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Speech for Greater Glasgow and Clyde Health Board Psychiatrists Annual Learning Event ‘Member’s update’ on Thursday 17th May 2018 Emirate’s Arena, Glasgow.

Many thanks for inviting me to speak to you today to share some thoughts about the current state of Psychiatry in Scotland. It is a year since starting as Chair of the Royal College– the journey has been steep in places but also very rewarding.

In April the Scottish Government mental health team welcomed members of the World Health Organisation who are preparing for the publication of a new edition of the International Classification of Disease\(^1\) relating to mental disorder.

There was considerable interest in what we are doing in Scotland and I was reminded what unique opportunities we have to be world leaders in mental health.

It was, in particular, a comment from one of our third sector partners which stood out – did the World Health Organisation involve those with lived experience in their work? They had not. Sometimes we forget or take for granted some of our greatest assets. One of those assets is partnership working between those with lived experience and those with practitioner experience, those who work everyday as clinicians. It would be unnatural for us to consider any mental health policy initiative without such a partnership approach – it is one of our greatest strengths. Organisations of those with lived experience cannot be dismissed for not taking into account practitioner views. Those of us who represent practitioners cannot be dismissed for not taking into account lived experience of those who use our services and carers.

We have a Mental Health Strategy which took into account both lived experience, as well as practitioner experience. That ongoing engagement with the Scottish Government gives the Strategy authority. The challenge is to translate the vision of the strategy into reality. The vision that people will know from Unst to Cairnryan that we have a service supporting mental health which is second to none. The vision that the same passion and drive we see in preventing and treating physical ill health is present in preventing and treating mental ill health: the right
prevention; the right treatment, at the right time, by the right professional, in the right location. Treatment and service structures informed by world-class research.

Does the number of people seeking mental health support mean we are more mentally unwell as a people? I like to think it is because we are tackling that reservoir of unmet need research tells us is present - that we, as a nation, are more comfortable talking about our mental health and asking for help. We are tackling stigma through ‘See Me’ and other campaigns. Jim Crabb, the Chair of the Faculty of General Adult Psychiatry in Scotland, has challenged us to rebrand the profession\(^2\). We must take advantage of celebrity and Royal family support for mental health. We are changing the way, as a society, we think of mental health and wellbeing and that is a good thing.

Some of that transformation is at Government level. I expect our minister and the government mental health team are constantly reminding other colleagues across government to take into account mental wellbeing. As we all know our current culture of sanctions and benefits is not good for mental health and I am hopeful we may be moving towards a more supportive system in Scotland.

Every one of us has a challenge to support those Scottish residents unnerved by Brexit and unsure of their status – somehow, I don’t think mental wellbeing was high on the list of objectives when those in the Home Office considered a ‘hostile environment’ policy.

But what can be changed at that Governmental level? Perhaps when planning decisions are considered, as well as an environmental impact assessment, we should have a mental wellbeing assessment. We should foster a culture of promoting mental wellbeing in our schools, in our colleges and Universities, in our communities, in green spaces, in our transport infrastructure and in our workplaces.

Mental wellbeing at work will become ever more vital as those in their twenties, thirties and forties prepare for retirement in their late 60s. We will need to be smarter at achieving harmony in the work/life balance.

Psychiatry, along with all the other mental health practitioner groups, face a challenge in providing sufficient staff to match the demands. Despite the demands, the number of psychiatrists remains almost the same - whilst many medical specialties have increased their numbers in Scotland, over the last 5 years we have not seen such increases in the number of
Consultant Psychiatrists\(^3\). We have made considerable advances in Psychiatry recruitment and the most recent fill rate of trainee posts, I think, reflects the success of the Royal College of Psychiatry’s Choose Psychiatry initiative. Scotland has benefited but we would like to do more; it would be great if Scottish Government would match the recruitment funding elsewhere in the UK. I would like every medical student in Scotland to receive a pack of information promoting the opportunities a career in psychiatry in Scotland has to offer. It was a great pleasure to speak to the psychiatry winter school here in Glasgow in January and I bet many of you who participated never expected to be career speed dating with medical students in the snow.

