Mental health at the fault line

The damaging impact of health & social care integration on Scotland's mental health services

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

About the RCPsych in Scotland

As the professional medical body for psychiatry in Scotland, we set standards and promote excellence in psychiatry and mental healthcare. We lead, represent and support psychiatrists nationally to policymakers and other agencies, aiming to improve the outcomes of people with mental illness, and the mental health of individuals, their families, and communities. We have over 1,500 Members, Fellows, Affiliates and Pre-Membership Trainees in Scotland.

About this document

Scotland's integration arrangements vary considerably between local areas and the structures, governance arrangements, decision-making processes and priorities described in this report may not fully reflect the position in every NHS Board, Integration Joint Board (IJB) or Health and Social Care Partnership (HSCP).

This document is intended to provide a broad overview of the integrated landscape and represents the Royal College of Psychiatrists in Scotland's best assessment of how these structures operate in practice across the country. While individual areas may have different arrangements or priorities, the issues highlighted reflect recurring themes identified by members working in secondary care and specialist mental health services.

The report is written from the perspective of the Royal College of Psychiatrists in Scotland (RCPsychiS) and is intended to inform policymakers about the experiences, challenges and opportunities facing secondary and specialist mental health services within the current system.

The vital context

Although this report focuses heavily on governance structures, funding flows and organisational accountability, it is vital not to lose sight of what these arrangements mean in practice. The issues described in this report are not abstract administrative challenges. They have real consequences for real people. According to Scotland's 2022 Census, 11.3% of the population reported having a mental health condition. This proportion more than doubled from the 4.4% reported in the 2011 census.

Secondary and specialist mental health services support some of the most vulnerable people in Scotland, including those experiencing severe mental illness, acute mental health crises, significant risk, and complex long-term conditions. Decisions about governance, funding, workforce and accountability ultimately determine whether people can access timely care, whether services have sufficient capacity to respond, and whether patients receive effective support and treatment when they need it most.

Mental health care must be regarded with the same esteem as other forms of acute healthcare. Delays, fragmentation and failures in decision-making can have profound consequences for patients, families and communities.

Throughout this report, discussion of structures and systems should therefore be understood in the context of their impact on patient care, patient safety and outcomes. The central question is not how organisations are arranged, but whether the current system enables Scotland to provide the high-quality mental health care that patients need and deserve.

Integration of health and social care

In 2014, the Scottish Government introduced legislation to bring together health and social care services through a system of integrated planning and delivery.

This created 31 integration arrangements across Scotland who became responsible for the planning and funding of services which had previously been managed separately by NHS boards and local authorities.

The aim of this was to create a more joined up system, improve patient care, and to shift resource towards community-based and preventative care. However, these intended benefits have not been achieved equally across all services. In particular, mental health services have been disproportionately affected by the complexity and fragmentation created by integration.

The current landscape – what are health boards, IJBs and HSCPs?

Scotland's health and social care system is structurally complex, with care being delivered through:

- 32 local authorities
- 14 territorial NHS Health Boards
- 30 Integration Joint Boards (IJBs) (and one lead agency arrangement)
- 31 Health and Social Care Partnerships (HSCPs)

These bodies overlap geographically and functionally, but they do not sit neatly together. They have very different roles and responsibilities.

At a high level:

- NHS Health Boards employ staff and are responsible for clinical governance, quality assurance and patient safety.
- IJBs develop strategic plans, hold delegated budgets and decide how funding is prioritised across the integrated services delegated to it. They issue directions, with budgets attached, to health boards and local authorities that determine how delegated functions are to be delivered.
- HSCPs are responsible for operational planning and delivery of services locally on behalf of the IJB.

