Indicating mental health in Scotland

Jennifer Smith-Merry, Richard Freeman and Steve Sturdy
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Executive Summary

This report reflects on the use of indicators, targets and other measurement tools as regulatory technologies within mental health policy in Scotland. The research is part of the European Commission funded KnowandPol project which investigates knowledge in relation to health and education policies within eight European countries. The work of the Scottish Health team throughout the project focuses on mental health policy in Scotland. Our work reported here investigates the way that national policy regimes interact with those operating on a supranational level. This represents the second case study of ‘Orientation three’ of the project which is designed to investigate the creation of a “knowledge based regulation tool”.

The data discussed in the report derives from a series of interviews with key actors involved in the production or use of indicators and other measurement tools in Scotland. We interviewed seven people for this part of the research and drew on the data from all previous stages of our research which has included over 40 additional interviews, extensive documentary analysis and observation of policy creation processes. This provided us with a large body of data to draw from for our analysis. In conducting our analysis we asked what types of measurement tools, indicators and targets are in use in Scotland and how and for what purposes these are created and used.

We found that tools for measurement, indicators and targets are used extensively within mental health policy and services in Scotland. Their use has become normalised at both a national and local level where they are used to drive work in mental health and monitor progress. We note the following key points:

- Scotland has sought to develop a new way of using indicators and targets which is based on a ‘culture of trust’.
- Fears about the use of indicators, including that the data that is collected is too limited to be meaningfully used and that the wrong indicators are being used so that the wrong actions are being targeted.
- Fear that indicators could be used in a negative way as a means of hard regulation which sets up an environment of terror and threats that is not conducive to an ‘authentic’ uptake of the government’s goals.
- That a target or indicator is effective in creating new knowledge through drawing attention to an issue that may otherwise be forgotten.
- Dialogue around the use of indicators which takes place between the government and health boards occurs through meetings, letters and board visits.
• That this dialogue is characterised by a kind of ‘polite cooperation’, which can be referred to as a ‘communicative approach’ to indicators.

• That the Mental Health Division within the Scottish Government seeks to distinguish itself from England and their use of a culture of targets and terror for coordinating the work of the NHS.

We conclude by drawing attention to the development of a normative discourse of measurement within Scottish mental health policy. This discourse is promulgated through the development of key technologies of measurement such as the Scottish Recovery Indicator, the Warwick Edinburgh Mental Well-being Scale and the NHS HEAT targets. These technologies enforce the policy goals of the Scottish Government while also enforcing a culture of measurement and targets within the work of the NHS in Scotland. We also note a particular focus on self-assessment which functions as a strong form of governmentality and consider the development of a ‘Scottish way’ of using indicators, based in a dialogue of ‘polite cooperation’.
Introduction

This report critically examines the use of tools of measurement such as surveys, indicators and targets in mental health policy in Scotland. This research has been conducted as part of the KnowandPol project which reflects on the way knowledge functions in relation to policy making for health and education in Europe. The KnowandPol project is made up on twelve research teams working across eight European countries. Six of the research teams are focusing on education policy and six are focusing on health. This report derives from the work of the Scottish health team who have focused on Scottish mental health throughout the project and is the fourth major case study undertaken as part of the project. This stage of the KnowandPol project is the second of two case studies which examine the role of regulation in policy. For this case study we have chosen to focus on the use of measurement in mental health policy. We think about measurement very broadly, and include all types of measurement, such as surveys and formalised targets.

The research discussed in this report derives from an analysis of key documents and a set of interviews with actors involved in devising or implementing indicators for mental health in Scotland. We conducted seven interviews expressly on the use of indicators in Scotland. This data was supplemented by data from over 40 other interviews on mental health in Scotland which have been conducted as part of earlier stages of our work. The analysis also derives from documentary analysis of key policy documents which discuss the use of indicators. In analysing our data we answered the following questions:

- What types of measurement, indicators and targets are used in mental health policy in Scotland?
- Who creates them and why?
- Who uses them and how are they used?
- What knowledge is produced through their use?

This report reflects on these questions by looking first at the literature on measurement and then examining the history of the use of tools of measurement in Scottish mental health policy. We then examine specific types of measurement used in mental health in Scotland and look at how they are put to use. We conclude by making some general observations about their use in Scotland and consider whether we might be able to state that there is a ‘Scottish way’ of using measures, indicators and targets.
1. Measurement in general

Most literature discusses measurement and indicators in an unquestioning way which reflects on the outcomes of certain measures or posits new ones without questioning how they came to have such currency within certain policy regimes and how they are put to use in different contexts.

Much of the critical literature on indicators comes from a small collection of academics writing mainly about the use of indicators within English policy making. They write of a long history of the use of performance indicators stemming back to the work on scientific management by the American Frederick Winslow Taylor which was first published in 1911 - and some say even further to the work of Bentham in the 1790s (Hood, 2007; Bevan and Hood, 2006). During the bulk of the 20th century, however, performance measurement was most obviously associated with Soviet regime management. In the UK a focus on performance measurement was taken up anew with the Conservative government during the 1980s and a quest for “results driven government” (Mullen, 2004; Hood, 2007; 2008; Bevan and Hood, 2006). A “culture of measurement” steadily developed during the 1980s and 1990s in the UK (Jacobs and Manzi, 2000). Performance data had been collected to some degree since the inception of the NHS in 1948 but became increasingly central to NHS planning in the 1980s and 1990s (Hood, 2007; Jacobs and Manzi, 2000; Greener, 2003). While the development of the use of performance indicators has been a global movement, England has taken it up with unparalleled vigour, especially since the New Labour victory in 1997 (Hood, 2007; 2008; Greener, 2003).

A range of different factors has been responsible for the development of the use of performance indicators since the 1980s. The use of performance indicators was a core aspect of the application of new public management in the 1980s, where “performance measurement has been perceived by managers as an effective legitimizing strategy for organizations in an environment critical of the public sector” (Jacobs and Manzi, 2000: 89). Also an increasing decentralisation of services during this time was viewed as necessitating increased centralisation of ‘control’ to give “more leverage over professionals” and “reassure voters that extra tad funding was producing demonstrable improvements” in services (Hood, 2008: 7). Advances in computing technologies which put the ability for managers to easily visualise numerical data have also been suggested as contributing factors by some authors (Mullen, 2004; Greener, 2003).

The growth of a performance management culture has been at least in part blamed on a “movement that spanned the worlds of consultancy, academia and central agencies in government” (Hood, 2007; 2008: 9). All of these groups have found utility in the growth in the use of indicators, and all for different instrumental reasons. For consultants and academics they have become commodified for their monetary or research value, for politicians because they show “demonstrable achievement for voters”, and for managers
as they provide what they believe to be a “transparent steering processes” (Hood, 2008: 9).

While the application of performance indicators has developed in an ‘ad hoc’ fashion with little guiding theoretical framework underpinning them Hood (2007: 95) has defined three forms of “management by numbers” (Hood, 2008: 11). These are “target systems” which use indicators to demonstrate performance against set targets, “ranking systems” which rank services against one another according to a given indicator, and “intelligence systems” which collect data for no immediate comparative reason (Hood 2007: 95). He writes that any “…serious research programme on modern public services has to go beyond practico-descriptive accounts of such systems to look carefully at the scope and limits of performance metrics in each of those three forms, their intended and unintended effects, and the factors that shape their use.” (Hood, 2007: 95).

There has been a growing mistrust in indicators - discussed in much further depth later in the report - where, as Gray and Hood (2007: 92) comment “…in theory and practice, we are coming to regard performance measurement as an obstacle as much as a facilitator of performance delivery.” Other authors have drawn attention to the statistical complexity of indicators which is not always well understood or acknowledged (Jacobs and Manzi, 2000). It is not always clear what indicators are in fact indicating or that like is being compared to like within the application of the measures (Greener, 2003). There is also no consideration of the effect of socio-economic conditions within a given area on NHS board performance - a factor which the King’s Fund estimate could account for more than 40% of performance (Greener, 2003: 244).

Jacobs and Manzi (2000) have used a Foucauldian governmentality approach to reflect on the use of indicators as a technology of governance within organisations. Likewise, in her work on Scottish housing policy Kim McKee (2009: 166,169) uses the work of Nikolas Rose to reflect on the development of ‘technologies of performance’ and comment that there has been a “displacement of expertise by measurable targets.” Targets and an understanding of their formation, implementation and use have instead become the new form of expertise within the system. We will consider this idea in relation to our own data in the discussion section of our report.
2. History of indicators in Scotland

Several of our respondents commented that historically Scotland was “not very good” at indicators and that measurement of mental health had developed from nothing to a great deal over a rather short period of time (240510; 150909). It was in the late 1990s that work on the development of mental health services started to pick up some momentum after many years of lacking any sort of clear policy direction (Loudon and Coia, 2002). The 1997 *Framework for Mental Health Services* was seen as an important document for the refocusing of attention on mental health (Smith, Freeman and Sturdy, 2007). This document, released by the Scottish Office at around the same time as the referendum which granted Scotland its own parliament, rearticulated the approach to services already in existence and identified principles and ‘priorities for action’ (Scottish Office, 1997). Part of this rearticulation included a discussion of the development of appropriate ‘outcome measures’ for mental health services. The discussion of indicators was very much centred on individual services and local service areas who were expected to either devise their own measures or draw on a range of existing measures such as: ‘The Health of the Nation Outcome Scale’, ‘The Camberwell Assessment of Need Scale’, ‘Measure Yourself Medical Outcome Profile’, Clinical Outcome and Response Monitoring’, ‘Lancashire Quality of Life Profile’, ‘General Satisfaction Questionnaire’ (Scottish Office, 1997). There was no national application of targets or indicators for mental health services and no suggestion that standardised measures should be developed across the system.

