editorial

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MICHAEL SMITH

Devolution and 'public psychiatry' in Scotland

When questioned about the impact of the new Scottish Parliament, Scots are likely to respond with a mixture of pride and defensiveness, aspiration and scorn. To those who campaigned against two centuries of control from Westminster, the first sitting of the Scottish Parliament on 12 May 1999 represented a national triumph. An era of national pride and responsive, effective governance for Scotland, had begun. To others, this new chamber was merely a 'wee pretendy Parliament' – an additional layer of bureaucracy with little utility. This article reviews the influence of Parliament on mental health in Scotland during its first term.

Since 1999, education, agriculture, transport, justice and the health service have been under the control of directly elected Scottish politicians, rather than administrated by the Scottish Office. Health spending represents 40% of the Scottish budget, and mental health accounts for 1.3% of that total, i.e. just over £700 million. In financial terms, therefore, mental health represents about 5% of all Parliamentary business.

Mental health has been a significant focus of Parliamentary time. One of the first acts of the new Parliament was to approve an emergency bill [The Mental Health (Public Safety and Appeals) (Scotland) Bill] regarding the detention of people with personality disorders, which received Royal Assent in September 1999. The Mental Health (Scotland) Bill is one of the major pieces of legislation to pass through Parliament in its final term. But devolution applies not only to Parliament, but also to many other bodies with an interest in mental health, including the Royal College of Psychiatrists.

Just as the Minister for Health in Scotland has to show he is able to use his new powers and budget effectively, so does the Scottish Division. So what is the evidence? Is the Scottish Division of the College just "English psychiatry in a kilt"? Or can it be both distinctive and effective?

What is so different about Scotland?

Although the population of Scotland is only equivalent to the size of a large English region, the country covers a third of the UK landmass and reflects a broad range of communities: from the concentrated inner-city deprivation of cities such as Glasgow, to the remote (and often gaelic-speaking) rural population in the Highlands and Islands. Scottish education and legal systems are different from those in the rest of the UK, and this distinctiveness is reflected in the Scottish print and broadcast media.

Just as a Scots' physical health is infamously poor, mental health north of the border is significantly worse than in England. For example, Scotland has double England's level of intravenous drug misuse, rates of suicide in young men have increased by 50% over the last 10 years (and fourfold over the last 25 years), and prescribing rates for both hypnotics and antidepressants are significantly higher than those in England (and rising). A total of 30–40% of absences from work in Scotland are caused by mental health problems, yet 117 000 people in Scotland with mental health problems want to work but are currently unemployed.

Unlike the "unprecedented micromanagement from the centre" (Smith *et al*, 2001) experienced by the National Health Service (NHS) in England and Wales, the NHS in Scotland (NHSiS) is managed more loosely. There are also significant policy differences north and south of the border. For example, service targets were not a feature of the Scottish National Service Framework, and (at the time of writing in October 2002) there are no plans in Scotland to introduce foundation hospitals, nor ranking or grading of hospitals.

The emphasis here has been on a more consultative and collaborative model, and there is a consensus that clinicians retain more respect and involvement than they do in the South. But to be effective, this approach depends on good communication between policy makers, clinicians and other stakeholders throughout the country.

What are mental health services like in Scotland?

Changes in Scottish mental health policy have been described previously in this journal (Loudon & Coia, 2002) and will not be reviewed here.

To a large extent, devolution has confirmed differences in character and autonomy that were already tangible in Scotland. For example, organisations such as the Scottish Intercollegiate Guidelines Network (SIGN),

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the Academy of Scottish Royal Colleges, the Scottish Health Advisory Service (SHAS), the Mental Welfare Commission for Scotland (MWCS), the Clinical Standards Board for Scotland (CSBS) and the Health Technology Board for Scotland (HTBS) have distinctive Scottish origins and character.

Each has, in the words of a senior Scottish psychiatrist, "a tradition of feet firmly planted on clinical service level and ears open to the opinion of clinicians". The HTBS, for example, accepts nominations for investigations mainly from Boards, Trusts and clinicians, whereas the agenda for the National Institute for Clinical Excellence is set by the Department of Health.

However, there are concerns that the organic development of health service management in Scotland has become too diffuse, at least in mental health services. For example, more than 20 departments within the Scottish Executive have responsibilities for different aspects of mental health.

Significant consolidation is now taking place. The number of NHS Trusts was reduced early in the first Parliamentary term, and their functions will soon be taken over by 14 strengthened health boards and many more local health care co-operatives (LHCCs). Three of the 'clinical effectiveness' bodies referred to above will be brought together into one "Quality and Standards Board for Health in Scotland". But there have been some weaknesses in mental health service planning. Clinical developments have fallen short of the aspirations of the National Service Framework, and there are concerns that the various quality agencies have not achieved sufficient purchase or coherence in order to drive service improvements.