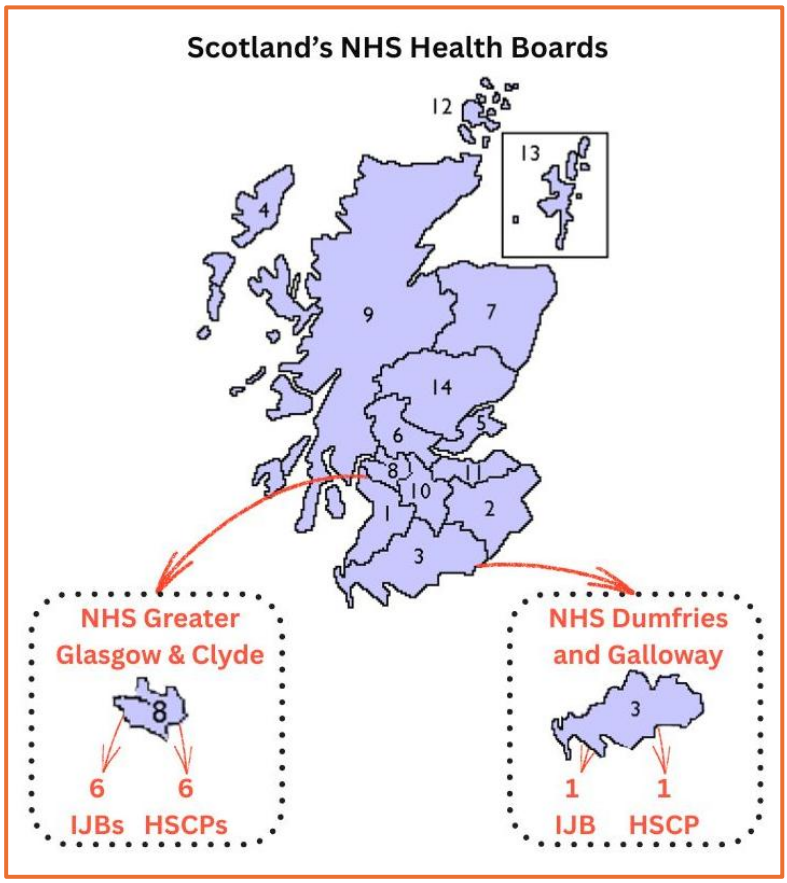
Each integration scheme sets out the arrangements for how services are planned, delivered and monitored within their local area. These are developed by local authorities and Health Boards and signed off by Scottish Ministers.

Most health boards and local authorities delegate to a third body (the Integration Joint Board). This is known as the Body Corporate approach. The exception is in Highlands, where the Lead Agency approach is used, which sees NHS Highland delivering adult services on behalf of the Council, and Highlands Council delivering some children's services on behalf of the Health Board.

A complexity of integration is that most NHS boards have multiple IJBs within their boundary. This means that most NHS boards work with multiple IJBs and HSCPS, each with their own governance arrangements, leadership team, strategic priorities and budget decisions.

There is a huge extent of variation in governance agreements - for example, the NHS Dumfries and Galloway area is governed by a single IJB and delivered via one HSCP. However, within the NHS Greater Glasgow and Clyde area, there are six separate IJBs and HSCPs within its boundary area, corresponding to the six local authority areas: Glasgow City, East Dunbartonshire, West Dunbartonshire, East Renfrewshire, Renfrewshire and Inverclyde.

The larger the number of delivery bodies involved, the greater this complexity can become. Different bodies may face different financial pressures, adopt different priorities, provide different services and make different decisions about investment and delivery of services. This can lead to duplication of work and variation in services across areas served by the same NHS Board - despite sharing the same workforce, governance arrangements and overall health system.



The damaging impact of integration on secondary and specialist mental health services

Secondary and specialist mental health care sits in the fault line between the NHS and integrated boards. This has meant in practice that mental health services have been disproportionately negatively affected by integration.

While integration was intended to create a more joined-up system, it has had the opposite effect for mental health - and has in fact caused major fragmentation. This is impacting on the quality of care that patients are receiving.

Responsibilities that were previously held within a smaller number of organisations are now spread across multiple bodies. As a result, no single organisation has responsibility for these issues at the same time.

A note on terminology

'Secondary care' refers to healthcare services provided by specialist clinicians following referral from primary care or another professional. Within mental health, this includes services delivered by psychiatrists and multidisciplinary specialist teams.

Psychiatry is predominantly a secondary care specialty. While psychiatrists work closely with primary care, social care and community services, their role is typically focused on the assessment, diagnosis and treatment of people with moderate to severe mental illness, complex mental health needs, and those requiring specialist intervention. It should be noted that Scottish psychiatric care is predominantly provided in the community.

