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Executive, 2001). Clinicians and service users have been well-represented. In line with the ECHR and a theme of open accountability, it recommends 10 principles against which the operation of a new Act should be judged. The first Act to be passed by the Scottish Parliament was in response to the freeing of an individual from the state hospital, at Carstairs, by a sheriff court. This highlighted ambiguities around the management and treatment of those suffering from personality disorders in Scotland. The MacLean Committee has reported on its review of services for serious violent and sexual offenders (Criminal Justice, 2001).

An Act based on enlightened principles to develop a system of practice for adults with incapacity has recently been passed by the Scottish Parliament, and will be implemented from 2001.

Factors working against positive change

Although mental health services have been a priority for the NHS in Scotland for over 20 years, any change in the allocation by health boards on the proportion of resources devoted to them has been very slow. For child and adolescent services the expenditure per head of population served was found to vary threefold between boards. At health board level there has been a lack of intuitive understanding of mental health issues, no strategic approach to positive mental health and no tradition of collaboration with other service providers, or users of services. There is a poverty of intelligence available to boards on the mental health needs of the populations they serve, and the activities of the mental health services.

Since 1991, the lead role for the development of community care has lain with local authority social work departments. The difficulties besetting joint commissioning and resource transfer are not unique to Scotland. Different planning cycles and financial reporting systems or conflicting priorities compromise joint working. Some areas do better, and all involved need to learn how to learn from good practice, to adapt and apply the lessons locally.

Primary care has a well articulated view of the mental health needs of practice populations. As yet, the rebrigading into PCTs has not had time to develop the necessary meeting of minds between primary and secondary care. There is a need for mental health services to respond positively and flexibly to the development of integrated care plans and pathways.

Progress has been slow in fostering real involvement of users of services and those who care for them. 'Allies in Change', a consortium of voluntary and user groups with support from not-for-profit organisations, has obtained Health Department funding to set up training to assist users in representing themselves effectively in the planning and service monitoring processes and thus impact on the move to a user-led model. Although in operation for little more than a year, this project has found a way to draw in carers and staff as well. It has produced excellent good practice guidance.

Conclusions

This paper is not inclusive of all the changes in mental health services in Scotland but is an attempt to introduce some of the differences to a wider audience. If we wish, as doctors, to remain part of a UK-wide NHS family we must acknowledge and respect our different priorities and aspirations. There has to be space on our Royal Colleges' agendas and systems for matters peculiar to Scotland, Wales and Ireland to be dealt with in a way that is different from England, without a threat being perceived to the overall integrity of the organisation.

References

CRIMINAL JUSTICE (2001) *A Report of the Committee on Serious Violent and Sexual Offenders*. Edinburgh: Scottish Executive.

MENTAL HEALTH REFERENCE GROUP (2000) *Risk Management*. Edinburgh: Scottish Executive.

— (2001) *Needs Assessment for a Comprehensive Local Mental Health Service*. Edinburgh: Scottish Executive.

SCOTTISH OFFICE (1997*a*) *A Framework for Mental Health Services in Scotland*. Edinburgh: Scottish Office.

— (1997*b*) *Designed to Care*. Edinburgh: Scottish Office.

SCOTTISH EXECUTIVE (2000) *Our National Health: A Plan for Action, A Plan for Change*. Edinburgh: Scottish Executive.

— (2001) *New Directions. A Report on the Review of the Mental Health (Scotland) Act 1984*. Edinburgh: Scottish Executive.

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Commentary: the Scottish scene†

Loudon and Coia (pp. 84–86, this issue) have provided an informative snapshot of the Scottish scene that is clear, succinct and objective. They set out the main organisational structures and framework within which we operate north of the border, and touch upon some of the factors working against positive change.

What they have not conveyed is the huge amount of time and energy that is being devoted to redesigning and developing mental health services, despite the impact of structural changes within the care systems, and the daunting size of the change management task.

†See pp. 84–86, this issue.

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For example, the launch of the *Framework for Mental Health Services in Scotland* in 1997 (Scottish Office) needs to be set in the context of the NHS and local authority changes happening around that time. I work in the Scottish Borders, a rural area with a scattered population of 106 000. The local directly managed mental health unit became part of a community NHS trust in 1995, and was translated into a primary care trust, with the inclusion of primary care and other services, 4 years later. In 1996 the local regional council and four district councils were replaced by a single unitary council. These upheavals resulted in a significant movement of key personnel and required time to be devoted to setting up new structures within the new organisations merely to maintain existing services. Perhaps what is surprising is the extent to which progress has been made under these circumstances.

The pace of change appears to be accelerating, perhaps partially a function of the new Scottish Parliament. With health representing 40% of the parliament's budget, Scottish health is being debated more than ever before. In the period immediately before devolution there was only one debate at Westminster on Scottish health issues, and that was a short adjournment debate. In the first 18 months of the Scottish Parliament there have been around 50 debates on health and community care matters.

Within the past few months the Scottish Health Plan (Scottish Executive, 2000), the Millan Committee report (Scottish Executive, 2001) and Clinical Standards Board for Scotland (2000) standards for schizophrenia have been published, all of which will have an impact on the delivery of mental health services.

The Health Plan (*Our National Health*; Scottish Executive, 2000) reconfirms the three clinical priorities; coronary heart disease, cancer and mental health. But adds another priority, the health of children and older people. This raises questions about what being a clinical priority means. New national targets for maximum waiting times for cancer treatment have been published, and by next year there will be maximum waits for angiography and angioplasty. There is a risk that these somatic priorities, already able to be measured on hard data, will preoccupy NHS Scotland. With only soft information being available in mental health, or crude unrepresentative measures like whole population suicide, perceptions of priorities could be distorted, with funds being diverted away from mental health. *Our National Health* does emphasise the Framework and it is to be hoped that the new accountability review process set out in the National Plan will ensure that health boards deliver the Framework agenda.

National differences are of interest, and not always simple to explain. *Safety First*, the 5-year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness is the first to include Scottish data (Department of Health, 2001). It is expected to confirm the very much higher general population suicide rate in Scotland compared with England. The Scottish Executive held a seminar on suicide prevention in November 2000, an outcome of which was the intention to develop a multi-agency framework for suicide prevention. England already has a suicide prevention strategy, but none is planned for Northern Ireland.

Such diversity should be a source of interest and strength for the College and I echo the authors' call for College business to be less exclusively related to the Department of Health of England if interest from psychiatrists working in other parts of the British Isles is to be retained.

References

CLINICAL STANDARDS BOARD FOR SCOTLAND (2000) *Clinical Standards for Schizophrenia*. Edinburgh: CSBS.

DEPARTMENT OF HEALTH (2001) *Safety First – Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. London: Department of Health.

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

SCOTTISH EXECUTIVE (2000) *Our National Health: A Plan for Action, a Plan for Change*. Edinburgh: Scottish Executive.

— (2001) *New Directions. A Report on the Review of the Mental Health (Scotland) Act 1984*. Edinburgh: Scottish Executive.

SCOTTISH OFFICE (1997) *A Framework for Mental Health Services in Scotland*. Edinburgh: Scottish Office.

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