The Health, Social Care and Sport Committee is seeking views as part of its pre-budget scrutiny 2026-27. Its scrutiny this year is focused on the mental health budget

Scottish Recovery Network response to the Health, Social Care and Sport Committee's call for views makes it clear: mental health spending in Scotland is out of balance.

Scottish Recovery Network knows that by working together we can make Scotland a place where people expect mental health recovery and are supported at all stages of their recovery journey. Our work focuses on transforming Scotland's mental health system into one that embraces peer support and is powered by lived experience. This includes making sure people with lived experience lead in the design, delivery and evaluation of mental health support.

Our vision, mission, and work programme support and build on key recommendations from the Scottish Government and COSLA's Mental Health and Wellbeing Strategy, Creating Hope Together Suicide Prevention Strategy, Population Health Framework, and the recently published Health and Social Care Service Renewal Framework.

Cross cutting themes throughout these strategies recommend a significant shift in the way we do things to create a whole-system and cross sector collaborative approach. An approach that harnesses prevention and early intervention and the knowledge skills and experiences of people with lived experience, including peer support roles and lived experience leadership. A shift that sees mental health supports and services moving into communities and reducing institutional barriers with a focus on equality and tacking social determinants.

Question 1: Is the level of spending on mental health services appropriate?

No, the level of spending on mental health services is not appropriate, both in terms of the overall amount and the way it is distributed.

We believe that this pre-budget scrutiny (2026-2027), with a focus on mental health spending isn't asking the right questions. It should be less about the level of spend and more about where and what we are spending the money on. We have a mental health system that continues to not meet demand or need, in a time of acute financial pressures.

The Audit Scotland Adult Mental Health Report (2023) highlighted concerns that "increased mental health spending has not kept pace with rising demand," particularly for community-based services, and that integration with other sectors remains weak. It is time to do things differently.

Rebalancing the system

We know that to do things differently we need to rebalance Scotland's mental health system. We, and the many people, services and organisations we work with across communities, are concerned that mental health spend continues to focus primarily on NHS delivered services.

As with this call for views, the ongoing focus on NHS expenditure reinforces an unbalanced distribution of power, money and resources. It also creates a vacuum where many valuable supports, services, and under-represented communities are excluded from the national conversations/decisions about how we make Scotland's mental health system fit for purpose. Scotland has a much wider mental health system than the NHS, with supports and services provided across sectors, and in particular by the Third Sector.

The Scottish Government's direct investment in community based Third Sector mental health support, via the Communities Mental Health and Wellbeing Fund (CMHWF), has remained at £15 million annually since 2021 (with a supplement of 6 million in the 2021/2022 period due to strong demand). While we welcome this fund it represents less than 1.2% of NHS mental health spending in Scotland in all but one year, when it received the one-off boost. This is despite reaching thousands of people through localised, preventive, and early intervention support.

In fact in the current financial climate there is evidence that much of the progress made and the gaps in service provision being filled are under threat from cuts to community based and non-clinical services mostly delivered by Third Sector organisations. This is about a long overdue need for a change to the whole system. It is essential that there is a commitment to shifting resources and to addressing the fragile and short-term funding culture for Third Sector and community-based initiatives. This current culture makes many essential and successful services and supports unsustainable.

But it is not just about the money. Scotland's mental health system would feel more joined up and collaborative if different types of support were equally valued. We live with an out-of-date view across the general population that when facing mental health challenges there is only one gateway to support – directing people into the medical system for help via GPs and then secondary mental health services. This is reinforced by messaging and strategies that have an emphasis on mental illness and the medical model.

The Third Sector contributes significantly to Scotland's mental health landscape, through both small local organisations and national charities. However, funding is often fragmented, short-term, and difficult to quantify nationally, as it flows through multiple routes, including the Scottish Government, Health Boards, Integration Joint Boards, and Local Authorities. Sustainability of approaches that are often part of the solution to an overwhelmed

mental health system is challenging, often resulting in essential support being designed, developed and then lost.

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Through our work people share with us their experiences of mental health support that was there when needed and that worked with them to support their recovery. For example, the positive impact and outcomes of peer support comes up time and time again. Much of this is delivered by the Third Sector and is community-based. People want this valuable and much needed support given the recognition it deserves and the investment it needs to flourish in our communities and services. They emphasised that people do not always have to go through a medical route to get help and do not need to get trapped on waiting lists or in clinical pathways and services when other support may be more appropriate.