Throughout this report, references to mental health services are made primarily from the perspective of secondary care and specialist mental health services, reflecting the experience and expertise of members of the Royal College of Psychiatrists in Scotland.

Adult secondary mental health care services were among the services most fully integrated into the new system. However, rather than creating a single, joined-up structure, this has often resulted in fragmented decision-making, a lack of accountability and responsibilities being spread across multiple bodies. Clinical governance, workforce and patient safety remain

the responsibility of NHS Boards, while funding and strategic decisions sit with Integration Joint Boards, and day-to-day planning and delivery are managed through Health and Social Care Partnerships

Beyond adult mental health, the picture becomes even more complex. Different mental health specialties sit in different parts of the system and are subject to different governance arrangements.

For example, child and adolescent mental health services (CAMHS) largely remain within NHS Boards and sit outside most integration arrangements. This creates additional complexity, particularly at transition points between CAMHS and adult mental health services.

While CAMHS itself is not usually delegated, early intervention, prevention and emotional wellbeing support services often sit with HSCPs/IJBs. Children's social work and family support are also local authority-led and often integrated. This means that IJB decisions directly affect demand for CAMHS, even if they don't manage CAMHS services. Thresholds are where system fragmentation shows most clearly. Education, social work and the third sector sit outside of NHS governance and CAMHS decision-making, yet often manage unmet need where secondary care would not be the appropriate place. This concentrates risk at the CAMHS referral and threshold point. Issues perceived as inappropriate referrals/rejected referrals are often actually system design problems.

Transitions can therefore sit across multiple different systems (CAMHS = NHS board-led, adult mental health = HSCP / IJB-led) with different funding routes, priorities and accountability. This makes transitions a structural fault line, not just a service issue. For CAMHS, integration hasn't removed fragmentation, it has instead shifted where fragmentation occurs.

Prevention, early intervention, wellbeing services, children's social work and family support may sit across HSCPs, local authorities, education and third-sector providers.

Similar variation exists across other psychiatric specialties, including (to name a few) intellectual disability psychiatry, old age psychiatry, perinatal psychiatry, addictions, neurodevelopmental services, eating disorders, and forensic services, all of which may operate across different organisational boundaries depending on the area and service model.

The result is a system in which strategic priorities, funding decisions, workforce planning and service delivery often sit in different places. A single issue, such as workforce shortages, access to services or waiting times, may involve several organisations depending on the age group, service type or care setting involved.

Mental health is therefore governed by more moving parts than many other areas of health and social care. Mental health was already cross-cutting, and integration has multiplied the number of bodies with partial control rather than simplifying it.

This means that there is no single mental health governance structure in Scotland. The interaction between NHS Boards, IJBs, HSCPs, local authorities, education services and third-sector organisations varies significantly between areas and between specialties. In practice, the level of variation is so great that it is impossible to accurately map a single national picture of how mental health services are planned, funded and governed.

This complexity may explain why successive attempts to improve mental health services through national policy, targets and funding commitments have often struggled to achieve consistent results. Responsibilities, incentives and accountability frequently sit in different places, making it difficult to implement change consistently across the system.

Areas of concern

We have identified 5 key areas of major concern regarding integration and secondary and specialist mental health services:

1. Patient safety and governance – risk without authority
2. Finance – loss of transparency
3. Accountability – no understanding of where responsibility lies
4. Decision-making – no seat at the table
5. Duplication - waste and gaps

Concern area 1: Patient safety and governance – risk without authority

Secondary and specialist care mental health services support some of the most vulnerable people. Safe care depends on clear governance arrangements, effective clinical leadership, and a shared understanding of who is responsible for identifying, escalating and managing risk.

Integration has complicated these arrangements. While NHS Boards retain responsibility for clinical governance, patient safety and professional standards, many of the decisions that influence risk (such as service capacity, workforce levels, investment priorities and service redesign) sit elsewhere within IJBs and HSCPs.

This creates a disconnect between accountability and authority. Those responsible for managing clinical risk do not always control the resources or decisions needed to address it. As services come under increasing pressure, it can become difficult to identify who has the authority to act and who is accountable for outcomes.

