RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

Consultation of RCPsychiS Members – Views on Mental Health and Wellbeing Strategy first draft

Submission date: Friday 3 February

6. Please reflect any comments you have on the 'Introduction / Context' section below.

The College believes that the introduction would benefit from an outline of what has already been delivered in Scotland and lessons learnt from the most recent and previous mental health strategies.

The strategy should give greater recognition to the interconnectedness of mental and physical health from the outset, as we are concerned the significance of this is not outlined clearly in this new strategy. The mental health needs of those with physical illnesses should be specifically acknowledged, as well as the physical health needs of those with mental illness.

'Increasingly' should be removed from section 2.5.

Clarification on what is meant by a human-rights based system would be helpful. Furthermore, whilst we are pleased to see a definitions section later in the strategy, it would be beneficial to move this to the beginning of the document to help in setting the context and encourage consistent usage of terminology throughout.

Finally, detail on the profile of respondents to the initial consultation, for example, which organisations are represented and how many people they represent, would provide a better overview of engagement to date.

7. Please reflect any comments you have on the 'Vision' Section below.

The College believes that the strategy's vision should include reference to treatment delivery. This is an essential aspect of whole system working.

Treatment includes effective, evidence-based medical treatment, as well as psychological interventions and supportive care.

Under the Provide pillar, it is striking that, again, there is no mention of treatment. If the strategy is to be truly evidence driven, as outlined in the guiding principles, it is important that it recognises the existing evidence base on effective, evidence-based treatments for those with more severe mental disorders. We would therefore like to see explicit mention of treatment in this section alongside support and care.

8. Please reflect any comments you have on the 'Guiding Principles' section below.

It is the College's view that the guiding principles of the strategy should reiterate the importance of striving for parity of esteem between mental health and physical health, both equally valued and respected. This parity of esteem should come with greater parity in terms of funding for mental health services, comparable to funding for physical health services.

We also believe that the guiding principles should be evidence based and informed by guidelines such as SIGN and HIS recommendations, with consideration given to the other workstreams and strategies affecting mental health and wellbeing, as elaborated on in our response to question 20.

9. Please reflect any comments you have on the 'Outcomes - The Differences This Strategy Will Make' section below.

Whilst improved population wellbeing is an important aspiration, its pursuit should be independently resourced and not confused with the core funding of effective evidence-based medical and psychological treatment for mental illness. According to the latest Scottish Health Survey publication, possible psychiatric disorders are experienced by at least 22% of the Scottish population. Attempting to address both cross-governmental responsibilities and actions for population wellbeing, and mental health and illness within the same strategy risks diluting the ability to effect real change in either.

Relatedly, adverse childhood experiences (ACEs) play an important role in the mental health of people living in Scotland. Tackling the root causes of ACEs is an essential national aspiration. It is a matter of public wellbeing which cannot be funded from within the core mental health budget alone.

We believe that there should be a greater focus on how the success of the strategy will be measured. The outcomes are high-level, aspirational and

hard to disagree with, however, without being able to consider the route to implementing these outcomes, and what practical and realistic actions will take place to deliver such aspirations, it is difficult to feel confident in signing off on such outcomes. The current overstretched psychiatric workforce is struggling to meet the existing high demand on services, and an analysis of the workforce needed to deliver the actions and how this will be created, will be essential. At present, the workforce does not have space to provide baseline or outcome measures. Currently, participating in consultations is challenging for clinicians.

In summary, in order to fully support the outcomes, we would require more detail than is currently available within the draft strategy.

10. Please reflect any comments you have on the 'Mental Health in Scotland - Setting The Context' section below.

The College believes that the diagram used in section 6.11 should be amended. Later life mental health care should not flow into pre conception care. Rather, one strand of adult mental health could flow into pre-conception care and family mental health. Meanwhile, there should be consideration of how people in later life in Scotland live well with with multiple long term conditions, adding life to years. Dying well should also be a consideration for this group.

11. Please reflect any comments you have on the 'Data & Evidence - Known Causes and Challenges' section below.

The College would recommend that the fourth bullet point of section 7.16 reads that 'the pandemic exposed and exacerbated' rather than 'exasperated.'

