Feb 08	Release of report
	• Report released by Health Scotland into the public domain
	Dissemination of the review report
	• Dissemination of the report by Health Scotland

Appendix C

Contributing organisations and agencies

Association of Chief Police Officers in Scotland
Advocacy Matters
Age Concern
Alzheimer Scotland
Scottish Arts Council/Artfull
Barnardos
Black and Ethnic Minorities Infrastructure in Scotland
Breathing Space
Carers Scotland
Centre for Healthy Working Lives
Community Health Exchange (CHEX)
Children in Scotland
Choose Life
Cruse Bereavement Care Scotland
Cumbernauld Action for Care of the Elderly
Depression Alliance Scotland
Edinburgh Chinese Elderly Support Association
Heads Up Scotland
Learning and Teaching Scotland
Families Outside
Glasgow Centre for Population Health
Glasgow University
Health in Mind
Health Promoting Schools Unit
Help the Aged
Highland Users Group
JobCentre Plus
Mental Health in Later Life steering group
Men's Health Forum Scotland
Independent Mental Health Promotion Specialist
NHS Borders
NHS Dumfries and Galloway

NHS Fife
NHS Forth Valley
NHS Grampian Public Health
NHS Greater Glasgow
NHS Health Scotland
NHS Highland
NHS Lanarkshire
NHS Lothian
NHS National Services Scotland
NHS Western Isles
National Resource Centre for Ethnic Minority Health
Penumbra
Royal National Institute for Deaf People
Royal College of Nursing
Royal College of Psychiatrists
Samaritans
Scottish Association for Mental Health
Scottish Centre for Healthy Working Lives Faculty of Occupational Health
Scottish Development Centre for Mental Health
Scottish Executive
Scottish Further Education Unit
Scottish Institute of Human Relations
Scottish Prison Service
Scottish Recovery Network
See Me
Social Firms Scotland
Stresswatch
Scottish Trades Union Congress
Teacher Support Scotland
Universities Scotland
University of Edinburgh
Voices of eXperience (VOX)
Young Scotland in Mind
Youngminds
Youthlink

Appendix D

The National Programme's key initiatives

National Programme for Improving Mental Health and Wellbeing
www.wellscotland.info

Breathing Space
www.breathingspacescotland.co.uk

Choose Life
http://www.chooselife.net/home/Home.asp

Scotland's Mental Health First Aid
http://www.healthscotland.org.uk/smhfa/

Scottish Recovery Network
http://www.scottishrecovery.net/

See Me
www.seemescotland.org.uk/

Appendix E

Online survey proforma

Part one: Change

In this section we have included a series of outcome statements, to which mental health improvement policy in Scotland (largely driven by the National Programme) is aspiring. Taking each of these statements in turn, please indicate the level of change that you think has been achieved since October 2001 (the launch of the National Programme) towards achieving these goals.

Please indicate which level of change you think most accurately reflects each of the listed statements.

- Significant change
- Moderate change
- Minor change
- No change
- Have no knowledge of this area

Please think about these statements in relation to the experiences, work and activity of your own organisation/group/service.

Public promotion of mental health/positive mental health

- It is widely accepted that good mental health is essential to overall health and wellbeing.
- It is widely accepted that good mental health is just as important as physical health.
- Knowledge of how to look after good mental health is widespread.
- Mental health improvement is regarded as central to achieving the health improvement policy agenda.

Prevention of mental health problems/mental illness

- It is widely accepted that everyone can experience difficulties with their mental health that can put them at risk of developing mental health problems.
- The risks to good mental health are widely understood.
- There is better understanding that suicide can be prevented.
- Knowledge of the signs of suicidal behaviour and of what to do when someone is at risk has improved.

Knowledge of and access to support

- Knowledge of how and where to access help and support (e.g. materials, groups, networks, services) for mental health problems/illness has improved.

Inclusion, equalities, stigma and discrimination

- There is a wider understanding that it is wrong to stigmatise or discriminate because of a mental health problem or mental illness.
- People who experience mental health problems or mental illness are widely valued in all aspects of community and civic life.
- It is widely accepted that people who experience mental health problems or mental illness should not have their rights as citizens compromised in any way (e.g. right to work).
- The expectation that people do recover from long term and serious mental health problems is widespread.
- Support for people who have experience of long-term mental health problems to recover and stay well has improved.
- Diversity and equality (race, age, gender, sex orientation, spirituality or disability) is considered routinely in the planning and delivery of mental health improvement/mental health services.

Age groups

- The importance of promoting mental health and preventing mental ill-health in the early years is widely understood.
- The importance of promoting mental health and preventing mental ill-health among children and young people is widely understood.
- The importance of promoting mental health and preventing mental ill-health in later life is widely understood.