Mental health services are particularly vulnerable to this disconnect because risks often emerge gradually and across organisational boundaries. For example, long waiting times, varying thresholds for access, service fragmentation, workforce shortages and gaps between services can all increase risk to patients, but responsibility for addressing these problems may be distributed across multiple organisations.

Integration has also weakened and complicated some of the traditional routes through which concerns could be escalated and addressed. Before integration, mental health was a more visible planning and performance area within NHS structures. Today, governance arrangements are often more dispersed, with mental health risks considered across multiple boards, committees and partnerships. This can make it harder to identify where concerns should be raised and who has the authority to act.

For clinicians, this can create a significant challenge. Psychiatrists remain responsible for patient care, clinical decision-making and risk management, but may have limited influence over the system factors contributing to those risks. In some cases, clinicians are expected to manage increasing levels of complexity and demand without a corresponding ability to influence the decisions affecting capacity and resources.

The consequence is that risks can become everyone's responsibility and no one's accountability. While there is no shortage of commitment across the system, the fragmentation created by current arrangements can make it harder to identify emerging concerns, intervene early, learn from this, and ensure that patient safety remains the overriding priority. For services caring for some of Scotland's most vulnerable, complex and acutely unwell patients, accountability cannot be optional - it must be clear, visible and actionable.

Governance structures should support safe, effective care, as well as development and learning. Where accountability, authority and responsibility are separated, there is a risk that patient safety becomes harder to protect, risks are harder to manage, and opportunities for early intervention and learning are missed.

Case Study: Audit Scotland report - governance complexity impacting mental health services

An independent review of a Scottish health board's mental health services in 2020 identified complex governance arrangements, unclear leadership responsibilities and poor communication between partner organisations as significant barriers to improvement of mental health services.

The review found that responsibility for planning and delivering services was spread across multiple organisations, making it difficult to understand who was accountable for key decisions and outcomes. Concerns were also raised about trust between organisations, the ability to respond effectively to service pressures, and the lack of clear oversight of improvement activity.

Several years later, an Audit Scotland report in 2025 of the same system highlighted ongoing challenges relating to governance, accountability, progress reporting and clarity of roles and responsibilities.

This demonstrates how overly complex governance arrangements can become a risk in themselves. When responsibilities are divided across multiple organisations, it can be difficult to identify who has the authority to act, who is responsible for service improvement, and who is ultimately accountable for patient outcomes.

Concern area 2: Finance – loss of transparency

There is a lack of transparency and accountability between NHS Boards, IJBs, HSCPs and the Scottish Government over how funding for mental health is allocated and spent. Funding decisions are often made at one level of the system, while the impact of those decisions is felt elsewhere.

This makes it extremely difficult to track how much money is actually reaching mental health services and whether investment is being used as intended. As funding moves through multiple layers of the system, it increasingly loses its identity as 'mental health funding'. Responsibility for allocation becomes more dispersed, transparency reduces, and it becomes harder to understand how resources are being prioritised locally.

There remains limited visibility over where funding ultimately ends up once delegated to local systems and how it is being spent. There is no

accountability or enforcement mechanism to ensure that this money is actually spent on the mental health services it is intended to reach.

The absence of a clear funding trail means there is often no straightforward way to demonstrate whether funding commitments have been met, whether investment has delivered value, or whether resources intended for mental health have been absorbed by wider system pressures.

This is particularly concerning given that investment in mental health funding has increased significantly in recent years. NHS Scotland mental health spending reached £1.486 billion in 2023/24, representing 9.03% of total net front-line health expenditure. Yet many of our members report a very different reality on the ground: services facing reductions, increasing thresholds for access, workforce pressures, and limited capacity to invest in service improvement.

This apparent disconnect raises important questions about how investment is flowing through the system and whether current governance arrangements allow resources to reach frontline services effectively. Without greater transparency, it is difficult to assess whether funding is achieving its intended impact or whether it is being diluted across multiple layers of planning, commissioning and administration.

Additionally, budgets were integrated, but risk was not. IJBs hold delegated budgets and set priorities, while clinical risk, patient safety and statutory duties remain with NHS Boards. This creates a disconnect between those controlling resources and those responsible for managing the consequences when services come under pressure.