This disparity in investment and value remains deeply embedded. The system is caught in a self-perpetuating cycle of "more of the same," with limited space for innovation, transformation, or truly needs-led, whole-person support. As a result, the mental health needs of Scotland's population are not being met.

Question 2: What information can help support assessment and evaluation of the allocation of the mental health budget?

Due to an overly dominant medical model, current assessment and evaluation of the allocation of the mental health budget tends to favour tradition and business as usual rather than much needed innovation and reform. We are caught in a loop that is too focused on waiting times and targets when we should be concentrating on people's experiences and outcomes.

Currently it is all about gaining access to a system that is not working. Indeed many people tell us that access to support is

denied when they (eventually) get there. We sit in a culture of a lack of accountability around the true effectiveness of long-standing mental health supports and services. There is also a significant disparity in calls for evidence and impact between sectors. Out with NHS mental health services there is an ongoing demand on groups, organisations and services to report and evaluate on a regular, often annual or project by project basis. In contrast there is a culture of and dangerous assumption that many NHS mental health services should continue under minimal scrutiny and pre-set measurements created by that very same system.

We call for transparency and accountability of the impact and outcomes of different types of mental health support across sectors but challenge the current thinking on measurement approaches, research and evidence.

Rethinking design, delivery and evaluation of services and supports

Our current systems have a culture and embedded processes that see research and evidence-based practice through a dominant medical model lens. Measurement and evaluation needs to go beyond the confines of clinical outcomes and waiting list reductions. Acceptance of a wider range of research and a shift in what is recognised as evidence are needed to capture the real picture of what works and what doesn't work.

People with lived experience of mental health challenges should be at the heart of mental health service design, delivery and review. This includes peer support approaches and lived experience leadership roles. People with lived experience have a wealth of knowledge, skills and experiences and have a significant role to play in supporting their own recovery and that of others. This is not about tokenistic input with people as passive responders to a pre-set agenda but about people with lived experience being active participants in the planning, design, delivery and implementation of measurement and evaluation of services and supports.

There is often a call for more evidence of the benefits of peer support and peer worker roles with decision makers prioritising evidence from randomised controlled trials when assessing the effectiveness of peer support. However, it is noteworthy that similar effectiveness data is not required when seeking to introduce psychiatrists, mental health nurses or psychologists to the workforce. Rather we ask for evidence of the intervention of those professional groups, for example medications or psychological methods. Where well designed randomised controlled trials which focus on recovery specific outcomes are completed, they do show positive effects. For example the recent UPSIDES-RCT trial which tested peer support approaches in five countries found beneficial impacts on social inclusion, empowerment and hope among people with severe mental health conditions (Puschner et al, 2025).

There is a wealth of evidence around the positive impact of peer support for people's mental health recovery. As the World Health Organisation notes, peer support services promote hope, sharing of experiences, and empowerment and are essential for recovery and rights-based mental health systems. This aligns with international research demonstrating peer support is widely endorsed in recovery-oriented frameworks across policy and practice.

Peer support is designed and delivered by people with lived experience. This means that it can contribute to achieving the Mental Health and Wellbeing Strategy for Scotland (2023) outcome of better-informed support and services shaped by people with lived experience and the principle of 'people led' services in the Health and Social Care Services Renewal Framework (2025).

Acceptance of a wider range of research and lived experience evidence is vital if we are to better understand what helps mental health recovery. Narrative research, lived experience engagement and co-design, and peer working tests of change are just a few of many examples of in-depth and quality feedback and data that we should be harnessing to inform our decisions around the allocation of mental health spend.

Question 3: Do you consider there to be evidence of preventative spending activities in relation to mental health (and if so, can you provide examples)?

Yes, there is evidence of preventative spending activities for mental health in Scotland. Examples include:

- Community-based peer support and peer support services helping people earlier and reducing crisis demand
- Recovery colleges which improve self-management, reduce hospital use, and increase hope and confidence
- Peer-led Third Sector mental health and wellbeing programmes, offering open-access activities, group learning, and one-to-one support that prevent escalation to acute services

These supports and services consistently demonstrate positive outcomes, but progress and investment in prevention and early intervention approaches in Scotland remains limited.