Suicide statistics came to be publicly used and reported on as a measure of mental health interventions in the late 60s and early 70s as stigma dropped and the figures became more reliable (110110). However their use as such a measure was not without criticism. The *Framework* document, for example, commented that although services had been using existing measures such as “suicide rate by Health Board standardised by population demography [and] mortality from suicide within one year of discharge” these statistics were “of little relevance” in reflecting the performance of services (Scottish Office, 1997: 16). Despite the unreliability of these figures for tracking service performance suicide statistics became a useful tool for drawing public and political attention to the poor state of mental health services in Scotland (Smith-Merry, 2008). In November 1999 a conference, The Sorrows of Young Men, was held in Edinburgh. This conference, hosted by the University of Edinburgh, led to the development and release of a 2000 report of the same name which focussed on the high rate of suicide in Scotland which sat at almost double the rate in England (Morton and Francis, 2000; Hunter et al, 2008). These statistics were widely picked up by the media (e.g. BBC News, 2000; 281107). A debate in parliament followed on the high levels of suicide in Scotland followed on the heels of the conference (Hunter et al, 2008). This led to the development of a National Planning Group which was charged with the development of a ‘national
2. History of indicators in Scotland

strategic approach to suicide prevention”, which would be taken up in the National Programme (discussed below) through the work of Choose Life (Scottish Executive, 2002).

The media coverage of the Sorrows of Young Men report spoke about the impact of social inclusion work on suicide rates and it was as a measure of social inclusion that the suicide rate was first put to work by the devolved Scottish Executive (BBC News, 2000; 150909). In 1999 one of the Scottish Executive’s very first policy documents was Social Justice…a Scotland Where Everyone Matters included a suicide indicator for young people: “Improving the health of young people through reductions in smoking by 12-15 year olds, teenage pregnancies among 13-15 year olds and the rate of suicides among young people.” The target group for the indicator was a 3 year average of the suicide per 100,000 people aged 11 to 24. By 2003 the rate against the baseline had risen rather than fallen. A national suicide indicator specifically developed in relation to mental health policy was first introduced after the launch of the anti-suicide initiative, Choose Life, in order to track progress (150909). It was included as one of the NHS HEAT targets. This target will be discussed in detail in section 4 of the report, below.

In 2001 the Scottish Health Advisory Service (SHAS), who had responsibility for improving “the quality of health service care and the quality of life for people with a mental illness; people with a learning disability or physical disability; and frail older people”, devised a set of quality indicators which it used to assess the quality of these services within each health board (Scottish Health Advisory Service, 2001a). The SHAS quality indicators did not contain targets but were a set of statements to which services were given a Likert scale rating and specific comments on areas of work (e.g. see Appendix 1, Scottish Health Advisory Service, 2002). Connected to this SHAS also developed a “self-assessment framework” against which health boards could use as an “internal audit” tool which would then be assessed in annual SHAS visits (Scottish Health Advisory Service, 2001b). SHAS was merged into Quality Improvement Scotland in 2003.

2.1. The National Programme for Improving Mental Health and Well-being - indicators for public mental health

After the 1997 Framework document the next major policy document in mental health was released in 2003 was an Action Plan driving the first iteration of the Scottish Executive’s population mental health strategy, the National Programme for Improving Mental Health and Well-being. The rise of the National Programme signalled the ascendance of a new way of understanding mental health as a multi-faceted and subtle concept which was nevertheless of equal importance to work on mental ill-health (150909). One respondent commented on this at length:

“There was no struggle there. I don’t think it would have been like that even 10 years earlier. I think things have kind of moved on and this multi-level understanding and a greater degree of sophistication and less - certainly among
policy makers – less concern about branching out of the narrow services focus….. Underlying it has been a genuine intellectual movement. I wouldn’t say revolution, but its something driving it which is at a level of ideas and a new way of thinking about how mental health and what might be important for a population.”

This new way of thinking about mental health as an important complement to work on mental ill-health necessitated a range of new measures. The National Programme Action Plan thus included a discussion of the utility of measurement and indicators and the development of a set indicators for public mental health “to measure and track progress nationally and locally” was a central activity of the new National Programme (Scottish Executive, 2003: 12). It stated:

“NHS Health Scotland, supported by the National Programme, are taking forward work to develop a set of core indicators for public mental health/mental health and well-being. This work will be used to develop national and local indicators for collection and analysis as a way of monitoring the state of public mental health/mental health and well-being across the country. These indicators will be of particular value to the local Community Planning Partnership process and local joint health improvement plans.”

As this quotation shows, the focus here is on the development of a core set of indicators that can be used in monitoring mental health in Scotland and as such need to be uniformly put to use. Between the launch of the Framework for Mental Health Services and the National Programme there had thus been a shift in understanding of the utility of outcome measures. The application of outcome measures was no longer an ad-hoc process based on the needs and focus of local areas and individual services, as it was in the earlier document. Instead measurement had become a core tool of central government who utilised measures to uniformly track progress on mental health across the country.

There was a dissatisfaction with measures used to document population mental health such as GDP (031109; 150909). Other measures used to document positive mental health were generally those for measuring mental ill-health which was viewed as unsatisfactory because they capture merely an absence of mental ill-health rather than aspects of positive mental health (Parkinson, 2006). This meant that a new set of acceptable measures would need to be created. The call for these new measures through the first National Programme Action Plan put in motion the development of a large programme of work which set about to develop a full set of adult mental health indicators (031109). The National Programme commissioned NHS Health Scotland to undertake the development of the indicators. Indicators were to be developed for the individual, community and society level and measure “positive mental health, negative mental health, [and] determinants of mental health – risk and protective factors” (Parkinson, 2006). The first step of the project involved assessment of existing measures in order to
determine their suitability. Where suitable indicators could not be found they were commissioned where possible. Table 1 below lists the full set of indicators which had been developed by the end of the project.

**Table 1: Indicators within the Scottish Adult Mental Health Indicator Set**  
(adapted from NHS Health Scotland, 2007)

<table>
<thead>
<tr>
<th>High level constructs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive mental health</td>
<td>Life satisfaction</td>
</tr>
<tr>
<td>Common mental health problems</td>
<td>Depression</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Alcohol dependency</td>
</tr>
<tr>
<td>Drug-related deaths</td>
<td>Suicide</td>
</tr>
<tr>
<td>Deliberate self-harm</td>
<td></td>
</tr>
</tbody>
</table>

**Individual Level**

<table>
<thead>
<tr>
<th>Physical activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult learning</td>
</tr>
<tr>
<td>Healthy eating</td>
</tr>
<tr>
<td>Drug use</td>
</tr>
<tr>
<td>Long standing physical condition or disability</td>
</tr>
<tr>
<td>Emotional intelligence*</td>
</tr>
</tbody>
</table>

**Community Level**

<table>
<thead>
<tr>
<th>Involvement in local community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteering</td>
</tr>
<tr>
<td>Influencing local decisions</td>
</tr>
<tr>
<td>Social support</td>
</tr>
<tr>
<td>General trust</td>
</tr>
<tr>
<td>Neighbourhood safety</td>
</tr>
<tr>
<td>Non-violent neighbourhood crime</td>
</tr>
</tbody>
</table>

**Structural level**

<table>
<thead>
<tr>
<th>Equality analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income inequality</td>
</tr>
<tr>
<td>Worklessness</td>
</tr>
<tr>
<td>Discrimination</td>
</tr>
<tr>
<td>Harassment</td>
</tr>
<tr>
<td>Financial inclusion</td>
</tr>
<tr>
<td>Noise</td>
</tr>
<tr>
<td>Greenspace</td>
</tr>
<tr>
<td>Overcrowding</td>
</tr>
<tr>
<td>Work-life balance</td>
</tr>
<tr>
<td>Control</td>
</tr>
<tr>
<td>Colleague support</td>
</tr>
<tr>
<td>Neighbourhood violence</td>
</tr>
</tbody>
</table>

* No data source has been found so far to allow assessment of these indicators.

The data for most of these indicators is gathered from the Scottish Health Survey, the Scottish Household Survey, the Scottish Crime and Justice Survey and the Scottish House Condition Survey. As the list demonstrates there were a couple of areas for which appropriate indicators could not be devised. Respondents commented that the problem in
finding data to match these indicators lay in their definition and the possibility of asking the right questions to get the right data (031109; Consultation data). In the case of spirituality for example one respondent commented:

“And it doesn’t cover spirituality. I think that’s an area of debate. Certainly I know a lot of the researchers such as Sarah Stuart Brown think it is part of mental wellbeing and they did look to include that in the scale but couldn’t really come up with a question to capture it because it’s not just religion. For some people it could be their religion but it isn’t and it is also sort of felt that the population isn’t quite there yet in their thinking about it. So that could be an area that it doesn’t quite capture.” - (031109)

Although no appropriate measure could be found for spirituality and other indicators these were left in for future development of the set.

Only one of the indicators - the Warwick Edinburgh Mental Well-being Scale (WEMWBS) has so far been applied to a target at a national level. The Scottish Nationalist Party (SNP) led Government has included improvement in the “Mean adult score on the Warwick Edinburgh Mental Well-being Scale (WEMWBS)” as one of its key performance indicators within the National Performance Framework. The National Performance Framework, instituted by the (SNP) after its election win in 2007, is a list of national goals which all Scottish policy is oriented around. 45 specific ‘National Indicators’ measure the Scottish Government’s progress towards these key goals (Scottish Government, 2009). As an example of the development and implementation of these measures within the work of the government and local areas we look in detail at the application of this indicator in section 4 below.

Despite the large number of indicators that were being produced through the work of the National Programme it was felt by some that the work of the Programme was not tangible because of a lack of commitments or targets related to the indicators (101008; 110110; National Dialogue event, Glasgow; Greenspace consultation event; Universities Scotland consultation event). This had two negative impacts for the work of the Programme. Firstly it meant that positive outcomes as a result of the work of the Programme were not able to be acknowledged, and secondly that some areas of the Programme were not being implemented because their was no associated target or indicator which could drive the work within local areas (110110). This was seen as a problem resulting from the ‘culture of targets’ which pervaded the work of local authorities and health boards (281107). These concerns were raised during the 2007-2008 consultation process for Towards a Mentally Flourishing Scotland which sought to determine priorities for the next stage of the National Programme. The use of targets and indicators was a main theme arising from the debate during the public consultation events which were held as part of the consultation:
2. History of indicators in Scotland

“We haven’t been talking about targets. Outcome measurements are important.”
- (Discussion group, Greenspace consultation event)

“Data talks. This is why you need data and you can use this scale [WEMWBS] to gain data and prove your services are working.”
- (Practitioner presentation, Lanarkshire consultation event)

“[It] needs a robust performance framework (as in the Renfrewshire case presented) for local areas. Need to be able to show what impact improving mental health and wellbeing has.”
- (Discussion group one, National Dialogue event, Glasgow)

“Money goes to areas that are measurable (and there are not many of these areas) so now we are working on making more things measurable.”
- (Government presentation, Universities Scotland consultation event)

“To be honest if you are not reporting a red light on a target for Delivering for Mental Health then you don’t have to do anything. So if you have for example a 50% reduction in the suicide rate (maybe accidentally) then you don’t have to do anything….There should be a per annum reduction in suicide - cleverer targets. Should be more about process not targets.”
- (Discussion group two, National Dialogue event, Perth)

Discussion about indicators at the events was very mixed with some condemning their use, others speaking regretfully of their inevitability within the system, and yet others speaking positively of their impact on mental health. The outcome of the consultation process was the policy document Towards a Mentally Flourishing Scotland Policy and Action Plan 2009-2011 which was launched in May 2009 and which included a large number of commitments (These are listed in Appendix A at the end of the report). Most of these commitments were not based on the achievement of numerical targets, but rather commitment to a specific action, some with associated target dates.