The result is a system where resources can be lost through duplicated structures, poor coordination and ineffective interventions, while patients continue to face long waits for care. Without greater transparency and accountability, it will be impossible to ensure that scarce resources are being directed towards the services and outcomes they were intended to support.

Case study: The economic case for mental health investment

Improving mental health is not only a health and social care priority, it is also an economic one. The Prague Declaration on Mental Health, agreed by European mental health leaders and organisations, recognises that investment in mental health delivers benefits far beyond healthcare. Improvements in mental health are associated with increased societal productivity, higher employment rates, reduced absenteeism, lower demand on public services and better social outcomes.

This is particularly relevant in the context of health and social care integration. Mental health services are often viewed as a cost pressure within the system, yet the evidence suggests that effective mental health interventions can significantly reduce costs elsewhere across health, social care, welfare, education, justice and employment services. Investment in mental health should therefore be viewed as a driver of economic and social development rather than simply a healthcare expenditure.

However, the potential benefits of investment can only be realised if resources are used effectively. The complexity of current governance arrangements, duplication of effort, fragmented decision-making and unclear accountability risk reducing the impact of funding intended for mental health services. In a period of financial constraint, reducing waste and improving transparency is not simply a governance issue, it is an opportunity to redirect resources towards activities that improve outcomes for patients while generating long-term savings for society.

The challenge is therefore not simply to secure greater investment in mental health, but to ensure that investment reaches frontline services, is used effectively, and delivers measurable benefits for patients, communities and the wider economy.

Evidence to the Scottish Parliament Health Social Care and Sport Committee 2026-27 pre-budget Scrutiny highlighted widespread respondent concern regarding the above. There was a common concern that the challenge facing mental health services is not simply the amount of money invested, but whether resources are being allocated effectively and achieving measurable outcomes. Multiple respondents argued that fragmentation, unclear accountability and poor transparency make it difficult to assess whether funding is reaching the right services and delivering value for money.

Concern area 3: accountability – no understanding of where responsibility lies

One of the consequences of integration has been the creation of a system in which responsibility for mental health services is spread across multiple organisations. NHS Boards, local authorities, IJBs, HSCPs and the Scottish Government all have a role to play, but it is often unclear who is ultimately accountable for decisions, outcomes or service failures.

For example, NHS Boards remain responsible for workforce, clinical governance and patient safety, while IJBs often control the budgets that determine service capacity and investment. HSCPs are responsible for operational planning and delivery - but may not have direct control over the resources and do not employ the staff required to implement change. As a result, responsibility for different aspects of service provision is frequently divided across organisational boundaries.

This fragmentation can result in a culture of split responsibility without clear accountability. When services come under pressure, it can be difficult to identify who has the authority to act, who should be held responsible for outcomes, or where decisions have actually been made.

The current arrangements can also lead to duplication of governance, planning and reporting structures, with similar discussions, priorities and oversight functions taking place across multiple organisations. However, there is no single body with the authority or responsibility to identify and reduce this duplication, streamline decision-making or ensure that resources are being used as efficiently as possible. This creates additional bureaucracy while making it harder to deliver meaningful service improvement.

For clinicians, patients and professional bodies, this lack of clarity creates significant challenges. Problems may be widely recognised, but there is often no obvious route for influencing change or securing action. Equally, when services fail to meet demand or deliver expected outcomes, it can be difficult to determine where responsibility lies and who should be accountable for addressing the problem. In practice, this risks creating a system in which accountability becomes diffused, making improvement more difficult and reducing confidence in decision-making processes.

There is also concern that, as governance and management arrangements have become increasingly complex, the number of leadership, managerial and oversight roles across the system have grown, while many services

continue to experience difficulties recruiting and retaining frontline clinical staff.

Clinicians perceive a disconnect between the expansion of managerial posts alongside cuts to frontline clinical services. This reinforces concerns that decision-making has become more distant from frontline services and that resources are being absorbed by administrative processes rather than direct patient care.

Case study: fragmented structures

Glasgow provides a useful illustration of how fragmentation plays out.