As Elaine Lockhart, our Chair of Faculty reminds us, there is no more compelling area than the provision of Child and Adolescent Mental Health Services but we will need the right mental health workers available. Recent data shows a small, but welcome increase in the number of Child and

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\(^3\) In December 2017, there were 1,126.5 whole-time equivalent (WTE) psychiatrists across all grades, 2.5% less than the same point of 2016. Meanwhile, the number of consultant psychiatrists has now fallen for five consecutive quarters and stood at 529.4 WTE in December 2017. There has been a 3.6% decline since December 2016.

Information Services Division, \textit{NHS Scotland Workforce Information – Medical trend}, 6 March 2018
Adolescent psychiatrists\(^4\) but those due to potentially retire in the next 5 years is a particular concern\(^5\).

As well as a recruitment strategy we need a retention strategy for psychiatrists. It was part of an earlier recruitment strategy that many mental health workers who commenced work before 1995 can retire at 55\(^6\). Right now, we must convince those who can take that early retirement to return part-time. If we get it right retaining those colleagues, then we will get it right when devising ways of retaining the younger workforce when they reach their late 50s and 60s.

One of our strengths is that an idea, such as the retention of those with MHO status, can be communicated to our colleagues in Government in a straightforward way. One of our challenges as a College is engagement with Health Boards and Integrated Joint Boards. I recently wrote to all mainland Health Board Chief Executives, Human Resource leads and IJB mental health leads on the topic of psychiatric workforce retention. So far I have only

\(^4\) Child and Adolescent Psychiatry has seen a 5.9% increase in the number of consultant psychiatrists between December 2016 and December 2017. Information Services Division, \textit{NHS Scotland Workforce Information – Medical trend}, 6 March 2018

\(^5\) 36.5% of the medical staff in the CAMHS workforce in December 2017 were aged 50 or more. Information Services Division, \textit{CAMHS Characteristics of the Workforce as at 31 December 2017}, 6 March 2018

\(^6\) Scottish Public Pensions Agency, \textit{Section 8 – Mental Health Officers and Special Class Members}. Available at: http://www.sppa.gov.uk/index.php?option=com_content&view=article&id=651&Itemid=1396#EIGHT ONE
received a handful of replies - but I will be writing again highlighting the need for local retention strategies.

If we expect a newly retired colleague to simply slot in to a hard to fill post, trying to do the work of 5 days in three and rebuild a multidisciplinary team then we are likely to be disappointed. I have asked our working retired group chaired by Tom Brown to help highlight what approaches are likely to be more successful.

Here lies the paradox – the Royal College, in partnership with other practitioner organisations, and groups representing lived experience, can and does positively engage with Government to form policy but our engagement with local Health Boards and IJBs to encourage and monitor the implementation of policy is disappointing.

This weekend I was hearing from senior psychiatrists telling me of a disconnect between practitioners and their managers. In parts of the country psychiatrists tell be they made to feel an expensive and unnecessary accoutrement. There is a myth that psychiatrists are the ones holding up change and if only we would be more flexible then problems would evaporate. These are dangerous myths borne out of untested management ideologies which equate psychiatrists to production line
workers and celebrate strict notions of management hierarchy. Our medical managers have often been put in a position of managing medics rather than leading services. This has resulted in the development of services with only tokenistic practitioner consultation and the role of psychiatrists airbrushed out. It has all the logic of running an airline without pilots and we should not be surprised in the result. I do not think it is coincidence that these ideologies of despair arose in the context of the financial crisis. At its root we need a substantial increase in healthcare funding. In real terms we have not kept pace with inflation – it is not so much doing more for less but keeping going with less. There was less money spent by health boards on mental health in 2016/17 in real terms compared to 2009/10. The proportion of net expenditure by boards on general psychiatry services has also declined for four consecutive years, from 9.2% in 2012/13 to just 8.3% by 2016/17. Shortly before he died Stephen Hawking said that the question is not, can we afford to fund the NHS but can we afford not to fund the NHS.

