Royal College of Psychiatrists in Scotland - response to draft mental health and wellbeing delivery plan

We welcome the opportunity to comment on the draft Mental Health and Wellbeing Delivery Plan. We support the ambition to improve mental health and wellbeing across Scotland and welcome the strong focus on prevention, early intervention and system reform. However, we have several overarching concerns that we believe require further consideration if the plan is to meet the needs of the whole population, including those with severe mental illness.

1. Clarification of 'business as usual' and omitted work

The draft plan states that foundational work now considered "business as usual" or covered elsewhere has been omitted. However, it is unclear what criteria have been used to determine this. We would welcome clarification on the status of a number of significant pieces of work which are not referenced thoroughly, including:

- Psychiatry Recruitment and Retention Working Group recommendations
- Scott Review
- Barron Review
- Adults with Incapacity reform programme (and original timeframe)
- Other workforce and service redesign programmes previously led by the Scottish Government

It would be helpful to understand whether these programmes remain active priorities, how they will be implemented and where progress against them will be reported.

2. Insufficient focus on severe mental illness

While the focus on prevention and wellbeing is welcome, the plan appears heavily weighted towards wellbeing, population mental health and early intervention, with comparatively little focus on people living with severe mental illness (SMI).

There is limited recognition of:

- Severe and enduring mental illness
- Long-term specialist care needs
- Acute mental illness
- Inpatient care pressures and pathways out of hospital
- Rehabilitation and recovery pathways
- Physical health inequalities experienced by people with SMI
- The mortality gap experienced by people with mental illness

We encourage the Scottish Government to strengthen the plan's focus on improving outcomes for people requiring specialist mental health care and treatment, and to include a specific

commitment to reducing the mortality gap and physical health inequalities experienced by people with severe mental illness.

3. Workforce concerns

We are extremely concerned by the lack of any specific actions to address the very serious workforce challenges within mental health services. Ensuring a well-resourced workforce is critical to the delivery of almost every other commitment in the plan.

The workforce actions focus principally on workforce data collection and training. However, there is little recognition of the significant workforce challenges currently facing mental health services.

Scotland is facing a psychiatric workforce crisis. The workforce is not growing sufficiently to keep pace with the well-documented rising scale of demand for services. As such, our workforce is overwhelmed and stretched to its absolute limit. Clinicians are increasingly finding themselves having to work in untenable conditions. As a result of this, we are experiencing a critical loss of our substantive (permanent) psychiatric workforce, jeopardising the ability of our services to provide safe care and treatment to patients. There is a major shortfall in psychiatrists able to fill roles in Scotland, and vacancy rates for consultant psychiatry roles are as high as 46% in some parts of the country. These workforce gaps have led to the widespread recruitment of locum psychiatrists as a temporary solution. An average of 1 in 4 consultant psychiatry positions are estimated to be vacant or filled by a locum across Scotland.

We are concerned by the absence of:

- Commitments to address vacancies and workforce shortages
- Actions relating to psychiatrist recruitment and retention
- Implementation of recommendations from the psychiatric workforce reviews already undertaken by the Scottish Government
- Recognition of challenges retaining experienced clinicians and multidisciplinary staff

The Scottish psychiatric workforce needs have already been mapped and modelled. The priority should now be implementation of the recommendations arising from that work. We recommend that the delivery plan includes explicit commitments to workforce sustainability, recruitment and retention across the mental health workforce and specific to psychiatry.

4. Service transformation and community care

We support the development of a national service blueprint and improved outcome measures. However, we would encourage the Scottish Government to ensure that indicators represent the full range of mental health need, from wellbeing through to complex mental disorders.

We also have serious concerns with regards to the repeated references to shifting more care into the community.

Mental health services have been at the forefront of shifting the balance of care into community settings for decades. The overwhelming majority of psychiatric care is already delivered in the

community. For example, less than 1% of the psychiatric care for working age adults is provided within inpatient settings, with over 99% of the care provided entirely in the community. In NHS Greater Glasgow and Clyde, Scotlands largest health board area, there are a mere 285 adult acute psychiatric admission beds for a population of 1.3 million people - with over 35,000 patients cared for in the community at any given time. This is against a background of historic underinvestment in community mental health services, especially core services such as Community Mental health teams and in the context of proposed cuts to these very same community services in various parts of the country.

The challenge facing services is therefore not one of further shifting care into the community, but of sustaining community provision in the face of workforce shortages and financial pressures whilst ensuring sufficient inpatient capacity remains available. There is an urgent need to invest in community services to sustain the gains of the past two decades in shifting the balance of care into the community, but this cannot be at the cost of cutting already overwhelmed inpatient services.