Although it does include commitments for the development and implementation of particular indicators such as the Scottish Recovery Indicator (Commitment 22), a set of child mental health indicators to match the adult indicator set discussed above (Commitment 4) and the creation of a suicide register for Scotland which is better able to track suicide within the community (Commitment 15). These commitments seek more knowledge about mental health and complement the work on adult indicators but, unlike Delivering for Mental Health which we will discuss next, do not apply particular numerical based targets. This may be a result of an awareness in the public mental health community around the difficulty of creating indicators which effectively link public mental health interventions with impact on particular mental health indicators (150909).
2.2. **Measuring services: the Benchmarking Project, the Mental Health Collaborative and Delivering for Mental Health**

“The need to be able to benchmark mental health services in Scotland has never been so important, both in supporting the delivery of services and in helping the NHS to attain its performance targets to meet the needs of local communities. Scotland is a leading nation in the provision of mental health services and work around mental health promotion and legislation. It is important that we retain our place in this respect, and the key to knowing the extent to which we are making a difference to the lives and wellbeing of our patients/clients and are providing an equitable high quality service, is the ability to benchmark mental health services on a ‘like for like’ basis. **This will not only be a first for Scotland but also for Europe.**“\(^1\) - (Shona Robison, Minister for Public Health. Scottish Government, 2008: 3)

**2.2.1. The Benchmarking Project.**

With this statement Shona Robison the Scottish Minister for Public Health launched the final report of the Benchmarking Project which recommended the development of a set of indicators which would “deliver improvement” in mental health services (Scottish Government, 2008). It aimed to do this through the development of a ‘Balanced Scorecard Approach’ which is “a strategic management and measurement system that links strategic objectives to comprehensive indicators” (Scottish Government, 2008: 7). The balanced scorecard included ‘strategic objectives’ relating to cost, patient quality, efficiency and future to which were attached specific indicators:

<table>
<thead>
<tr>
<th>Cost</th>
<th>Patient Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total spend for mental health per 1,000 population</td>
<td>Use of the AVON validated tool to measure patient needs and promote recovery oriented practice</td>
</tr>
<tr>
<td>% community spend/Total spend</td>
<td>Mortality rates for severe and enduring mentally ill population per 1,000 population</td>
</tr>
<tr>
<td>Total mental health drug costs per 1,000 population</td>
<td>% re-admissions &gt; 7 days/total admissions</td>
</tr>
<tr>
<td>Persons on incapacity benefit/severe disablement allowance with a mental health diagnosis per 1,000 population</td>
<td>% delayed discharges</td>
</tr>
<tr>
<td></td>
<td>Suicide rates per 1,000 population</td>
</tr>
<tr>
<td></td>
<td>% carer involvement/those who have a carer</td>
</tr>
<tr>
<td></td>
<td>% of voluntary inpatient/inpatients subject to compulsory treatment by Board</td>
</tr>
<tr>
<td></td>
<td>% of people on community CTOs/total known to the Community Mental Health services</td>
</tr>
<tr>
<td></td>
<td>Patient safety and risk management</td>
</tr>
</tbody>
</table>

\(^1\) Bold type in original.
The indicators listed here in Table 2 are the mandatory indicators. There were also a range of other local and national indicators developed which could be used in addition to these.

The creation of mental health indicators through the benchmarking project had been part of a project covering all of the areas of health responsibility covered by the government. Initially the creation of a scorecard for mental health had been seen as a challenge:

“...they said you couldn’t do it, that mental health was such a woolly subject that you actually couldn’t develop a balanced scorecard which is what we were trying to do. So we set off on that project and that has been going for the last four years.”         - (290610)

One of the initial challenges in the development of the indicators had been issues around definition:

“The first part of it was actually just to agree common definitions across the whole of the service, so that was like a year’s work with blood on the carpet to try and agree what people meant by a crisis function, assertive outreach, different services, but we got common definitions...”      - (290610)

This is reflected in the 2008 report of the project which provides a list of definitions and called for ongoing work around definitions (Scottish Government, 2008: 9; Scottish Government, 2008d). The Mental Health Benchmarking Core Steering Group, who coordinate the project, released a graph which demonstrates the level of disagreement over definition, which was generally low. For the 74 definitions that needed to be clarified most health boards made only minor changes for 1-4 of the definitions (Scottish Government, 2008d). Some health boards, such as Tayside, requested much more significant changes to a much larger number of definitions.

As with some of the items in the adult indicator set, discussed above, there were some items for which appropriate definitions could not be created. This can be seen in the following quote:

<table>
<thead>
<tr>
<th>Efficiency</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds per 1,000 population</td>
<td>Training/supervision index</td>
</tr>
<tr>
<td>% A&amp;E presentations with a mental health and/or</td>
<td>Information quality and capture</td>
</tr>
<tr>
<td>substance misuse diagnosis/total A&amp;E presentations</td>
<td></td>
</tr>
<tr>
<td>Average time to assessment and time to</td>
<td>Use of mental health information</td>
</tr>
<tr>
<td>intervention</td>
<td></td>
</tr>
<tr>
<td>Average length of stay</td>
<td>Number of accredited Integrated Care Pathway (ICP) standards implemented with 100% collection of prescribed datapoints</td>
</tr>
<tr>
<td>Total mental health staff numbers per 1,000</td>
<td></td>
</tr>
<tr>
<td>population by psychiatrists, AHPs, nurses,</td>
<td></td>
</tr>
<tr>
<td>psychologists, social workers, MHOs</td>
<td></td>
</tr>
</tbody>
</table>
"One of the bits we have really struggled with is measuring patient experience and we have been around that 5 times now. Because the collaborative had a go at it, VOX had a go at it, Penumbra’s had a go at it and it’s really difficult to measure because what are you measuring? Are you measuring the outcome for a patient clinically ...their satisfaction with services....benefits and back into work...social functioning...[?] And we've been around the houses on that and we have really struggled.”

Problems around definition has been raised as a significant problem for the effective implementation of indicators by academic commentators (e.g. Greener, 2003). We will discuss this issue further in the discussion section of our report.

### 2.2.2. Delivering for Mental Health

The policy document *Delivering for Mental Health* which sought to define the direction for Scottish mental health services was released in late 2006 (Scottish Executive, 2006). *Delivering for Mental Health* included 12 commitments which covered different key aspects of mental health service delivery. By those in the government the document was viewed as “significantly more ambitious” than the *Framework* document which it replaced because “for the first time in mental health, this was a policy document backed by a focused delivery plan” (Coia and Glassborow, 2009: 644). Unlike the *TAMFS* policy most of the commitments in *Delivering for Mental Health* contain specific targets which state that the commitment will be achieved within a certain time-frame. Often the targets also outline a specific rate at which improvement must take place, for example a 50% reduction in the admission on children to adult beds by 2009 (Scottish Executive, 2006).

*Delivering for Mental Health* was released after the start of the benchmarking project, but influenced it heavily as did the NHS HEAT targets and other government policy releases. One respondent spoke at length about the process of adapting the indicators to the needs of new policy as it was released:

“As we went along we thought there is no point having these indicators if they don’t actually reflect the policy and the commitments in mental health so we built in key measurements from each of the commitments in mental health into the benchmarking project. So these 22 indicators started to reflect that and all of the commitments like delivering ICPs...and HEAT targets were in the benchmarking. So the benchmarking evolved into a different project actually so apart from delivering the scorecard and the indicators, the indicators started to reflect what was going on in Delivering for Mental Health. And then the Quality strategy came along and it had the [6] quality domains...and what we did then was thought was ‘would these indicators fit into these domains? Have we got ones that fit in each

2 The commitments included in *Delivering for Mental Health* are listed in Appendix B at the end of this report along with a brief analysis which details the extent to which the targets have been met.
2. History of indicators in Scotland

domain?’ So we then adapted the scorecard and the indicators into the quality domains. And they did fit.” – (290610)

In addition to Delivering for Mental Health this quotation mentions two other key areas of policy work – HEAT targets and the Quality Strategy – as impacting on the content of the benchmarking project. The HEAT targets are a set of targets that orient action by the NHS towards key goals for health as set by the Scottish Health Minister (NHS Health Scotland, 2010). Current HEAT targets for mental health work on psychological therapies, suicide, readmission rates and dementia. The HEAT targets were originally devised in 2003 and are revised every three years. Current HEAT targets are listed in Table 3, below.

Table 3. HEAT targets as at September 2010 (Scottish Government, 2010)

<table>
<thead>
<tr>
<th>Target 1 (From April 2010): Psychological therapies. Over 2010-2011 the Scottish Government will work with health boards to develop a target which assesses access to psychological therapies.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target 2: “Reduce suicide rate between 2002 and 2013 by 20%, supported by 50% of key frontline staff in mental health and substance misuse services, primary care, and accident and emergency being educated and trained in using suicide assessment tools/suicide prevention training programmes by (2010/2013)”</td>
</tr>
<tr>
<td>Target 3: “We will reduce the number of readmissions (within one year) for those that have had a hospital admission of over 7 days by 10% (by the end of December 2009)”</td>
</tr>
<tr>
<td>Target 4: “Each NHS Board will achieve agreed improvements in the early diagnosis and management of patients with a dementia (March 2011)”</td>
</tr>
</tbody>
</table>

During the revision in 2007 a new target for dementia was added. Revision in 2010 has seen the removal of an anti-depressant target and its replacement with a psychological therapies target. All targets are measured at both a national and local health board level. Action on the targets at a local area level is agreed upon and monitored through local delivery plans.