At board level, NHS Greater Glasgow & Clyde is responsible for:

- Employing the mental health workforce
- Clinical governance and patient safety

For adult mental health services, however, strategic control and funding decisions are split across multiple IJB and HSCPs:

- Acute inpatient services are spread across 5 sites managed by 3 HSCPs
- Community mental health services are managed by 6 HSCPs
- Crisis services are managed across 4 HSCPs with differing models of care

For older adult mental health services:

- Acute inpatient services are managed by 4 HSCPs
- Community mental health services across 6 HSCPs, with varying thresholds for transition from adult services.

This means that within a single board area:

- There is 1 NHS employer
- Multiple systems for delivery of care with varying overlap and responsibility for inpatient, crisis and community services.

Even in a relatively straightforward geography, change for mental health services means navigating several overlapping governance arrangements.

The workforce implications are significant. NHS Greater Glasgow & Clyde employs the mental health workforce and remains responsible for patient safety and clinical governance, but many staffing decisions depend on funding and approval processes that sit across multiple organisations.

This creates a disconnect between responsibility and authority: the NHS Board is accountable for workforce pressures and patient safety but may not directly control the resources needed to address them.

In the context of severe workforce shortages and vacancy rates of up to 40% in some psychiatric specialties, the system cannot afford lengthy, complex processes involving multiple layers of approval before vacancies can be filled or services expanded.

Concern area 4: Decision-making – no seat at the table

Mental health services are shaped by decisions made across multiple organisations, yet mental health expertise is often absent from the forums where those decisions are taken.

Funding decisions, priority setting and service redesign are frequently determined within broader health and social care structures, where mental health must compete with a wide range of other pressures. As a result, influence often depends on local relationships and individual champions rather than formal mechanisms for clinical engagement.

Integration also reduced the visibility of mental health within the system. Before integration, mental health was a distinct NHS planning and performance area. Since integration, it has become one priority among many within HSCP and IJB structures, with fewer dedicated leaders, weaker accountability and less prominence in performance reporting. In contrast, acute physical health services retained clearer leadership structures, national standards and stronger routes for escalation.

At the same time, decision-making has become increasingly separated from clinical expertise. Psychiatrists retain responsibility for managing risk, ensuring patient safety and delivering care, but are rarely consistently represented within IJBs, HSCP leadership teams or the forums where difficult decisions about funding, capacity and service configuration are made.

This is particularly significant because psychiatrists hold a unique role within mental health services. As medically trained doctors, psychiatrists are responsible for assessing and managing complex clinical, psychological, social and environmental risks, prescribing and overseeing medical treatment, exercising statutory and medicolegal responsibilities, and caring for patients who may temporarily or permanently lack decision-making capacity.

Psychiatrists therefore bring a system-wide understanding of risk, capacity, workforce and patient need that is essential to effective planning and decision-making.

Psychiatrists carry significant responsibility and accountability for patient safety, clinical governance and risk management. However, they are increasingly expected to manage these risks without meaningful influence over the resources, workforce or strategic decisions required to address them.

This creates a disconnect between those making decisions and those managing the consequences. Decisions about workforce, service thresholds, access, capacity and investment are often taken without sufficient understanding of their clinical impact on patients and staff. The consequences can include poorer prioritisation of resources, reduced value for money, increasing pressure on already stretched services, and greater risks to patient safety.

Mental health service reform cannot succeed without meaningful clinical involvement. Psychiatrists bring a unique understanding of risk, service demand and patient needs, and must be involved as system leaders alongside policy and finance colleagues. Without that expertise, there is a risk that emerging problems are missed, accountability is weakened, and decisions fail to reflect the realities of delivering mental health care.

Member case study: clinical leadership with no seat at the table

"I am increasingly concerned about the lack of clinical leadership representation within the senior management structures of my HSCP, particularly in comparison to other parts of the system. In my current role as a Clinical Director, I do not have a seat at the HSCP senior management table, whereas clinical representation in primary care is embedded at that level.

I believe it is essential that senior clinicians are directly involved in informing strategic decisions and clinical governance arrangements. Without this, there is a real risk that key decisions are made without sufficient clinical insight, particularly in complex areas such as mental health services.

From my perspective, there is currently a lack of clarity around both structure and accountability for clinical governance within the HSCP. As a Clinical Director, I have found it challenging to understand where responsibility sits and how I can effectively discharge my role within the existing arrangements.