There is a consensus that prevention and early intervention approaches are central to good mental health and wellbeing for all and also, as a result, reduce pressure on health and other services, yet progress in this area is slow. This, in part, is due to prevention and early intervention approaches often being, by their nature, non-clinical. They offer a different kind of support from that offered by traditional clinical services. A shift towards prevention and early intervention will require a significant shift in mindset to one where non-clinical approaches are equally valued.

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It's been fourteen years since the Christie Commission final report (2011). It gave a framework for reform of the future delivery of public services in Scotland: People, Partnership, Prevention and Performance. Despite prevention and early intervention being a

policy priority the radical shift that the Commission urged for has not happened and is not reflected in mental health service delivery. The Commission said:

It is estimated that as much as 40% of all spending on public services is accounted for by interventions that could have been avoided by prioritising a preventative approach.

We're encouraged that the Health and Social Care Service Renewal Framework (2025) sets out major areas for change to deliver on policy goals including those in the Mental Health and Wellbeing Strategy for Scotland (2023). These include a commitment to a prevention and early intervention approach and delivering care that is 'people-led and value based'.

We're not starting from scratch. We know that there are extremely good examples of preventative and early intervention approaches to mental health recovery that are happening across Scotland (some examples below). Unfortunately these tend to be insufficiently funded, commissioned on a declining basis and scrabbling for funding and recognition. The value placed on them is limited despite positive outcomes. Opportunities are being missed.

Peer support in Scotland

Peer support currently plays a significant but often under-recognised role in prevention and early intervention. Peer support in prevention and early intervention can be found in different settings including:

- Community-based peer support groups
- Peer-led recovery learning
- Peer support organisations and services
- Peer support integrated with clinical approaches

Peer support is an early intervention and prevention support mechanism that if funded appropriately could save £ms on

unnecessary escalation of support required from statutory bodies at higher and more acute levels.

The Big Scottish Peer Support Survey Report, 2025.

In 2024 Scottish Recovery Network commissioned The Big Scottish Peer Support Survey. The survey aim was to capture data on mental health and wellbeing peer support activity and the related workforce in Scotland.

The survey found that while a wide range of organisations manage and deliver peer support, over 80% of those delivering peer support are, or are affiliated to, constituted Third Sector organisations, most of which have charitable status. This means that peer support exists in a framework provided by Third Sector or charity governance. This differs from many other countries where peer support has developed in public mental health services as well as in the Third Sector.

The survey highlighted that two-thirds of peer support groups and services are open access meaning that people can access peer support when they need it. Peer support offers choice and is developed in an inclusive, flexible and adaptive way. Peer support is well placed and adaptable to meet the different needs of people from different communities of interest and experience. While most peer support groups and services have a focus on general mental health and wellbeing, a considerable number focus on particular population groups such as women, men, carers, people from minority ethnic groups or LGBTQIA+ groups or on experience such as a particular mental health conditions, addiction, bereavement, parenting, neurodiversity, survivor of abuse, particular physical health conditions and disability. In addition more than half of peer support groups and services take referrals from other services and organisations across sectors providing opportunities for those supported by other services to access peer support.

Wellbeing Works in Dundee offer one-to-one support as well as a range of groups, activities and volunteering opportunities for anyone seeking support with their mental health and wellbeing. Their activities have a clear focus on prevention and early intervention. They see themselves as part of people's recovery journey ensuring that they have the tools and strategies to maintain their wellbeing and the connections and structure to continue their journey. Their peer workers are an integral part of a wider team and play a key role in getting to know people, supporting them to explore their aspirations, plans and what may help them. They then work with people to put this into action through involvement in activities, learning and volunteering with Wellbeing Works and other local organisations. An evaluation of the impact of Wellbeing Works activities in 2023 found that:

- 95% said that they felt listened to and heard
- 86% of people reported increased confidence
- 63% felt more optimistic about the future and 98% said they had something to look forward to
- 95% had learned something new

I enjoy the groups and feel like my voice is heard and I am valued

Person engaging with Wellbeing Works, 2023

Recovery colleges

There is strong evidence for the benefits of recovery colleges (Perkins et al, 2018). They are popular with students participating and help people set and make progress towards recovery goals such as improving self-esteem and self-confidence. Students report feeling more hopeful and connected with others and having more sense of control and agency in their lives.

There is also clear evidence of improved self-management and reduced hospital and community service use among recovery college students. In addition to the benefits to students there are

also opportunities for mental health practitioners to learn alongside people with lived experience. The evidence is that this not only improves their own wellbeing but results in them being more positive about and more understanding of mental health recovery.