2.2.3. The Mental Health Collaborative

Another key aspect the current use of indicators in Scotland is the work of the Mental Health Collaborative (240510; 290610; Coia and Glassborow, 2009). The Collaborative is led by the Mental Health Division and includes three regional teams which work to support NHS Boards. Their motto is “Applying quality improvement science to performance challenges.” (Scottish Government, 2010c). It is focused on culture change within Health Boards so that “front-line staff” are better able to use information to improve services by analysing current practices and in designing, implementing and evaluating change (Coia and Glassborow, 2009). The areas that it mainly focuses on are improvements that will lead to achievement of the HEAT targets on anti-depressants (now psychological therapies), readmissions and dementia.

Through the work of the Collaborative local areas are encouraged to be innovative in the development of new indicators. Local areas develop their own new indicators, processes

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3 HEAT is an acronym for Health improvement, Efficiency, Access and Treatment.
and targets, test them in their own work and then share them with other health boards.

One respondent commented on this process at length:

“So we have a suite of things partly informed by the mental health collaborative nationally and partly developed locally. We’ve pulled together I suppose you could call it a kind of diagnostic toolkit and the plan is we’ve use it in one team.... So that is informing improvement work. So we are now able to ask questions like 'why is this so low? And what should we set as a target for improving it to go up to 30% or do we go up to 40%? What do we set as a target and how do we go about changing what they’re doing to improve that face to face contact with patients so I think that kind of thing fits really well with a lot of the national improving patient experience stuff and we have been able to take measurement away from a kind of high level board-wide strategic view right down into local teams.”

- (240510)

This develops a culture of working with indicators which comes from the local level rather than being solely imposed by central government. The local areas have become implicated in the culture of measurement and are thus much more likely to take it on.
3. Case studies

This section of the report provides examples of indicators and measures that are or have been used in Scottish mental health policy – the Warwick Edinburgh Mental Wellbeing Scale, the anti-depressant prescribing and suicide HEAT targets and the Scottish Recovery Indicator tool. We include these examples in order to demonstrate the range and style of different indicators, targets and measures in use in Scotland.

3.1; Warwick Edinburgh Mental Well-being Scale (WEMWBS)

WEMWBS is used to measure the positive mental health (mental well-being) of the population (it is not used to measure well-being at an individual level). The development of the scale was commissioned by the Scottish Government in order to complete the Scottish Adult Mental Health Indicator Set because the existing data collected at a national level measured only mental ill-health not positive mental health (NHS Health Scotland, 2010b). This was seen as necessary as up until the introduction of WEMWBS data had only been collected on the mental ill-health of the population (110110). This approach was in line with the dual continuum model outlined in the TAMFS consultation document which sought to position mental health work with an equal emphasis on positive mental health and mental ill health:

"We need a scale to assess mental wellbeing. At the moment most of the scales that exist are really to assess mental illness and health problems and morbidity. There is the GHQ12 which people use and people often use these scales slightly inappropriately and then call it measuring mental wellbeing – the other aspect of mental health. And this is following the dual continuum model which I think certainly in Scotland and wider as well has been that people have taken on board. It’s not without its problems but for conceptualising things and ensuring that you just don’t focus on the illness side of the problem it’s a good model to follow."

- (031109)

WEMWBS is a 14 item scale which asks participants to respond to a positively worded statement. The highest possible score is 70 and the lowest is 14. In 2006 the average score amongst the Scottish population was 51, in 2008 it was 50, meaning that the positive mental health of the Scottish population was relatively unchanged (Scottish Government, 2010e).

WEMWBS is administered through the Well? What do you think? survey and more recently within the Scottish Health Survey (NHS Health Scotland, 2010c). The next round of national data collection for this measure will take place in 2010. Each local authority and health board is able to use the scale to measure its own performance against set targets, but this is administered on an ad hoc basis with no national comparisons available. During the TAMFS consultation the government speakers
encouraged its use as a way of measuring the success of local population health programmes (e.g. Universities Scotland consultation event). This was seen as useful in order to justify continuing investment in population mental health in competition over space in Single Outcome Agreements (SOAs)\(^4\). It was thought that if the success of population mental health strategies could prove their effectiveness through positive WEMWBS results they would be more likely to be included as part of a local authority’s SOA and thus more likely to be funded. The scale has also been included as one of the Scottish Government’s 45 National Indicators of performance (discussed above): “Increase the average score of adults on the Warwick-Edinburgh Mental Well-being Scale by 2011”. This was viewed as a ‘win’ for mental health improvement by validating their agenda and ensuring that the work of the National Programme would continue to be funded under the SNP (281107).

Respondents from the government and services commented on the utility of WEMWBS for their work:

“What we are seeking to encourage people to do is to use it to benchmark themselves against national or local populations but also to look at it over time.” - (110110)

“...we are [using WEMWBS at a local level] to get some baseline information and then we will repeat it in maybe three years time...” - (140510)

“There is huge enthusiasm [towards WEMWBS] at local level. There is so much antagonism in many of the voluntary sector organisations, community groups, self help groups – so much antagonism to the medical model and to always assuming that all you need to measure is illness. And I think there is almost a joy – it that’s not too strong a word – that there is something which people look at these items and they do seem to be tapping into what many of these groups and organisations feel are important aspects of people’s lives but which were previously being ignored.” - (150909)

Others were cynical about the use of WEMWBS, but thought that it needed to be developed in order to validate work on public mental health. This was because targets and indicators were viewed as the way that policy was being done in Scotland and a policy area needed to create targets if it were to be taken seriously in the current environment. These quotations demonstrate this perspective:

“I’m not a personal advocate of targets. I’m not a personal advocate of performance management. For me I’m more interested in how you’re doing as an

\(^4\) A recent Audit Scotland (2009) report on mental health explains Single Outcome Agreements: “With the introduction of the concordat between the Scottish Government and COSLA in 2008, certain council funds are no longer ring-fenced. This means that funds previously used fully or partly for supporting people with mental health needs (eg, Mental Health Specific Grant, Choose Life, Changing Children’s Services Fund (CCSF) and Supporting People) are now part of a council’s general allocation and councils decide what these funds should be spent on... It is too early to assess the impact of funding changes for councils on mental health services. The councils in our fieldwork have made no major changes to the levels of funding previously ring-fenced.”
agency or a public sector organisation at what we’re doing. I find the pseudo-science of performance management irksome and predicated on a rational model of A to B. I could bring all of your collective intellectual capacity into saying why that’s not necessarily a good thing. But that’s what governments do, it’s what politicians do - they promise a manifest of commitments which can then be turned into words and phrases and targets that show the public and the communities and people whether or not we’re going in that direction….We now have [National Performance Framework] indicator 15, which we knew we were going to have: indicator 15 of 45 government indicators is improve mental wellbeing by 2011, as measured by the Warwick Edinburgh Mental Wellbeing scale. So we’re in the game…. If you don’t have an indicator and you don’t have a target you’re not in the game. So we’ve got one and we’re in the game, and that’s just good policy management. Without that we’d be scrabbling to get on the top table.”

- (281107)

“If you are focusing on an area of health improvement and want people to put a focus on it then you can do this through an indicator.” - (101008)

Public mental health would not be taken seriously if it did not have an indicator attached to it.

3.2. Anti-depressant prescribing

Anti-depressant prescribing was until recently a HEAT target for mental health:

**HEAT target until April 2010.** “Reduce the annual rate of increase of defined daily dose per capita of antidepressants to zero by 2009/10 and put in place the required support framework to achieve a 10% reduction in future years (2009/10)”

This target was introduced against a background of very high levels of anti-depressant prescribing in Scotland (8.1 daily doses per 100 people). It was initially developed with the hope that the target would refocus work on depression and change treatment patterns in Scotland towards a model which includes ‘alternative’ treatments such as psychological therapies and social prescribing (exercise programmes, community involvement, ‘green gyms’). Table 1 below shows the prescribing rates over the period 2003-2009.

<table>
<thead>
<tr>
<th>Year</th>
<th>2003/04</th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
<th>2007/08</th>
<th>2008/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of prescribed items</td>
<td>3,401,945</td>
<td>2,477,416</td>
<td>3,529,668</td>
<td>3,654,128</td>
<td>3,826,624</td>
<td>4,005,603</td>
</tr>
<tr>
<td>Defined daily dose per 100 population</td>
<td>8.10</td>
<td>8.35</td>
<td>8.49</td>
<td>8.84</td>
<td>9.32</td>
<td>9.72</td>
</tr>
</tbody>
</table>

As this table demonstrates the Scottish Government failed to meet this target and the rate of anti-depressants prescribed has continued to grow. The prescribing rate now sits at 9.72 daily doses per 100 of the population. The government dropped the target and replaced it in April 2010 by a target which gauges the extent of use of psychological therapies which is the major alternative treatment method for depression offered in Scotland.

Little was known about anti-depressant prescribing before the application of the HEAT target, but a significant amount of research had been undertaken as a result of the application of the target. This led to a much greater understanding about appropriate and inappropriate prescribing and the prescribing practices of different groups of GPs (290610; 110110). This meant that although the target did not work to lower the rate of anti-depressant prescribing for the government it was still viewed as a ‘successful’ target.

While the government respondents considered the anti-depressant HEAT target successful in that it led to new learning, another respondent believed that it had failed as a target and it’s failure had been a result of bad design (140510). It was felt that the figure chosen for the anti-depressant target was “very strange” and that:

“Everyone knew when it was set ‘we are not going to meet it’ and then they decided to withdraw it because it was not being met. So I think they could have done it in a different way and pointed out that ‘we don’t want this increase in anti-depressant prescribing’.”

- (150510)

Although the government itself had some doubts about the soundness of the anti-depressant target they could not get rid of the target once it was set and had to wait until the reporting date on the target was reached (110110). This inability to do away with problematic targets was a dilemma for one of the government respondents (110110). They had originally made assumptions about the way anti-depressants and psychological therapies worked together, but later found these assumptions to be untrue and the target did not work in the way that they wanted it to.

“We wanted to be sure that we were seeing the best response and we made a presumption that involved both antidepressants and it also involved therapies...So we ended up measuring anti-depressant prescribing rather than fast access to therapies because we didn’t have either definitions, referral pathways or measurement systems that would allow us to do therapies. We will have them later in the year and the target will move on from being an antidepressant target to being a therapies target.”