Settings

- Good mental health is actively promoted in the workplace.
- Employers commonly take steps to help prevent mental health problems and mental illness in the workplace.
- Most people who experience mental health problems or mental illness are supported by their employers to remain in employment.
- Good mental health is actively promoted in schools and other educational settings.
- Mental health improvement is well integrated across community planning.
- Media reporting and depiction of mental health, mental illness and suicide is more balanced and appropriate.

Evidence

- Research and evaluation evidence is widely used in the planning and delivery of mental health improvement work.

Part two: Future Priorities

In this section, we are interested in your views about priorities for future mental health improvement policy.

Please give up to five priorities for future mental health improvement policy in Scotland.

(Please give reasons why you have identified these as priorities)

Part three: Background Information

How knowledgeable do you feel about mental health and mental health improvement?

Please tick as appropriate

☐ *Very* ☐ *Fairly* ☐ *A little* ☐ *Not at all*

What is your current role? (e.g. support worker, health promotion specialist, service manager, health improvement officer, teacher)

Please briefly describe how you think mental health improvement relates to your role

Who are the main clients/end users of your work?
(Please tick all the relevant groups)

☐ Early years
☐ Children and young people
☐ Adults of working age
☐ Older people
☐ All of the above
☐ Other (please specify)

What sector best describes your organisation's work?
Tick as appropriate

- ☐ Scottish Executive or other national public body or agency
- ☐ Local Authority*
- ☐ Health Service
- ☐ Voluntary Organisation (mental health)
- ☐ Voluntary Organisation (other)
- ☐ Service user or carer group
- ☐ Other (please specify)

* If you have answered 'Local Authority' please state the service/department

Is your current role different to your role in 2001?

Tick as appropriate

☐ Yes ☐ No

If yes, were you working in Scotland and in work related to mental health improvement in 2001?

Tick as appropriate

☐ Yes ☐ No

Appendix F

International questionnaire proforma

1. **Please can you describe your area of expertise in relation to mental health improvement.** *(Prompt: In relation to key aims of National Programme)*

2. **How aware are you of the National Programme's key aims and priority areas set out in its action plan for 2003–2006?**

	Very aware	Somewhat aware	Only basic knowledge
Key aims			
Raising awareness and promoting mental health and wellbeing			
Eliminating stigma and discrimination			
Preventing suicide			
Promoting and supporting recovery			
Priority areas			
Early years			
Children and young people			
Improving mental health and wellbeing in employment and working life			
Improving mental health and wellbeing in later life			
Improving community mental health and wellbeing			
Improving the ability of public services to act in support of the promotion of mental health and the prevention of mental illness			

3. From where, does your knowledge of the National Programme come?

4. What involvement or links do you or have you had to the National Programme?

5. Do you feel that the National Programme's key aims and priorities are appropriate?

6. Based on your knowledge of the National Programme, do you think that the National Programme has been informed by the best available evidence?

7. How effective do you feel mental health improvement policy has been in Scotland since 2001? *Prompt: Why?*

8. From your knowledge or experience, has the National Programme and its associated initiatives (Choose Life, Breathing Space, See Me, Recovery Network) informed or influenced work relating to mental health improvement in:

- your own country?
- other countries?

9. Based on your knowledge of current international developments, what are the key issues that Scotland should consider in planning a future strategic direction for its mental health improvement policy?

10. Any other comments?

Appendix G

Written submission form

1. *The National Programme for Improving Mental Health and Wellbeing has tried to establish a sense of urgency around the case for prioritising mental health and wellbeing.*

- How successful do you think this has been?
- Has the priority given to mental health and wellbeing increased within your organisation/field?
- What has helped and/or hindered this?

2. *The National Programme has established a coalition of organisations and individuals that lead the effort to improve Scotland's mental health and wellbeing.*

- How effective do you think has this been?
- Has it encouraged organisations/departments to understand their role in improving mental health and wellbeing and contribute to this? Please provide examples

3. *The vision of the National Programme is to improve the mental health and wellbeing of people living in Scotland and to improve the quality of life and inclusion of people who experience mental health problems.*

- Do you share the vision of the National Programme?
- Is this vision coherent and sensible?
- How extensively has this vision been communicated and owned?

4. *One of the goals of the National Programme has been to encourage organisations to act on this vision and integrate mental health improvement within their work.*

- To what extent has your organisation been able to do this?
- What has helped and/or hindered this?
- What obstacles remain?

5. *The National Programme was launched in October 2001 with an action plan in place since 2003.*

- In your opinion, what have been its main achievements?
- How has it made a difference to the work of your organisation?
- How has this impacted on the clients, practitioners or communities with whom you work?

6. *Thinking about future direction and priorities, how should the work of the National Programme be taken forward in order to consolidate achievements and improvements and contribute to build and strengthen the goal of improving Scotland's mental health and wellbeing?*

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