This lack of clarity extends to financial decision-making. While I am held accountable for the safety, quality and performance of services, I have little control over the budgets required to deliver them. If clinical posts remain vacant, there is a constant need to justify and protect that funding to ensure it is retained for future recruitment. There is a risk that resources intended for mental health services are absorbed into wider system pressures, while expectations on services remain unchanged.

As a result, I can find myself responsible for managing clinical risk, workforce shortages and service pressures without having meaningful influence over the strategic and financial decisions that contribute to those challenges.

I would strongly advocate for clearer definition of clinical governance structures and lines of accountability, formal inclusion of senior clinical leadership within senior management forums, greater transparency around mental health budgets, and greater consistency in how clinical leadership roles are represented across different parts of the system.

These changes would support safer, more effective decision-making and ensure that clinical risk, service quality and resource allocation are appropriately considered at the highest level."

– RCPsychiS member

Concern area 5: Duplication, waste and gaps

The current structure creates multiple layers of governance, planning and oversight, often involving several organisations with overlapping responsibilities. This can lead to duplication of effort and commissioning, repeated decision-making and reporting requirements and multiple forums progressing the same issues without clear ownership of solutions.

Integration has also significantly increased local variation. With 30 IJBs and 31 HSCPs, there are now multiple organisations developing separate strategies, priorities and service models for mental health services. While local flexibility can be valuable, there is no clear mechanism for ensuring consistency or minimising unnecessary variation across areas. National standards and quality expectations may be shared across Scotland, but the governance arrangements, funding decisions, service pathways and leadership structures used to deliver them can vary considerably between local areas. As a result, patients with similar needs may experience very different pathways, thresholds and services depending on where they live.

At the same time, services can fall between organisational boundaries. Issues that sit between health and social care, community and inpatient care, or child and adult services can be particularly vulnerable to gaps in provision because responsibility is divided across different bodies. This can result in several organisations working on the same challenge while other important issues receive insufficient attention. Resources are spent maintaining governance arrangements, managing interfaces and producing parallel plans and strategies rather than delivering direct patient care.

For mental health, this means that patients and clinicians often experience a system that is both overly complicated and insufficiently joined up. Fragmented pathways can increase pressure elsewhere in the system, including for emergency departments, Police Scotland, prison healthcare and social care services. The result is inefficiency, variation in services and missed opportunities to improve outcomes despite significant effort across the system.

In a period of significant financial challenge, Scotland cannot afford to waste resources through duplication, fragmented governance and poorly coordinated pathways. Every pound spent maintaining unnecessary complexity is a pound that cannot be invested in frontline mental health services. Given the well-established economic case for mental health investment, reducing waste should be seen not only as a governance issue but as an opportunity to improve outcomes while reducing future costs across health, social care and the wider economy.

Case study: duplication and waste

The current system can result in multiple organisations investing in different parts of the same pathway without a shared strategy or clear oversight. This can lead to duplication of services in some areas, gaps in others, and an inefficient use of limited resources.

Neurodevelopmental services provide a good example. Within a single NHS Board area, different HSCPs and IJBs are commissioning different ADHD and autism services according to local priorities, budgets and strategies. This can result in multiple assessment, triage, wellbeing and support services being commissioned across the same NHS Board footprint, each with different eligibility criteria, referral routes and delivery models.

At the same time, the NHS Board retains responsibility for many of the diagnostic and clinical elements of the pathway. As a result, patients may still face long waits for assessment and support, despite significant spending elsewhere in the system. Multiple organisations are therefore investing in the same broad area of need, but without a single body overseeing how resources are deployed across the entire pathway

The issue is not that services are being commissioned, but that they are often commissioned separately and without a clear view of the whole system. As a result, money can be spent maintaining multiple local solutions while fundamental problems - such as diagnostic waiting times, workforce shortages and access to evidence-based care - remain unresolved.

For mental health more broadly, this illustrates a wider challenge created by integration: responsibility for funding, planning and delivery is distributed across several organisations, but accountability for outcomes is often unclear. This increases the risk of duplication, inefficiency and gaps in care, even where there is substantial effort and investment across the system.

RCPsychiS recommendations

Scotland is facing significant and sustained pressures on mental health services. Addressing these challenges requires both immediate action and a critical examination of whether current governance arrangements are enabling effective planning, investment and service delivery and, most crucially, the best possible care for patients.