- (110110)

Such was the power of the indicator as a symbol of the system that it could not be removed even once the government knew that it was not producing the right results from the system. The anti-depressant target, although problematic, had to see out its term as a target before it could be replaced with a more appropriate psychological therapies target.
3.3; Suicide

Suicide is one of the NHS HEAT targets for mental health:

**Target 2:** “Reduce suicide rate between 2002 and 2013 by 20%, supported by 50% of key frontline staff in mental health and substance misuse services, primary care, and accident and emergency being educated and trained in using suicide assessment tools/suicide prevention training programmes by (2010/2013)”

This target was introduced in response to the very high level of suicide in Scotland relative to similar countries. In 2002 the Scottish suicide rate sat at 17.8 per 100,000 population, with the Scottish male suicide rate at 27.8 per 100,000 and female rate at 8.5 per 100,000 (this is in contrast to a rate of suicide amongst English men of 16.7 per 100,000 and women of 5.0 per 100,000) (ScotPHO, 2010). Table 2, below, shows the crude age-standardised suicide rate per 100,000 of the Scottish population between 2002 and 2007.

**Table 5: Age-standardised suicide rate, Scotland 2002-2007 (ScotPHO, 2009)**

<table>
<thead>
<tr>
<th>Year</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age standardised suicide rate (all genders)</td>
<td>17.8</td>
<td>15.7</td>
<td>15.4</td>
<td>15.0</td>
<td>15.0</td>
<td>16.3</td>
</tr>
<tr>
<td>Age standardised suicide rate (Men)</td>
<td>27.8</td>
<td>23.7</td>
<td>24.9</td>
<td>22.4</td>
<td>24.0</td>
<td>24.9</td>
</tr>
<tr>
<td>Age standardised suicide rate (Women)</td>
<td>8.5</td>
<td>8.2</td>
<td>8.6</td>
<td>8.1</td>
<td>6.5</td>
<td>8.2</td>
</tr>
</tbody>
</table>

Success against the target is measured using a three year rolling average. The target figure being worked towards is a rate of 13.9 per 100,000 for the period 2011-2013. The most recent data (2006-2008) shows a suicide rate of 14.2 per 100,000 compared to a base rate of 17.4 per 100,000 (2000-2003), which is a reduction rate of 11.4% (Choose Life, 2010; ISD Scotland, 2010).

As discussed above suicide statistics had been used successfully in order to draw attention to mental health as an area of policy need during the first months after devolution. However, as some of our respondents discussed it was not at all certain just what suicide statistics represent and how they should be interpreted in relation to policy action.

Although suicide rates fluctuate from year to year this chart demonstrates that by 2009 most health boards had achieved a reduction in the level of suicide. A less than expected reduction in the national level is mainly due to the limited reduction in the suicide rate in Greater Glasgow and Clyde, where more than a quarter of suicides in Scotland take place.
Respondents contradictorily spoke of the suicide rate as both a ‘robust’ and a ‘weak’ indicator (110110; 150909). The evaluation of the first and second phases of the national suicide prevention strategy Choose Life also questioned the robustness of the target (Russell, Lardner, Johnston and Griesbach, 2010). One respondent spoke at length about the weakness of suicide as an indicator of anything given “the known complexity of suicide and its determinants” (150909). They were very cautious about its use and in attempts by the government to strongly link it to anything:

“These are the kind of very simple minded approaches or solutions that often get adopted that are really poor, just as when a minister stands up and crows about the fact that the suicide rate went down. When I saw these figures …I picked up the phone and I said I’m really pleased to see this fall but before you speak to your minister taking responsibility just remember that in a year’s time it will go up and then what are you going to do? I said ‘if you don’t believe me then go and look at the last 30 years. You don’t get consistent trends’. And I said ‘There is something odd about this’ at the time. ‘It’s too good to be true.’ So I think the issue here for me would be the simplicity of the causal model which seems to underlie any use of this as to making statements about interpreting any change or no change as meaning something or other. I think its very dangerous.”

- (150909)

The review of Choose Life also questioned the extent to which a 20% reduction in suicide was a useful measure at a local level especially for smaller local areas whose rate tended to fluctuate (Russell et al, 2010). Despite these criticisms it was still included as an appropriate ongoing indicator measuring the impact of Choose Life (Russell et al, 2010). It seems that despite reservations about its application the suicide rate would continue to be an indicator for mental health, perhaps because of its powerful emotive force which serves to emphasise any issue to which it is associated.
The second part of this HEAT target aims to train key staff in suicide assessment and prevention with a goal of 50% of all front line staff trained by 2010. Movement towards achieving this target is progressing slowly with an increase from 16% in December 2008 to 22% in June 2009 (Scottish Government, 2009d). Some of the larger health boards found this target more difficult to meet because they were coming from such a low baseline and having to train such a large number of staff (140510).

Like the anti-depressant target, which was originally set to have an impact on the level of psychological therapies being offered, the training target did not aim to have an impact on suicide. One of our government respondents stated that the main purpose of the training target was actually not to measure suicide training:

“In the suicide target what we are measuring in the NHS is a training target and what we are really measuring or at least what we like to think we are measuring is in fact a community awareness of not just suicide but self harm. For us self harm is much more important and it’s the training to actually be more aware of that.”

- (290610)

To actually impact on suicide they were doing work in other areas - with Choose Life, the anti-stigma campaign ‘see me’ and in the creation of the suicide register:

“If you are actually going to influence the rate of suicide the piece of work that we’ve done to do that is related to... the suicide register for the whole population. Because to reduce the actual suicide rate only 28% who commit suicide are in touch with mental health services so its got to be the whole population you are impacting on. So the suicide register which is with Health Scotland is really the driver.... then you can look at who are the people who kill themselves, what are the issues. Is there anything we can look at on the prevention side for these groups of people over time.”

- (290610)

Work on these areas which would ‘really’ impact on suicide were seen to be long-term projects which could not be effectively measured by an indicator. This setting of targets to target areas not actually mentioned in the target is confusing and could be viewed as problematic because boards might naturally orient their resources to the wrong areas.

### 3.4. The Scottish Recovery Indicator\(^5\)

The Scottish Recovery Indicator (SRI) has been designed as a self-assessment tool measuring the extent to which services are implementing a recovery-oriented practice model within their work. It uses online form-based technology. Those completing the tool are led step by step through the tool and must answer questions relating to the extent of recovery practices within different aspects of their services. For example the practices

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\(^5\) Please note that the section of the report that discusses the SRI has also appeared in another of our reports: Smith-Merry, J., S. Sturdy and R. Freeman (2010) Moving towards recovery in Scottish mental health policy and practice. We include it again here because it is pertinent to our discussion of indicators as it is a good example of the emphasis on self-assessment in Scottish mental health policy and practice.
relating to patient assessment are reflected on in order to ensure they take into account important aspects of an individual’s “basic needs”, which are listed as housing, nutrition, physical health, entitlements, personal care and spiritual care. Possible evidence of the service providing this is given, e.g.:

“Entitlements: Service assists with entitlements, advocacy and general advice e.g. legal, financial and housing. (Where indirectly provided, respondents should evidence knowledge of local agencies and offer examples of individual referrals.)

Personal care: Service provides help with personal care, as required. This could include personal hygiene, attention to clothing, haircuts, etc.

Spiritual care: Service records expression of religious or belief-based needs and enables access as required.” - (Scottish Recovery Network, 2010)

The following guidelines are given on the operation of the tool:

"There are three steps to completing the SRI

Step 1: Planning and preparation
• Ensure information is available
• Consider who will need to be involved
• Allocate tasks
• Determine timescales

Step 2: Collecting data
• Look for evidence in sampled assessment forms
• Look for evidence in sampled care plans
• Look for evidence in service information
• Interview service provider group
• Interview service user group
• Discuss strengths and issues raised

Step 3: Service development plan
• Consider indicator ratings
• Prioritise highlighted issues
• Determine timescales
• Allocate tasks
• What support might be needed

What you will need to use the SRI

To complete the SRI you will need:
• Agreement and commitment from your colleagues. To successfully use the tool you should have commitment from as many members of the team as possible.
• Access to, and permission to view, service user assessments and care plans as well as service information, policies and procedures.
• The capacity to arrange interviews with people providing services
• The capacity to arrange interviews with current or previous service users.
• At least 13 hours.” - (Scottish Recovery Network, 2010)

It is suggested that the tool should be completed with reference to the data contained in assessments, care plans and service information and through interviews with service providers and those who use the service (Scottish Recovery Network, 2010).

The tool’s creation was initially suggested as a result of the discussions around the implications of Rights, Relationships and Recovery (NGO 2). It was seen as necessary to clarify what was important and possible in terms of recovery-oriented practice:

“At the time of the nursing review it was thought we were asking a lot of people to do things and people didn’t really know what they should be doing and what recovery practice in process was.” - (NGO 1)

These discussions led to the formalisation of plans for the creation of the tool as an aspect of Delivering for Mental Health which contained the following commitment:

Commitment 1: “We will develop a tool to assess the degree to which organisations and programmes meet our expectations in respect of equality, social inclusion, recovery and rights. The tool will be piloted in 2007 and be in general use by 2010.” - (Scottish Executive, 2006d)

In 2009 the implementation of the SRI was again committed to in the Towards a Mentally Flourishing Scotland: Policy and Action Plan, 2009-2011 which guides work on population mental health in Scotland (Scottish Government, 2009).

The SRI tool was modelled on a US tool, the Recovery Oriented Practice Index (ROPI) which was developed by Anthony Mancini, an academic working at Columbia University, for use within the New York State Office of Mental Health (Scottish Executive, 2007b). This tool was identified as an appropriate base from which those in the SRN could work toward the development of a Scottish indicator (Government 2). However, in order to make the tool effective in the Scottish context it had to go through a process of ‘Scottishisation’ (Community 2; NGO 1). This involved adapting the tool with language and practices appropriate to Scotland (NGO 1; NGO 2). Part of this process involved making the tool much more centred around process and self-assessment, rather than external evaluation:

“The ROPI was much more stick than it was carrot...It was an external evaluation and that is the antithesis of recovery for us in Scotland. So it might be that in America you can go and say to a service this is what you are doing wrong and this is what you are doing right but we have a different interpretation of recovery. Recovery is ‘you are doing the right thing for you at the right time.” - (NGO 2)

As this quotation demonstrates, self-assessment - as opposed to external audit - was viewed as a Scottish value (Community 2). The definition of what recovery meant in a
Scottish context came from the narrative research project (NGO 2). A development group met and went through the tool in order to ensure that its language - they “sat rephrasing sentences” - and content were appropriate (NGO 1). The tool was also tested within several pilot sites to make sure it worked within the Scottish context and further changes were made.