We would welcome recognition that:

- Community mental health services require sustained investment
- Inpatient and community services are complementary
- Investment in one should not come at the expense of the other
- Current bed pressures and inpatient capacity challenges require attention

We would also welcome acknowledgement of the fragmentation of mental health service delivery and accountability that has emerged through current integration arrangements and recognition of the important role of HSCPs within service transformation plans.

The aim of integration was to join up services and improve patient care by shifting resourcing to community-based and preventative care. However, this has not been the case for mental health, which has been disproportionately negatively affected by integration.

Mental health sits in the fault line between the NHS and local authorities, and so integration has actually resulted in fragmentation for mental health services. Integration may have brought these areas together in theory, but in practice, clinical authority remained with NHS Boards, funding decisions shifted to Integration Joint Boards (IJBs) and operational delivery became fragmented across Health and Social Care Partnerships (HSCPs). While adult mental health services were among the most fully delegated into integration arrangements, this has resulted in fragmentation rather than coherence - with split responsibilities, blurred accountability, and decision making dispersed across multiple organisations. At the same time, child and adolescent and forensic mental health services largely sit outside of integration, creating further complexity - particularly at transition points and around prevention and early intervention.

The result is a system where strategy, finance and delivery are often held in different places, influence depends on understanding local governance, not just national policy, and the same

issue (for example, workforce or service access) can sit with different bodies depending on age group or care setting.

This has resulted in fragmentation rather than coherence, with responsibility split across different bodies depending on age, service type and setting. Mental health is therefore governed by more moving parts than almost any other areas of health. Mental health service delivery was already cross-cutting, and integration has multiplied the number of bodies with partial control rather than simplifying it. Additionally, budgets were integrated, but risk was not. IJBs hold delegated budgets and set priorities, but clinical risk and statutory duties remain with NHS Boards and financial pressure sits with IJBs, which have fewer levers to manage demand. Additionally, because clinical governance for mental health sits with NHS Board, but delivery sits with HSCP, this is leading to a mismatch with clinical governance and corporate governance being held separately - resulting in poor productivity and weak governance overall.

Decision-making affecting mental health services has been systematically de-clinicalised, at the same time as risk and responsibility have remained firmly clinical. That mismatch has mattered enormously for our members. Integration separated authority from our members' expertise.

The major issues with integration must be addressed in order to deliver the aims of this plan.

5. Community mental health hubs

We welcome proposals to expand access through community-based mental health hubs and walk-in services. However:

- Effectiveness of new models should be subject to robust independent evaluation
- Outcome measures must be clearly defined from the outset
- Models should be adaptable to rural and remote communities
- Investment in these hubs should be additional to, not instead of, funding for existing specialist secondary care mental health services within the NHS

There is a risk that these developments are viewed as substitutes for core NHS mental health services when they serve different populations and levels of need. Both models of care are valuable and complement each other, serving the needs of people with very different levels of complexity, risk and mental health need. The reality on the ground is that IJB's are addressing deficits in budgets with planned cuts to core community mental health service provision and it is important that investment in other forms of community supports are not viewed as an alternative to this.

6. Crisis and acute mental health care

We welcome investment into crisis services. However, the crisis section of the delivery plan focuses heavily on children and young people, NHS24 and triage cars. It does not sufficiently address wider adult crisis care or acute mental illness.

We encourage consideration of:

- Consistent specialist mental health crisis services across Scotland
- Mental health provision within Emergency Departments
- Liaison psychiatry services
- The interface with Police Scotland
- The distinction between acute psychiatric illness and broader mental distress
- Improved access to urgent specialist assessment

We are not convinced that expansion of NHS24 psychological therapies alone will significantly reduce pressure on Emergency Departments. Many individuals presenting to A&E require specialist assessment, physical assessment and intervention that cannot be replaced by remote advice or psychological support. We would instead welcome actions which ensure that people in emergency departments can access mental health care when they present. A broader action on unscheduled mental health care feels absent from the delivery plan.

We would also highlight that provision of robust and sustainable specialist mental health services, anticipatory care planning and assertive outreach services play an essential role in preventing avoidable crisis presentations.

7. Prevention

Given the strong emphasis placed on prevention throughout the delivery plan, the proposed actions appear relatively narrow in scope.

We would encourage stronger recognition of:

- Prevention of severe mental illness through early intervention
- Physical health prevention for people with mental illness
- Alcohol-related and drug-related harms
- Commercial determinants of health
- Improving access to primary care and physical healthcare for people with severe mental illness

Prevention should encompass both population wellbeing approaches and targeted prevention aimed at reducing the long-term impacts of severe mental illness. Whilst we are pleased to see a commitment in the SNP first 100 days of Government document to treat mental health on par with physical health, this must be tied to actionable items.