In Scotland there are a small number of recovery colleges – **North Ayrshire Wellbeing and Recovery College** (RAMH), **Mindspace Recovery College** in Perth, **Discovery College** (Centred) in Highland and the **Moray Wellbeing Hub Wellness College**. Recovery colleges support people's recovery from mental health challenges through learning and education that is co-produced and delivered by people with lived experience and people with professional experience. The recovery colleges in Scotland are community-based, open to all and run by Third Sector organisations. They offer a wide range of courses and group learning opportunities.

Recovery colleges are much more prevalent in other countries such as England, Northern Ireland, Republic of Ireland, Scandinavia, Canada, Australia, Japan, Hong Kong and are being developed in Wales. They emerged in the USA with the first being set up in Arizona in 2000. Recovery colleges arrived in England around 2010 and there are now over 70 recovery colleges across the country. In these countries investment in recovery colleges forms a core part of the development of more recovery focused mental health services. They sit alongside and provide something different from mainstream mental health services and provide a bridge to mainstream education. In England many NHS Trusts fund recovery colleges enabling them to reach into NHS services and also to play a key role in reaching out to people, groups and organisations in the community.

Mental health spend

The mental health spend on preventative activities is currently not working. In The Big Scottish Peer Support Survey most peer support groups and services reported that they had faced challenges in the past year – 2024. The challenges most often faced are related to

funding/fundraising and lack of understanding of peer support amongst decision makers. Many people also cited the challenge of meeting high demand for peer support on limited resource.

Policy plans and promises have not resulted in the mental health system transformation needed to embrace preventative and early intervention approaches truly and effectively. Change isn't easy but we are on the cusp of countless opportunities to really make ambitious changes to our mental health system. Changes that could address many of the inequalities in people's lives, resulting in better mental health across the country. Changes that could ensure everyone can access the support they need when they need it.

Question 4: Do you consider these to be the right priorities for mental health investment?

The Scottish Government has set out its priorities for mental health services in its Mental Health and Wellbeing Strategy. This strategy identifies the following priorities for investment:

- Child and Adolescent Mental Health Services (CAMHS) and psychological therapies
- Addressing waiting times backlogs
- An extension of support for distress
- Ongoing implementation of the Scottish Government's Suicide Prevention Strategy
- Delivering improved community-based mental health and wellbeing support for children, young people and adults

While nobody could disagree with any of these priorities, the question isn't about whether they are the right priorities or not but about how they are going to be achieved. The current approach of giving more money to existing services is not addressing back logs or extending support but instead resulting in community-based prevention and early intervention supports and services facing significant cuts which have serious implications for the rest of the mental health system.

Embedding mental health recovery into policy, service design and delivery means shifting our perspective. We need to move away from what we do currently (more of the same) to embracing lived experience leadership. This will allow us to better understand what supports recovery and make the transformational changes needed to make our mental health system fit for purpose. It will also help ensure that recovery, which is prone to misappropriation and abuse (Slade et al, 2014) remains true to its founding values (Owen, Watson & Repper, 2024).

Our recent **Growing Peer Support in Scotland** Community Roundtable discussions – 2025, highlighted the desire for the creation of a community-led mental health system focused on relational, human approaches to support and recovery. This radical vision is also one supported by government with the commitment to health and social care that is 'people-led and value-based'. Achieving this transformative vision requires new thinking, new perspectives and new solutions. It needs a much more significant role for lived experience leadership in designing and delivering the new future and for peer support to be an equally valued and integral part of our mental health system.

Question 5: To what extent are these priorities reflected in mental health service delivery?

Building on our response to question 4 there is a wealth of research that confirms that relationships are central to recovery and to the experience of mental health services (see for example, Davidson et al, 2005). Experiencing relationships with mental health workers who understand, respect and believe in you enables people to hold onto hope, believe in themselves and their own possibilities.

The current mental health workforce does not allow for the transformation and culture change needed in Scotland's mental health services and supports. This is another area where a dominant medical model means we find ourselves in a vacuum where more of

the same roles are invested in despite a call for more non-medicalised roles as well as those in clinical positions.

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The people in our networks tell us they welcome the development of new roles such as community links practitioners, community connectors and peer workers. These roles and recovery focused approaches support people to identify what works for them and connects them with the right help to suit their needs. However, they want more buy-in and investment in these newer non-medicalised roles and for them to be a much more important part of the mental health system. For this to happen there needs to be a much stronger focus on mental health recovery and the central role of the Third Sector and communities in mental health and wellbeing.