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7 Spending figures have been calculated using data from 2005/06-2016/17 from Information Services Division (ISD) Scotland, Cost Book table R340, available here: http://www.isdscotland.org/Health-Topics/Finance/Costs/

8 Proportions were calculated using data from 2005/06-2016/17 from ISD Scotland, Cost Book table R300, available here: http://www.isdscotland.org/Health-Topics/Finance/Costs/

9 https://videos.rsm.ac.uk/video/professor-stephen-hawking---talk-nhs-keynote-lecture
The NHS is strongest when there is a collegiate approach to education, service quality, planning and management. The old mechanisms of practitioner influence have been replaced by management systems which do not always sufficiently heed the practitioner perspective. We rightly acknowledge the need for third sector, and lived experience views – the presence of third sector organisations on IJBs is to be welcomed – but when I ask about the practitioner perspective on IJBs I am usually met with a blank look.

Can we replicate the partnership working we have at a national level, locally? I hope we can. If each IJB must take into account the views of a local partnership, combining lived and practitioner experience, then many of the unresolved issues of governance and accountability might be addressed. Local mental health partnerships could monitor the implementation of the Strategy, review governance reports, and contribute to service developments.

Whether or not we see such a development, another crucial part of the Strategy – one which will drive forward mental health improvement – is the collection of meaningful data. Too often we reduce the complexities of providing healthcare to crude measurements – they may grab headlines but risk skewing the priorities of Health
Boards to treat figures and not patients. As you know mental health outcomes are not easy to measure as illustrated in a recent piece in the British Medical Journal\textsuperscript{10}. Yet measurement is crucial if we are to succeed in our mental health Strategy. It means we can move from the individual case and discover the general truth. We can move from anecdote to evidence. It provides a mechanism to benchmark data and reduce the risk of differences in what service you might expect between different areas.

In contrast to the World Health Organisation, when I recently met with the data analysts of the NHS Information Services Division, it was along with representatives of organisations for those with lived experience to inform the new mental health dashboard of information. Complementing the new ISD dashboard, which I hope will be launched before the end of the year, the Royal College is producing a quarterly data digest of mental health measures in Scotland available to any member on request.

I look forward to the day when I can see the spectrum of supported community living places in each IJB area that our closure of hospital beds has partly funded. I look

forward to the day when there is routine gathering of recovery-informed outcome measures. I look forward to the day when we have a mechanism to report when someone is admitted out of area or specialty.

More than that, the strategy has a broader goal – a national mental wellbeing goal – the goal of finding new ways to take the temperature of the nation’s mental health. That will require a broader innovative approach. I look forward to the day when our donations to mental health research match those for diabetes, heart disease or cancer; where our donations supporting those reaching the end of their life with dementia match the support for those reaching the end of their lives in our hospices. When terminally ill we should all be able to die with dignity. When at our most vulnerable we should be supported to live to the full with dignity.

For our country has a proud tradition of compassion. I am often struck that it is the groups organised by our unregistered nursing colleagues and technical instructors which are the most popular. Despite any finish time I usually have to chase away home junior psychiatrists wanting to get things right. Going the extra mile is the norm not the exception. We have a vocation to help others stronger than any contract.
Along with compassion we also have a tradition of innovation. At last Autumn’s Royal College meeting I heard of Professor Jonathan Cavanagh’s groundbreaking research linking inflammatory markers with major mental illness – it put shivers down my spine. One way in which we can be stronger is to reinforce the links between our academic communities and the NHS. Senior NHS managers must value academic links as an essential not an expensive extra. The health of those academic relationships, the health of our training, reflect the overall health of our services.

The College exists to promote psychiatry and to support you in your work. Later this year we look forward to the creation of a Scottish council of the college – putting in place the structures which help us be effective in a devolved administration. This is an opportunity to refresh the ways we do things. Many people here contributed to Andy William’s group report on approaches to personality disorder. Together with our partners I hope to persuade Scottish government to approve that topic as a new feature of the Strategy. The winter meeting will host the President’s lecture and I hope to be announcing the speaker for that event in due course. Before that we have Scottish faculty meetings, The UK trainee forensic and ID conferences and the Autumn meeting with trainee poster
competition and the theme of novel treatment approaches in depression.

It is hard to always maintain a positive approach. Yet the vision of the mental health strategy: our partnership between lived and practitioner experience; the political will from every corner of parliament; the mental health team at Scottish Government; our NHS and health and social care partnership; our third sector providers; our world class research; our natural instinct to help, shared by old and new Scots alike. The challenges? In comparison to our strengths they appear much smaller – but there is much work to do.

Thank you very much