People with severe mental illness (SMI) living in Scotland have a life expectancy 15-20 years less than the general population. This gap is even wider for those with learning disabilities (LD). 2 in 3 of these deaths are from preventable causes - by conditions such as cancer, respiratory, cardiovascular and liver disease. 5% of deaths from SMI are from suicide - whilst 95% are due to other causes. People with SMI and LD experience significant, persistent and unique barriers to accessing healthcare. General strategies to improve public healthcare access often fail to reach people with SMI and LD - and can even widen inequalities. Tailored approaches are therefore

essential. The mortality gap continues to widen - despite the fact that overall life expectancy in Scotland has increased over the past 20 years. We are calling for the delivery of a fully funded national strategy to cut the mortality gap at least in half by 2050 for people in Scotland with severe mental illness and learning disabilities.

We want to see:

- A commitment to ensure that access and treatment targets apply equally to mental and physical healthcare.
- To improve health outcomes for individuals with SMI and LD, establish comprehensive data collection processes linked to a targeted outreach programme that facilitates regular physical health checks and timely treatment.
- A national audit of Primary Care and other healthcare provision for people with SMI and LD to ensure that we are reaching those most in need of support.
- Annual reporting of mortality differences to measure progress against the target

We would also like to see the delivery plan acknowledge that prevention and early intervention in the case of severe mental illness can be very different from prevention in population-wide mental health. In the case of SMI prevention can, for example, take the form of preventing recurrent psychosis episodes.

Prevention must also be discussed and addressed throughout the whole life course, and is not relevant only to younger people.

8. Neurodevelopmental support

We welcome the commitment to adopt the College's four-tier neurodevelopmental model. However, most proposed actions and funding commitments in the delivery plan seem to focus predominantly on children and young people.

We recommend:

- Greater focus on adult neurodevelopmental services
- Clear funding commitments for adult provision
- Clarification on pathways for individuals diagnosed privately
- Appropriate regulation, standards and governance of private providers
- Investment to ensure equitable access across Scotland

Without appropriate investment in adult neurodevelopmental services and pathways, significant unmet need will remain. The proposed actions do not adequately recognise the scale of unmet need among adults in Scotland, and the impact that this has on the individuals concerned and on society as a whole.

9. Justice and forensic pathways

We welcome the intention to improve mental health support across justice pathways and forensic services. However, there is insufficient clarity regarding the future governance model

for forensic services and implementation of the recommendations arising from the Barron Review and subsequent forensic governance work.

We would welcome:

- Clarification on the intended governance arrangements
- Assurance that resource implications have been fully considered
- Meaningful engagement with psychiatrists and forensic clinicians
- Recognition of the importance of balancing least restrictive practice with effective risk management and proactive treatment

Given increasing concerns regarding interfaces between mental health services, courts, custody settings and policing, psychiatrists should be actively involved in these discussions and future planning.

10. Outcomes, targets and parity of esteem

Finally, we welcome the intention to develop improved outcome measures. We would encourage Scottish Government to include:

- Clear interim mental health standards and targets while longer-term measures are developed
- Explicit reference to the actions associated with a commitment to parity of esteem between mental and physical health
- Reduction of the mortality gap as a key outcome
- Recognition and addressing of the increased stigma towards people living with severe mental illness
- Workforce capacity, sufficiency, and optimisation as a necessary outcome, not simply workforce sustainability

The current outcomes and priorities would be strengthened by a clearer focus on severe mental illness, physical health inequalities and parity of esteem.

11. AWIA reform

The date given for the delivery of the first AWIA reform Bill at the Minister-led group was Autumn 2027 at the last meeting. It would be very disappointing for the date to slip to the 2029 date suggested here.

Summary

In summary, we welcome the ambition of the delivery plan and support its focus on prevention and system improvement. However, we believe the document requires a stronger focus on severe mental illness, workforce sustainability, acute and crisis care, physical health inequalities, the SMI mortality gap, and delivery of previous commitments and reviews. We would also welcome greater clarity around funding, accountability, outcomes and

implementation. We are committed to working alongside the Scottish Government to deliver this.

About us

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 Government and other agencies, aiming to improve the outcomes of people with mental illness, and the mental health of individuals, their families, and communities.

We are a devolved nation and council of the Royal College of Psychiatrists. We have over 1,500 Members, Fellows, Affiliates and Pre-Membership Trainees in Scotland.

Contact

For further information, contact:

Jane Gordon, Policy and Public Affairs Manager
jane.gordon@rcpsych.ac.uk