The problems in Scotland will be familiar to psychiatrists throughout the UK. Many psychiatric in-patient units provide poor quality accommodation, are overoccupied and have been forced to emphasise medication and containment, rather than providing a therapeutic environment.

Staff shortages reflect a lack of morale in all disciplines, which is particularly acute in psychiatric nursing, with 14% of vacancies unfilled. Many community teams are inadequately developed and integrate poorly with primary care and the voluntary sector. General practitioners and practice nurses often lack training in mental health problems, resources are not always targeted at interventions of known effectiveness and the development of tertiary specialist services (particularly for eating disorders) has been patchy at best.

Developing a mainstream consensus

How should we tackle such issues? The Scottish Parliament is committed to "openness, accountability, the sharing of power and equal opportunities", according to its convener, MSP David Steel (source: SP website). However, such power-sharing raises problems, as well as opportunities, for the College in Scotland. When planning mental health services, psychiatry is only one of several interested agencies, many of which are better equipped to make themselves heard by policy makers. As Persaud (2000) said:

> ". . . while acknowledging they would rather see a doctor than anyone else when seriously ill, lay public and politicians also prefer practically any alternative, other than a physician, when determining who should decide how health care is delivered. Psychiatrists seem even more marginalised than other medical colleagues in public debate about practice.

Developing a broad mental health agenda requires liaison between all sectors of the 'mental health community', including users and carers, the Scottish Executive and Parliament, the voluntary sector, Scottish media and the general public. This approach might usefully be termed 'public psychiatry', and has been a significant focus for the College in Scotland in recent years. For example, in partnership with four voluntary organisations in Scotland, the College successfully lobbied the Scottish Parliament to set up a Cross-Party Group on mental health, to which the College provides administrative support. A second lobbying campaign raised funding from the Scottish Executive for a national anti-stigma campaign ('see Me'; www.seemescotland.org), run jointly by the College and four Scottish voluntary organisations. Complementing the anti-stigma campaign is a programme to improve mental health and wellbeing, in which the College also plays a part.

The College holds a biannual joint conference with users and carers and the voluntary sector. Whereas interpretation of these meetings will inevitably be subjective, there is a consensus among both College members and users of services that the joint meetings have been helpful in improving trust and communication, as well as developing a shared agenda for change.

The College was one of several organisations represented on the Millan Committee's wide consultation for a revised Scottish Mental Health Act. Some proposals have proved controversial (e.g. the regulation of neurosurgery for mental disorder, and community treatment orders). But the Bill is clearly focused on health rather than public safety, and is based on principles (of autonomy, 'least restrictive alternative' and participation, among others), that have been broadly welcomed.

Conclusions

The aim of this paper is to outline some of the ways in which Scottish psychiatry is different from that in other parts of the UK and Ireland, and to describe how the Scottish Division has responded to such differences.

The Division is developing a distinctive response to mental health developments; one that makes the most of Scotland's smaller size and greater autonomy in policy-making. Like the HTBS, we should interpret developments in other parts of the UK in a Scottish context, rather than trying to reinvent the wheel (Mackay, 2002). This will depend on continuing joint work with other Scottish organisations with a mental health interest. Though some might have viewed psychiatrists with suspicion, or even hostility, in the past, we hope that genuine trust will emerge from our continued joint working.

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This is not merely wishful thinking. Psychiatrists, carers and users of services were asked during our last joint conference to answer the question, 'what do we want for mental health in the next 2 years?' Some of the answers that emerged from group discussion were as follows: direct and meaningful involvement in allocation of resources; better access to information; better communication between hospitals and primary care; more time; quality not crises; to learn from voluntary organisations about flexibility and user involvement; and better funding and support for staff training.

These are changes that most of us can sign up to. We have already shown that we can be effective through our active Cross-Party Group, a progressive new Mental Health Act and an energetic anti-stigma campaign. By continuing to work together it should be possible to shape an effective and distinctive mental health service in Scotland.

Declaration of interest

None.

References

LOUDON, J. & COIA, D. (2002) The Scottish scene. *Psychiatric Bulletin*, **26**, 84–86.

MACKAY, A. (2002) Health technology assessment and mental health. *Psychiatric Bulletin*, **26**, 243–245.

PERSUAD, R. (2000) Psychiatrists suffer from stigma too. *Psychiatric Bulletin*, **24**, 284–285.

SMITH, J., WALSHE, K. & HUNTER, D. (2001) The "redisorganisation" of the NHS. *BMJ*, **323**, 1262–1263.

M. Smith Consultant Psychiatrist and Senior Research Fellow, Section of Psychological Medicine, Division of Community-based Sciences, University of Glasgow, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G12 0XH

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