It is the College's view that the strategy must explicitly acknowledge the current gaps in the workforce and challenges around workforce capacity. This is the single, most important factor impacting on services' ability to deliver high quality, person-centred, integrated care and treatment. While there is reference in section 7.17 to the wellbeing of the workforce, it does not adequately address the sheer scale of the shortfall in skilled specialist workforce. Nor does it consider the range of factors contributing to this.

The barriers and challenges throughout the mental health and wellbeing system, in section 7.18, require further elaboration. This is followed by just one example about stigma impacting on recruitment. However, there are far more important challenges associated with recruitment and retention

that are not addressed or referenced. It is also not clear what barriers are being referred to here.

The College would recommend more of an emphasis on the collection of good quality data in the strategy, as was outlined in the initial consultation. The responses to the consultation highlighted the need for investment in robust data gathering and IT infrastructure, and for the Scottish Government to take the lead in improving data reporting.

12. Please reflect any comments you have on the 'How We Will Achieve Our Outcomes - Promote, Prevent, Provide' section below.

The College believe that section 8.5 should reference the importance of evidence-based treatments.

This section should also give greater acknowledgement to the role of primary care services, including the volume of people with mental illness and poor mental health who receive support, care and treatment in primary care mental health teams. Evidence suggests that the proportion of mental health consultations with GPs has significantly increased since the pandemic from 30% to 50%. Workforce considerations in primary care (GP and MDTs) also need to be urgently addressed.

13. Please reflect any comments you have on the 'Making It Happen - What Do We Want To See?' section below.

We believe that there should be greater appreciation of the “tiers” of support, from mental wellbeing and community support services to primary care, to secondary care, to tertiary care and even more specialist services. The ability for people to move through tiers easily and to receive treatment, support and care from different tiers at the same time should be a key aim of the strategy.

For example, a person with a diagnosis of schizophrenia may need specialist medical treatment as well as wellbeing support, concurrently.

14. Please reflect any comments you have on the 'Transforming Our Approach To Mental health And Wellbeing - What Does A Better Future Look Like?' section below.

It is the College’s belief that this section should be more ambitious. All tiers of mental health input and service need to attract a balance of resource that will allow them to accept referrals from other tiers and confidently refer to more intensive and specialist services when required. Without

such balance, community services become unable to provide their expertise to those who could benefit, as they struggle to manage disorders beyond their level of training.

We believe that the Provide pillar should reference the importance of primary care services, including our GP colleagues and the wider primary care multidisciplinary teams. There is currently a real gap in reference to primary care more broadly across the strategy and a lack of recognition of the very important role and responsibilities played by primary care in the provision of mental health care and treatment. This is particularly striking in section 10.10, for both children, young people and adults. This is also at odds with the government's own stated intention of improving the provision of mental health care and treatment in primary care. It is essential that gaps throughout the current system are addressed to ensure people receive support, care and treatment in the right place, at the right time, and from the right team. This should be a central focus of early intervention and prevention.

The College recommends that the Provide pillar should make the case for improved access to health checks for those with severe and potentially enduring mental or episodically recurring illnesses, not just those with a learning disability.

Section 10.24 should reference those with severe mental illnesses.

The strategy does not feature adequate reference to the needs of people with neurodevelopmental disorders and where those needs will be met. We recommend that this is included within the Provide pillar.

15. Please reflect any comments you have on the 'Workforce' section below.

The College believes that the strategy should focus, particularly, on explicit strategies for staff retention. Staffing is a crucial issue for our members, who are currently under severe pressure as a result of the ever-increasing demand for mental health services. It is our belief that we need to become far less reliant on agency locums, so that patients can be confident their consultant is fully trained and provides continuity, as well as providing the wider role of the consultant psychiatrist, including teaching and training, leadership, governance, research, quality improvement and service design.

The strategy must focus on both retention and recruitment, as neglect of the former will mean that mental health services continue to lose experienced staff members. We have a crisis in Scotland now, and so whilst a concerted effort to improve recruitment is necessary, it alone will

not help in the short to medium term, due to the amount of time it takes to train a psychiatrist.