The ‘formalisation’ of recovery goals within service provision which the tool represented was seen as important. As one respondent reflected it:

“...took the discussion away from it being a nice cosy service user discussion about ‘isn’t recovery a nice thing’ into something we wanted to directly apply to how we were doing services...”

- (Government 2)

The tool aided in the ‘journey’ being undertaken by services moving towards a recovery consciousness. Through being obliged to undertake the SRI self-assessment exercise it was argued that services would reconceptualise their service provision through a recovery lens and be able to more effectively implement the recovery model (Practitioner 2; NGO 2; Practitioner 1). One respondent reflected on this process:

“What we have found in tests and now is that the conversation is everything. So you have a team of people doing it...and having a conversation about it and saying ‘well the implications for us are we never talk about strengths.’ ‘We are an acute admissions ward, why would we want to talk about strengths? They are ill.’ ‘Well actually when you talk about strengths people talk about what they can do and that creates hope.’ ‘Oh right. Ok. That’s an interesting concept, I hadn’t thought of that before’”

- (NGO 1)

Another respondent viewed the self-assessment aspect of the tool as appropriate because it allowed recovery to grow organically – a process that could not be rushed – to become ‘owned’ by services and integrated thoroughly into practice (Practitioner 2). More important here than the data produced through the use of the tool was the process of it being used. Through using the SRI this technology drew attention to recovery in services in a way that would not otherwise be possible.

Importantly for our respondents the data produced through the use of the SRI was not ‘assessed’ by anyone but the service who was entering the data (NGO 1; NGO 2). For individual services the data from the SRI was seen as important as it served to provide “evidence” about the extent of recovery practices within the organisation. They could then work from a baseline to improve their performance against each part of the indicator (Practitioner 1). It also served to demonstrate that recovery work was indeed being done and was not just a vague concept to which lip service was being paid: “...the recovery indicator tool has shown us that there is a lot of recovery oriented work going on but it is really hard to evidence it because paperwork and the way we document things doesn’t reflect that.” (Practitioner 1; Practitioner 2).
The next stage of our report will look generally at how indicators are used by Scottish services and government.
4. How indicators are used

“We have recognized that, used inappropriately, targets can distort systems. So we have tried to use them in an intelligent way, always focusing on the underpinning improvements that the target is seeking to deliver, rather than viewing the target as an end in itself. This intelligent use of targets has enabled us to keep clinicians engaged throughout the process and is leading to an increased use of information to drive improvement....Crucially, a culture of trust over the proper use of information has been established in Scotland. Maintaining this trust will be the key to our ongoing use of information to drive improved outcomes.”

- (Coia and Glassborow, 2009: 647)

“To think through data, support for change, performance management, tangibles so we can actually line up real people out there in the real world who do real jobs to spend real money to actually do the things we want them to do.”

- (110110)

Both of these quotations come from sources within the Scottish Government. They demonstrate an aim to use indicators as a way of keeping a check on the system and implementing policies, but also a concern that they should be used appropriately and ethically. In other words they considered that they could be useful, but that they could also ‘go bad’ and be used inappropriately. Our interviews with individuals working across the system demonstrated a similar ambivalence towards indicators.

There were concerns initially amongst those working in health boards, including as Managers and Chief Executives, over the introduction of indicators for mental health (290610). However amongst those working in mental health this attitude had gradually shifted as they began to see the utility of them for emphasising mental health as an important area of work (290610; 140510; 240510; 110110). As one respondent commented:

“The NHS in general hates targets. If you talk to anyone in acute NHS they will say ‘It’s a perverse incentive.’...It’s quite interesting how the NHS views targets in mental health which is ‘This is really good. We are such a Cinderella specialty.’ ‘It’s forced our Chief Exec to talk to us for the first time in five years.’”

- (290610)

Because of the culture of targets that had developed within the health services it was felt that areas would be ignored by Chief Executives if there was no target or indicator which was measuring the progress of their health board. The target worked to put the area of work as a priority on the health board’s agenda:

“So the targets have helped to kind of focus our attention on it to a greater extent because I think without for example the dementia HEAT target we probably wouldn’t have had the same focus board-wide on dementia registers than we have had over the past two and a half years.”

- (240510)
“The big advantage of it is that with the targets have come a focus on targets on mental health from the Chief Execs and senior people in the health services and they’ve peered into the dark corners and that’s allowed staff time to actually look at these services and to take time to provide answers to questions, grow new questions and I think that might not have happened without the targets.”

- (290610)

“Overall I think it’s easier because its on the Chief Executive’s radar basically. Otherwise you could just be [forgotten]. I’ve worked in mental health improvement in a different health board area but for a long time, probably about 15 years and there is a big change in the visibility and it is seen as important.”

- (140510)

If a target were applied Chief Executives would prioritise mental health for funding where other areas might not be (110110; 140510). This was seen as especially important in a time of recession where money within health boards was tight (290610):

“There was a move to social prescribing anyway but I think that in terms of - I mean I had been hoping to set up exercise referral for a number of years and there was never ever any funding...but I think it gave some sort of impetus to get these sort of things funded.... I think the impetus has come from the HEAT target.”

- (140510)

The application of a target to an area was also seen as an important way of generating new knowledge and new understandings about an area of work (140510; 290610; 110110). The target allowed for a great deal more attention to be applied to an area of work and to really know what would be effective and why certain patterns would keep repeating. As discussed above, the anti-depressant prescribing target was viewed as an important example of the way a target could be effective in producing new knowledge.

4.1. What counts

Other respondents commented on fears that indicators and measures such as WEMWBS were being used incorrectly to measure the wrong thing and draw the wrong conclusions (150909; 031109; 140510). Several respondents spoke of a history of using GDP or measures of mental ill-health such as the PHQ-9 to measure positive mental health in the community (031109; 150909; 110110). It was felt that if these measures were measuring the wrong thing with respect to mental health and would therefore distort work on positive mental health when used as an indicator of successful work in the area (031109).

There was also concern that within some areas the collection of the indicators was too limited to be of value. This meant that they could not be put to use to do the work they needed to do or might be used to make assumptions that were not correct. WEMWBS, for example, was only of use if it was collected at a local level as the current data gained
from national surveys was not extensive enough to be broken down to health board level (150909; 031109; 140510). One respondent spoke about the challenge of getting WEMWBS included in national surveys which would give them a greater ability to use the data in meaningful ways:

“Unfortunately very little of the data is available at a level that will help single outcome agreements, which is obviously an issue....There has been these single outcome agreements and then suddenly there has been this data need. But the systems aren’t there to capture it. And the main one that could capture it is the household survey which has a big enough sample - about 16000 per year - and its designed to give local authority data every two years....[the] analytical division [in the government] made a big push trying to get WEMWBS in that survey and the rationale and everything but unfortunately they didn’t manage to. If it had got in there obviously that would have been fantastic for the single outcome agreements.”

- (031109)

Local health boards had to then work out how to collect WEMWBS data at a local level. This was a significant problem as during the TAMFS consultation the government had sold WEMWBS as an effective tool for gathering information on the success of local mental health improvement initiatives (031109; e.g. Universities Scotland consultation event).

4.2. Reporting and negotiating

Respondents spoke about the process of reporting and negotiating which goes on between the Mental Health Division in the Scottish Government and individual health boards over the results of indicators. Health boards are required to report on indicators on a regular basis – monthly in the case of the HEAT targets (290610). Dialogue between the government and health boards takes place primarily through the six-monthly board review visits, letters and meetings. One respondent outlined the usefulness of dialogue focusing on indicators as part of the board review visits:

“We go out every six months on board review visits so we’ll take some of the indicators with us....We’ll know when a board has got absolutely really poor community services but before we haven’t really been able to say... ‘We know you’ve got really poor community services’ and they say ‘Oh no we haven’t’. We’re saying ‘well actually now we have indicators that say this is what’s happening in your inpatient services.’ So there is something more concrete to look at with [indicators].”

- (290610)

One respondent working in a health board spoke of the way they put the feedback they got from the Government through the Mental Health Collaborative to work:

“We’ve found that to be really useful. ISD compile the – they kind of crunch all of the numbers down for the HEAT targets from all the mainland and islands boards.
So they've been really good at producing monthly composite reports so [our health board] where I work we can benchmark ourselves against other boards in relation to the targets and that's actually been really good because previously we didn’t have any idea of how we were actually doing so it helps us.” - (240510)

As this discussion shows the dialogue between the government and the health boards has been characterised by ‘polite’ cooperation.

Until early 2009, when the process changed, the documents through which the relationship between the Government and health boards was conducted were made publicly available. An example of the language used by the government in discussing health board performance can be seen in the following quotations from letters to Highland and Grampian health boards:

“We were pleased to hear that there were more clinical psychologists in post and more therapies available throughout the Highland area. You advised that you thought it was unlikely that you would achieve the target but might get a reduction in the rate of increase.....We discussed the difficulties around the reprovision of adolescent inpatient beds in the North of Scotland and in particular NHS Highland’s refusal to provide funding to support the progress to a business case for such reprovision. You explained that the reasons for this were financial constraints and that you had not withdrawn from overall discussions. This is an area of concern and importance that has gone past the original timescales set. We would strongly urge the Board to reconsider its decision and to support the progression of this issue.” - (Huggins, 2009)

“We were pleased to note the significant work your Board has done in this area and particularly in relating this to work improving access to psychological therapies. You have several research projects in conjunction with Aberdeen University underway, examining prescribing practice and identification of depression in primary care.... We were pleased to note that you have agreed a training plan and are planning to exceed our target for staff numbers trained. Whilst you accept that training may be tailored to accommodate approved prior learning, you are keen to ensure it remains multidisciplinary and that individuals to not opt out of team training. We were pleased at your plans to include A&E staff and note the difficulties you are experiencing similar to other Boards in engaging GPs in training.” - (Coia, 2009)

The language here, even when being critical, is overwhelmingly positive, respectful and encouraging - almost artificially so. There is no use of threats and the emphasis is on the accounts given by the board which are reflected back by the government, thereby emphasising the work of the health board in taking initiative to make its own progress towards the target. The language the government takes up is paternal or maternal – a guiding parent keeping their possibly wayward children on track so that they can meet the goals which the parent knows are best for them. The language is deliberate and the
words seem to be very carefully chosen to build up a certain type of relationship. One government respondent characterised the relationship between the government and the health boards as consciously being set up in a ‘supportive’, ‘trusting’ and ‘reciprocal’ way:

“I think targets are alright and indicators are alright as long as you have a mutual trust, that there is reciprocity, that if you find a board is struggling you provide support in and try and genuinely work out why it’s struggling and what the issues are. And that you work to deliver improvement and recognise that sometimes it takes a while to improve. So it’s a feeling of working with people rather than top down.”