We are not making any recommendations regarding the structures themselves, as we recognise that this is for Scotland's policymakers to evaluate, however, we do recommend with urgency:

A Scottish Parliament inquiry into the impact of health and social care integration on mental health services

More than a decade after the Public Bodies (Joint Working) (Scotland) Act 2014 was passed, and ten years after integration arrangements became operational, there has been no comprehensive assessment of their impact on mental health services.

The Scottish Parliament should undertake a cross-committee inquiry into the impact of health and social care integration on secondary care and specialist mental health services. Given the breadth of the issues identified, this inquiry would be relevant to the work of the: Health, Care and Sport Committee, Equalities, Human Rights and Civil Justice Committee, Finance and Public Administration Committee, Public Audit Committee, and Public Service Reform Committee.

Mental health services provide a practical test case for Scotland's public service reform ambitions. If reform is intended to reduce duplication, improve accountability and maximise the impact of public spending, then the highly fragmented governance arrangements currently surrounding mental health services warrant particular scrutiny.

A parliamentary inquiry would help establish whether the current system is delivering value for money, whether it is enabling resources to reach frontline services, and whether structural complexity is diverting funding and leadership capacity away from patient care. Any efficiencies identified should be reinvested directly into services, workforce capacity and improving outcomes for patients and families.

The inquiry should examine the following areas:

1. Intended outcomes and unintended consequences

The inquiry should examine whether the expected benefits of integration, with reference to mental health, have been realised and evidence for their benefit.

2. Accountability and governance

The inquiry should examine whether current arrangements provide clear accountability for the planning, delivery and performance of mental health services.

This should include:

- How responsibilities are divided between NHS Boards, IJBs and HSCPs.
- Whether current arrangements support effective oversight of mental health services.
- Gaps in accountability for service improvement, service failure and patient safety.
- The case for a national mental health accountability framework setting out clear responsibilities, governance expectations and escalation routes.

3. Financial transparency and investment

The inquiry should explore how mental health funding is allocated, monitored and reported throughout the system.

This should include:

- Whether mental health funding can be effectively tracked from Scottish Government allocation to frontline services and a consideration of ringfencing of funding.
- The transparency of spending decisions made by NHS Boards and IJBs.
- Whether existing arrangements achieve value for money and support improved outcomes.

4. Clinical leadership and decision-making

The inquiry should examine whether mental health expertise is sufficiently represented within integrated decision-making structures.

This should include:

- Representation of psychiatrists and other senior mental health clinicians within IJBs and HSCP leadership structures.
- The role of clinical leadership in service redesign and investment decisions.
- Links between clinical governance and integrated governance arrangements.
- Opportunities to strengthen clinical input into strategic decision-making.

5. Workforce, service planning and delivery

The inquiry should consider whether current structures support effective workforce planning and service delivery.

This should include:

- Workforce planning responsibilities across NHS Boards, IJBs and HSCPs.
- The impact of integration on adult mental health services.
- Governance arrangements for CAMHS and other services that sit largely outside of integration.
- The impact of current arrangements on service access, transitions, waiting times and patient outcomes.

6. Duplication, waste and system efficiency

The inquiry should assess whether current integration arrangements create unnecessary complexity, duplication or administrative burden.

This should include:

- Multiple commissioning arrangements within single board areas.
- Administrative and governance costs associated with integrated structures.
- Variation in local service models and pathways.
- Examples where fragmented planning has led to duplication, inefficiency or gaps in care.

7. The economic case for reform

The inquiry should consider the wider economic impact of mental ill-health and the benefits of investing in effective mental health services.

This should include:

- Whether current governance arrangements support efficient investment in mental health.
- Opportunities to redirect resources from duplication and administrative complexity into frontline services.
- The principles set out in the Prague Declaration on Mental Health, which recognises mental health investment as a driver of economic growth, productivity and long-term public sector savings.

Inquiry outcomes

The inquiry should make recommendations to the Scottish Government and integration partners on how to improve transparency, accountability, clinical leadership and value for money within mental health services. It should also consider whether the current model of integration remains fit for purpose for secondary care and specialist mental health services, and what reforms may be required to improve outcomes for patients across Scotland.

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