The College would appreciate a further breakdown of the workforce statistics provided in the strategy, any workforce data should specify whole time equivalent (WTE), as a head count gives a false picture, as well as indicating where posts are staffed by locums.

16. Please reflect any comments you have on the 'Definitions' section below.

The College would recommend that section 12.2 begins with 'good mental health,' rather than 'mental health.'

The use of terminology should be more consistent in the new strategy. As mentioned in our response to question 6, the definitions section towards the end of the document should be moved to the introduction, and terminology used in the body of the document should be more consistent. Currently, mental health, mental ill health, mental illness and wellbeing appear to be used interchangeably. They are not interchangeable.

More consideration is needed for what we mean by mental health, mental illness and mental wellbeing. The College recommends, for consistency, aligning any definitions with the standards of WHO and ICD 11.

17. Please reflect any comments you have on the 'Mental Health Legislation' section below.

As a College, we have actively participated in the Scott Review process and welcome the opportunity to engage with the developing reform programme. Again, it will be essential to fully understand the workforce implications of new developments in order for them to be implementable and their ambitions realised.

18. Please reflect any comments you have on the 'Improving Data and Evidence' section below.

The College believes that Scotland needs to have better nationally collected data, across primary and secondary care services, as well as data relating to public mental health. This data, and the associated workforce and expertise, should be used to inform service reform and delivery.

19. Please reflect any comments on the 'Interdependent Strategies and Policy Drivers' section below.

The College acknowledges the effort made to recognise the multitude of parallel workstreams, strategies and legislative developments currently taking place. However, it is critical to fully understand how all of these interdependent pieces will dovetail in order for each, and for the collective sum, to be successful. This should be a key priority.

We would strongly support the maintenance of adequate funding for the ongoing development and provision of primary care mental health services.

20. Please reflect any additional feedback or comments below.

The College would encourage the release of more accompanying detail on how the aims of the new strategy will be implemented, and how their success will be measured. The Minister for Mental Wellbeing and Social Care has said publicly that this detail will feature in an accompanying Delivery Plan. We would welcome the opportunity to feed our members' views into the design of this Delivery Plan, which should take place alongside the development of the strategy in order to demonstrate a clear path to delivering the proposed outcomes, rather than after the outcomes have been finalised. A timeframe for the strategy itself and accompanying delivery plans and other documents, as well as for the engagement process, would be valuable.

Our members are concerned that the strategy has not been fully costed. We are also concerned that funding for different aspects of mental health and mental wellbeing delivery has not been ringfenced. Furthermore, we would like to understand the strategy's costings for training and other governance arrangements for those in the third sector, including those who offer their services on a voluntary basis.

We also support Scotland's Mental Health Partnership's call for longer-term funding arrangements to support a more sustainable mental health system. There is often enormous pressure to deliver a particular service within budget, showing 'good' results/outcomes, for that part of the service, within the financial year, with no guarantee of repeat funding. There needs to be investment that takes a long view – spending more now to reap benefits later, with better outcomes for patients as well as a cost effective use of resource. An example of this is offering the evidence-based mentalisation-based treatment for people with severe personality disorders, which can take eighteen months of treatment, providing two and a half hours of treatment a week. The benefits for people are long

lasting and include improved quality of life, reduced medication, as well as reduced visits to ED and admissions to hospital.

We fully endorse the co-production of service design with people with lived experience of services, whether as patients, as carers, or as clinicians, all working collaboratively. There are often barriers which make it difficult for some lived experience groups to engage and additional steps must be taken to ensure their views are fully represented.

We support the three pillars featured in the strategy (Promote, Prevent and Provide) and appreciate that these are featured extensively, following engagement with Scotland’s Mental Health Partnership.

The importance of coordination between services should be stressed and considered in greater detail, particularly between services for physical illness and services for mental illness. Our members are concerned that the development of a National Care Service has the potential to create barriers between mental and physical health services. Current proposals also have the potential to create barriers between other mental health services and forensic mental health services.

21. Please provide any views you have on using MS Forms as a platform for gathering feedback from stakeholders.