- (290610)

This approach appears to deliberately set itself apart from the climate of ‘terror’ which has been said to have characterised the use of targets within the NHS by the UK government.

In around 2000 a ‘targets and terror’ system was employed within the NHS and a process of “naming and shaming” was applied by the UK Government to English NHS boards who did not meet targets (Bevan and Hood, 2006; Bevan, 2008; McKee, 2009; Greener, 2003). Gray and Hood (2007: 92) comment about the development of “hanging offences”, by which they refer to “career-threatening failures to meet the most significant performance targets set by government”. Without explaining why, Bevan and Hood (2006) state that this was not the case in devolved UK governments. Hood (2007: 97) states that it was the size of English public service that allowed the ‘terror’ aspects of performance management to be used where they were not in other places in the UK. Whatever the reason, the Scottish Government has deliberately decided on the development of a discourse around measurement which portrays them as friendly and approachable.

One respondent associated the style of negotiation of indicator results which the government took up as being something specifically fostered by the SNP:

“I think this government is quite different in that sense. Previously the previous governments were really, not to put to fine a point on it, heavy handed. This government’s got a different approach. They are much more supportive. If they see a problem and we are not meeting a target and things are beginning to slip they’ll get in touch and say ‘Look, we can help you with this. Let us know what we can do. We can be a bit more proactive.’ So I think it’s a much better way to operate.”

- (250510)

Mullen (2004: 218) writes that in comparison to targets which use terror, ‘threats’ and ‘sticks’, a use of performance indicators which promotes “learning, investigation, explanation and self-motivation, and involving alerting, tracers, trust and respect for professional values and autonomy have positive effects on performance.”

Jacobs and Manzi (2000), draw attention to the work of Ian Sanderson who was for several years until 2009 Director of Corporate Analytical Services within the Scottish
Government. Sanderson (1998) writes that concerns about the use of indicators could be dealt with by the introduction of a more participatory, “communicative” approach to their development which takes into consideration of what is of value to the different participants in the process. It seems that this approach was taken up by others working with Sanderson during his appointment, as the following quotation demonstrates:

“What’s been different in Scotland from England is that people don’t lose their jobs if they don’t achieve the target. It is more of a discussion point. So for example we have struggled with the anti-depressant target but everybody knows so much more about depression. And nobody has lost their job because they haven’t met a target. So it doesn’t set up ridiculous perverse incentives. What it’s done is allow people to explore things.”

This quotation points to the use of a ‘communicative’ approach much as Sanderson was advocating. This respondent also emphasised with a sense of pride the difference between the Scottish approach and that taken in England. This articulation of Scotland as taking a separate, better, approach to England is something that has come across in every stage of our work through the KnowandPol project. The Scottish way of approaching targets seems to use a much softer form of regulation than that in force in England (or perhaps just a ‘softer’ form of hard regulation). As we reflect on more in our concluding discussion in the next section of the report, the willingness of those working within health boards to submit to this ‘softer’ regime of measurement hinges on the progressive consensus which - at least for the moment - pervades Scottish mental health policy.
5. Concluding discussion

“If you are focusing on an area of health improvement and want people to put a focus on it then you can do this through an indicator.” - (101008)

Measurement has become a prominent and integral part of the way that mental health policy is created and implemented in Scotland. Drawing on Jacobs and Manzi (2000) we are able to identify a ‘discourse of measurement’ which has come to pervade the way that all aspects of mental health in Scotland are understood. The language of measurement has been slowly normalised through successive policy documents from the late 1990s. This has led to the gradual implementation of targets and indicators within the work of the NHS and its agencies.

How they work

In this report we have articulated the way that the discourse of measurement is manifest in the form of technologies such as the Scottish Recovery Indicator, WEMWBS and the HEAT targets for suicide and anti-depressant prescribing. Through the use of these technologies the goals of mental health policy are made concrete within the system. There are three main ways that a focus on measurement assists in these goals being achieved:

1) process: practitioners come to understand mental health in a different way through using the technology.

2) obligation: managers are compelled to act on mental health when they know that their performance will be judged and compared in relation to the performance of other health boards.

3) education: the application of a target focuses work on the area as the government, practitioners and services are forced to educate themselves about the topic to find out how best to improve it.

The case studies that we presented above articulate how each of these function in practice: The SRI leads practitioners on a journey through which they come to reconceptualise the practice of mental health within their service in a recovery oriented way. WEMWBS is a tool used to make concrete the work being done in public mental health. Its imbedding within the national performance framework and in local area planning forces service managers to invest in public mental health. Anti-depressant and suicide reduction targets work to raise the profile of an issue and to focus attention on it in order to find out more about it so that appropriate work may be devised.
**Self-assessment**

One of the most interesting findings that we have identified through this research is the way that self-assessment is used in Scottish mental health work. Self-assessment is the main way that measurement is put to use in Scottish mental health work. National indicators may be assessed by the government and this may force health boards to act on mental health, but, as we heard in our interviews, this is secondary to their use within boards.

The operation of the Mental Health Collaborative, discussed above, provides a clear example of the processes of self-evaluation. Here health boards develop their own indicators and measurement tools or choose from those already developed elsewhere in order to assess their own services. They are also able to choose to compare themselves to others by applying the same measurement tools as those used in other health boards. They are then able to choose to initiate a dialogue with other health boards in order to determine how they may best improve their practice and thus their progress against the indicator. The key word here is *choose* – self-assessment will only work if health boards believe that they are choosing to undertake this process themselves. It is important for central government then to keep this belief alive – if the actors no longer believed that they had a choice it is much more likely that they would become resistant to their use.

Self-assessment makes the indicators seem innocuous because there is not a high level of scrutiny which creates an illusion of autonomy. McKee (2009) has articulated this process in relation to Scottish housing policy and practice. Using governmentality and drawing on the work of Mitchell Dean, McKee (2009) has reflected that self evaluation promotes “the self-governing properties of autonomous agents” (p.160). This process can be clearly seen in the work of the Mental Health Collaborative. Here the use of measurement has become normalised in the system to the extent that it has become self-perpetuating. HEAT targets were applied at a national level and then local health boards developed their own ways of working on the targets which were assessed, in turn, through the development and use of local area targets and indicators. As one respondent noted: “...we have been able to take measurement away from a kind of high level board-wide strategic view right down into local teams” (240510). Through devising their own targets local areas take ownership of the work through creating types of measurement that make sense in their own local context. Here the will to measure is not applied externally, but is freely taken up and applied.

When discussing Scottish housing policy McKee (2009) believes that the autonomy of self-assessment is illusory, because for those that are not able to effectively self-govern the government will step in with “more coercive measures” (p.163). However, in relation to mental health policy in Scotland any coercion is deliberately muted through the use of an elaborate dialogue of positivity and politeness, as demonstrated in the quotations taken from government-health board communications in section 6.2 above.
Also drawing on Foucault’s work on governmentality, Jacobs and Manzi (2000:88, italics in context) succinctly identify the power of an institutionalised and normalised self-assessment environment:

“Thus the notion of self-control in organizations is a crucial indicator of power. This voluntary submission through what Foucault terms ‘interiorization’ is the most effective deployment of power. Individuals and groups will often willingly submit to monitoring, discipline and punishment to achieve organizational objectives to which they feel committed.”

In Scottish mental health policy services do willingly submit to monitoring. As we have noted in previous work there is generally a strong commitment to the government’s policy goals amongst those working in the sector (Smith-Merry, Freeman and Sturdy, 2008).

**A Scottish way of measuring?**

Several of those that we spoke to in our interviews hinted that the way that they went about measuring mental health in Scotland was uniquely Scottish (DC, SP, 250510). Although we fall short of stating here that there is a ‘Scottish way’, we have found through this research that there are several characteristics of the way that measurement is done in Scottish mental health policy. These are an emphasis on collaboration, ‘politeness’ and self-evaluation.

The dialogue within the documents discussed in section 6.2 above, which the government used to comment on indicator progress, can be used to illustrate the first two of the key aspects of the Scottish measurement culture operating in mental health. The dialogue in these documents is polite and respectful and there is a distinct collaborative approach being expressed. Similar to McKee’s (2009) comments quoted above though, we are uncertain as to the extent to which this collaboration is real, given the power imbalance between the health boards and the government who wholly funds their work. The language of government-health board communications and the attitude of policy makers fits with the model of ‘progressive consensus’ building which we have identified in other research as being a key characteristic of the mental health community in Scotland. It figures that self-assessment will be most successful as a form of governance within this type of environment. The capacity for self-evaluation to work as a regulatory tool relies on the good-will of actors who will go out of their way to find out how their work is progressing and take action based on that. A climate of terror and threats would make local areas resistant to measurement and less likely to implement the government’s message in a meaningful way.

Ian Greener (2003: 238) has suggested that within the NHS indicators have been “sold” as a “tool for self-evaluation at the local level but end up being a tool for greater central control.” In Scottish mental health policy measurement can be seen to be a very efficient form of government control and an example of governmentality. This is because actors
working within local areas willingly take on the technologies of central government control and work to apply them within their local contexts. This works to imbed government policy directives made in central government within local levels thereby strengthening the government’s message on mental health.

The whole system of operation of Scottish mental health policy hinges on the fact that a majority of those involved in the system want to be involved and follow the path that the government has set. Were this progressive consensus which pervades Scottish mental health policy to become somehow undermined the Scottish way of doing measurement in mental health would no longer work.
Appendices

Appendix A

**Commitment 1:** “The Scottish Government will work with partners and existing networks to develop by 2010 a web portal on mental health improvement for those working with infants, children and young people.”