The adoption of peer working in Scotland, despite it being generally accepted as an indicator of a commitment to a recovery focused system, has lagged behind many other countries. These other countries (including England, Wales, Republic of Ireland, Netherlands, Denmark, Sweden, Norway, Finland, Canada, Australia, Aotearoa New Zealand and the USA) see developing a peer workforce as part of a coherent strategy of culture change to embed recovery and lived experience in the mental health system.

The Big Scottish Peer Support Survey tells us that around 60% of peer support groups and services work with unpaid peer workers. The dominance of unpaid peer workers differs from all other roles in mental health services and supports. It also differs from the balance of paid and unpaid workers in other countries such as England, Republic of Ireland and Australia where there has been investment in lived experience leadership and a peer workforce in mental health services.

Peer support can play a significant role in ensuring that clinical services provide whole person focused, trauma informed, relational support. There are peer workers in NHS Community Mental Health Teams, other cross sector mental health teams, in Primary Care and in-patient services. This is relatively underdeveloped in Scotland and much more prevalent in other countries. There is clear evidence that peer workers in clinical services not only greatly contribute to recovery outcomes such as increased self-esteem, hope for the future and empowerment but can also play a role in changing attitudes, practice and cultures (Cooper et al, 2024).

South Angus Peer Support Service

Peer workers can play a key role in Primary Care. The **South Angus Peer Support Service** (Penumbra) enables people of all ages to access mental health peer support through their GP practice or secondary school. It provides one-to-one support and self-management focused group programmes for adults and for young people aged 11 to 16 years. This service, which started in 2018, is provided by Penumbra and funded by Angus Health and Social Care Partnership and works alongside a similar peer support service provided by Hillcrest Futures in North Angus. Since 2018 over 12,500 referral (and growing) have been received with people being contacted within three days of a referral and seen within 14 days.

Peer workers work collaboratively with practice staff as part of a multi-disciplinary team ensuring that people get appropriate mental health support more quickly. There is evidence that this is preventing crisis and reducing referrals to secondary mental health services. The service is open to everyone experiencing mental health challenges and is not dependent on diagnosis. The focus is on providing space for the person to explore what's going on for them and find their own solutions.

Question 6: How could transparency in relation to decisions around mental health spending in Scotland be improved?

It's about more than transparency, it's about who holds the power in shaping mental health services and how that power is shared. We must go beyond simply "consulting" people with lived experience. It's time to embed lived experience leadership at all levels of Scotland's mental health system, not as a token gesture, but as a core component of governance, strategy, and funding decisions across all sectors.

This means creating senior roles for people with lived experience with decision-making parity, for example, at Director level, within Scottish Government, service governance structures and mental health ombudsman. Other countries are already demonstrating what's possible. Scotland now has an opportunity to lead, not lag, in building a mental health system that's people-led, equitable, and truly transformative.

In conclusion

Mental health spending in Scotland is unbalanced, overly focused on clinical NHS services, and must be urgently restructured to support whole-system, community-based, and peer-led approaches that promote prevention, early intervention, and recovery. The NHS should not be the sole focus or gateway for mental health support. As a country we need to rebalance spending across the whole mental health system and shift the focus from 'how much' to 'where' and 'what' we spend on.

Central to this transformation is investment in, and partnership working with the Third Sector. Recognising and sustaining community-based innovation and harnessing the positive impacts of peer support roles and peer-led activities like recovery colleges. This innovation needs to be scaled up, not side lined.

It's time for transformation of Scotland's mental health system. The current system is failing to meet demand and is stuck in a cycle of

"more of the same". It's about systematic change, not just service tinkering. This transformation requires valuing all forms of support, especially those outside traditional medical routes and embracing the knowledge and skills that lived experience leadership brings not only to service design, delivery and evaluation but decisions around mental health spending.

Reshaping the mental health system in this way would open up access, help to reduce waiting lists, provide solutions to an overwhelmed system and workforce and result in better, more person-centred support. But this can only be achieved if we rebalance resources, value and power across sectors.

Thank you for the opportunity to feed into this Pre-budget scrutiny of mental health spending. We would be happy to chat further about this response and it's key points and we look forward to working together to make mental health recovery real for everyone in Scotland.

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