**Commitment 2:** “Promoting Well-being and Meeting the Mental Health Needs of Children and Young People: A Development Framework for Communities, Agencies and Specialists involved in Supporting Children, Young People and their Families outlines the competencies needed for mental health improvement work with children and young people. We will build on this work and focus on infant mental health improvement. NHS Health Scotland will work with partners to improve the skills and knowledge of front-line staff with a particular focus on inequalities.”

**Commitment 3:** “There are many effective interventions for mental health improvement among infants, children and young people; however, many of these are not in general use. NHS Health Scotland will initiate a programme in 2009 to disseminate the evidence base for mental health improvement and support its use through practitioner briefings and narratives to present the case to decision makers and planners.”

**Commitment 4:** “NHS Health Scotland will work with key stakeholders to develop a set of national indicators for children and young people’s mental well being, mental health problems and related contextual factors by 2011.”

**Commitment 5:** “The National Union of Students represents students in most of Scotland’s universities and works in partnership with the Scottish Further Education Unit. NUS Scotland will deliver a three-year project aimed at long-term gains in mental health improvement practices.”

**Commitment 6:** “The Scottish Government will address mental health improvement in later life through the creation of a national group (hosted by NHS Health Scotland) which will produce an action plan in response to All Our Futures and the UK Inquiry by 2010.”

**Commitment 7:** “Working with see me..., the Scottish Government will pilot and evaluate awareness-raising approaches on dementia with a focus on encouraging people to seek early diagnosis. The pilot will take place in the first part of 2009 in Dundee and the outcomes will be reported to the National Dementia Forum.”

**Commitment 8:** “NHS Health Scotland will publish and disseminate new dementia Resources Worried about your Memory? and Facing Dementia: how to live well with your diagnosis. Facing Dementia provides practical information for people who have recently been diagnosed with dementia. Worried about your Memory? is aimed at helping people who are concerned about their memory to decide whether they should see a doctor.”
Commitment 9: “The Scottish Government is implementing Good Places, Better Health which will look at the relationship between the physical environment and children’s health. It will concentrate on four child health priorities including mental health improvement, with the evidence being used to support policies and decision-making at national and local level. The work will be ongoing to March 2011.”

Commitment 10: “Culture and the arts can also support a range of local outcomes and the Scottish Government is collaborating with local government and other Community Planning and stakeholder interests in developing a toolkit to help Community Planning Partnerships to work with culture and creativity in delivering priority outcomes; this will include action in support of mental health improvement.”

Commitment 11: “The Scottish Centre for Healthy Working Lives will work with partners to develop a comprehensive programme of work to promote mentally healthy workplaces, with a specific focus on public sector workplaces and small-to-medium sized enterprises.”

Commitment 12: “The Ministerial Task Force on Health Inequalities said in Equally Well that we need to do more to address the factors that lead to people losing work or remaining out of work as a result of poor health. The Scottish Government will undertake a review of the current Healthy Working Lives policy early in 2009 with increased emphasis on mental health improvement.”

Commitment 13: “The Scottish Government will take forward work to develop consensus on what it would mean to be an exemplar employer and agree standards and consider an implementation plan for public health bodies to achieve the standards.”

Commitment 14: “The Scottish Government will take forward a further review of Choose Life in conjunction with key delivery partners, including NHS Health Scotland who have a lead responsibility for national implementation, and local government, who have a lead responsibility for local action. The review will be overseen by a National Suicide Prevention Reference Group with the work being completed by 2010. The work will be informed by an independent review of the second phase of implementation (2006-2008).”

Commitment 15: “Working with partners, NHS Health Scotland will develop a secure, confidential suicide register for Scotland by December 2009.”

Commitment 16: “The Scottish Government will work with partners to improve the knowledge and understanding of self-harm and an appropriate response. In taking forward this work we will: • agree a definition of self-harm and develop a non-stigmatising language and description of self-harm; • increase awareness of self-harm and its determinants; • map and assess existing training provision and projects across Scotland; • increase our understanding of effective methods of prevention and offer guidance to those delivering both general and specific services; • develop local and national information.”
Commitment 17: “During 2009 the Scottish Government will take forward work to develop referral criteria and information systems that would support the creation of access targets for psychological therapies.”

Commitment 18: “The Scottish Government will work with NHS Boards to implement the Equally Well recommendation that work to address depression, stress and anxiety is targeted in deprived communities, building on the action already being taken forward under the Keep Well programme (which is focused on anticipatory care) and the Living Better programme (which is focused on the mental health of those suffering from long-term conditions such as diabetes and chronic heart disease).”

Commitment 19: “see me….will develop a strategy for tackling stigma within public services and will work with public services, trade unions, employers’ bodies and the media to raise the profile of mental health in respect of the Disability Discrimination Act.”

Commitment 20: “The Scottish Government will put in place a programme of support for local areas to implement With Inclusion in Mind.”

Commitment 21: “NHS Health Scotland will review evidence-based approaches and develop health improvement information on smoking cessation, weight management and physical activity designed for people with mental health problems; and will work with NHS Education for Scotland to build knowledge and skills in the workforce.”

Commitment 22: “The Scottish Recovery Indicator will be available from end April 2009 and should be in use by the majority of mental health services by 2012. The Scottish Government will monitor its use.”
Appendix B

Commitment 1: “We will develop a tool to assess the degree to which organisations and programmes meet our expectations in respect of equality, social inclusion, recovery and rights. The tool will be piloted in 2007 and be in general use by 2010.”

This commitment sought to put in place a framework which would assist services to orient themselves towards the principles of recovery, rights, equality and social inclusion which were outlined within the 2003 Mental Health Act and Rights Relationships and Recovery (the 2006 review of mental health nursing).

An online self-assessment tool, the Scottish Recovery Indicator, was developed to fulfil this commitment. It was piloted in 2007 and is now being introduced into practice settings more widely (Scottish Recovery Network, 2009).

Commitment 2: “We will have in place a training programme for peer support workers by 2008 with peer support workers being employed in three board areas later that year.”

The Wellness Recovery Action Plan training was developed and has been used to train peer support workers across Scotland. Peer support workers have been employed in pilot sites within 6 health boards (this was double the number committed to). This pilot was evaluated in late 2009 (Scottish Government, 2009b).

Commitment 3: “We will work with GPs to ensure that new patients presenting with depression will have a formal assessment using a standardised tool and a matched therapy appropriate to the level of need. We will also develop treatment models for those who have depression and anxiety and who have coronary heart disease and/or diabetes who are identified under the new QOF arrangements.”

Progress towards this target is being made through the development of the programme Doing Well by People with Depression and the development of an Integrated Care Pathway for Depression (Scottish Government, 2008b).

Commitment 4: “We will increase the availability of evidence-based psychological therapies for all age groups in a range of settings and through a range of providers.”

This commitment is vague when applied at a national level. Nationally a guide has been developed which presents the evidence basis for psychological therapies (NHS Health Scotland, 2008). Each health board has devised its own targets in relation to this commitment and all health boards have now implemented programmes addressing the commitment. A new national HEAT target is currently being developed to better assess progress on psychological therapies.

Commitment 5: “[By 2009] We will improve the physical health of those with severe and enduring mental illness by ensuring that every such patient, where possible and appropriate, has a physical health assessment at least once every 15 months.”
There is currently no national data available which assesses progress towards this target. Local area data report continuing work within each health board (Scottish Government, 2009c).

**Commitment 6**: “NHS- QIS [NHS Quality Improvement Scotland] will develop the standards for ICPs [Integrated Care Pathways] for schizophrenia, bi-polar disorder, depression, dementia and personality disorder by the end of 2007. NHS Board areas will develop and implement ICPs and these will be accredited from 2008 onwards.”

At a national level this target was achieved with the development of ICP standards by the end of 2007 (NHS Quality Improvement Scotland, 2007). The second part of this target relates to the implementation of ICPs at a local level. However the movement of local health board areas towards this target has been patchy.

**Commitment 7**: “Key frontline mental health services, primary care and accident and emergency staff will be educated and trained in using suicide assessment tools/suicide prevention training programmes. 50% of target staff will be trained by 2010.”

This target has been included as a part of the HEAT suicide target. As discussed above, there has been a small increase in the number of staff trained with an increase from 16% in December 2008 to 22% in June 2009 (Scottish Government, 2009d).

**Commitment 8**: “Ensure that people are managed and cared for more effectively in the community and avoid inappropriate admissions by ensuring that the crisis standards are achieved by 2009”

While the data on this target is difficult to gather and no national level data has been released, it is clear from the submissions made by local areas that progress towards this target has been slow.

**Commitment 9**: “We will establish acute inpatient forums across all Board areas comprising service providers, service users and carers as well as other stakeholders such as Local Authority colleagues”

Acute inpatient forums have been developed within all health board areas.

**Commitment 10**: “We will improve mental health services being offered to children and young people by ensuring that by 2008: A named mental health link person is available to every school, fulfilling the functions outlined in the Framework.” **Commitment 10a**: “Basic mental health training should be offered to all those working with, or caring for, looked after and accommodated children and young people.”

Commitment 10, which consists of two separate targets, seeks to fulfil the recommendations of The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care (Framework) (Scottish Executive, 2005). The first part of this commitment has not been met, with half of the health boards still working on this target by 2008 (Scottish Government, 2009c).
Progress towards the second target has been better and is continuing. Four health boards have met this target: Greater Glasgow and Clyde, Lanarkshire, Lothian and the Western Isles (Scottish Government, 2009c).

**Commitment 11**: “We will reduce the number of admissions of children and young people to adult beds by 50% by 2009.”

This commitment would result in a reduction from 186 admissions in 2006/07 to 93 in 2009/10. By 2008/2009 the number of admissions of children and young people to adult beds had reduced to 142 (a reduction of 24%) meaning an equal reduction needed to take place in the final year of the target’s life (Auditor General for Scotland, 2009).

Lack of action on this target has been blamed on the time that is needed to make new beds for this population (Scottish Parliament, 2009). It is estimated that an extra 36 extra beds should be in place by the end of 2010 due to the creation of new specialist child and adolescent mental health facilities in the west of Scotland (Scottish Government, 2008c).

**Commitment 12**: “We will implement the new Care Programme Approach for all restricted patients by 2008.”

A Care Programme Approach has been implemented within all relevant health board areas (some health board areas do not have restricted patients).
Bibliography


