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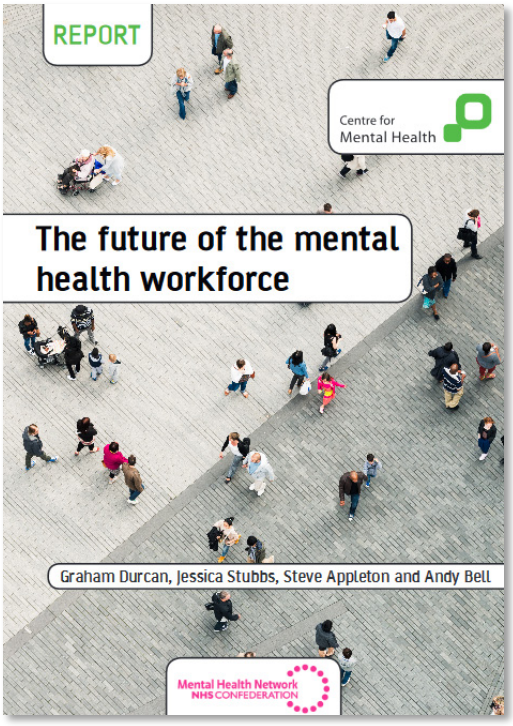
The future of the mental health workforce



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"Mental health is everyone's business, and every part of the NHS has a role in promoting positive mental health and ensuring people with mental health problems can access appropriate support. Mental health is also the business of local government, of schools, employment services, the criminal justice system and many other public services. It is hoped that further work can be taken forward to examine how best to ensure the workforce across health and social care can best support improving mental health for all" (p. 8)

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Centre for Mental Health was commissioned by the NHS Confederation and Mental Health network to explore what the **mental health workforce of the future** should look like. Data on the current picture of the workforce and finding from research are presented to identify challenges and opportunities that lie ahead for the mental health workforce.

The policy context[1]

The Five Year Forward View for Mental Health[2]

The success of the 5YFV depends upon the availability of a workforce to implement its recommendations (e.g. expansion of IAPT programme). Implications for workforce development include; children and young people, perinatal mental health, common mental health problems, community, acute and crisis care, secure care and health and justice. There is an emphasis on prevention and working 'upstream' requiring a rethink of the roles and skills of mental health practitioners (See also HEE's *Stepping Forward to 2020/21*. A KM summary of this report is available here).[3]

Future in Mind[4]

Workforce implications resulting from this DH taskforce investigating improving child and adolescent mental health support included; creating a workforce with the right skills mix to promote mental health, multi-professional training for all, a strategic approach to workforce planning and accredited training.

Wider Developments[5]

The future shape of mental health will also be affected by the following factors;

- Apprenticeships
- Education funding reforms
- New roles
- Flexible working
- Retention
- STPs
- The 'Brexit' effect
- The Carter Review
- Inequalities in access and outcomes
- Access and waiting times
- Reducing inappropriate out of area placements

The current mental health workforce[6]

Psychiatry: in 2014 across the UK 14.63 psychiatrists were working in the mental health sector per 100,000 people in the general population. Overall numbers have not changed significantly but attrition rates amongst those aged 53 or less are higher and there are lower rates of trainees progressing into higher ST.
Mental health nursing: across the UK 67.35 nurses were working in mental health per 100,000 people. The RCN has highlighted concerns about the "downbanding" of the mental health nursing workforce and high vacancies.
Nursing support staff: 1,611 nursing support staff in post in 2016, a decrease from 2009.
Psychology and psychological therapy: 12.8 psychologists per 100,000 in 2014. The number of psychotherapists has increased significantly. IAPT provides a significant career pathway and is an entry point for a career in mental health.
Social care: Most often employed or funded by local authorities. Estimated 1.55 million jobs in the social care sector in England. The social care workforce increased by 18% between 2009-2015 but LA jobs decreased by 8% between 2014-15.
Primary care: 34,914 FTE GPs in 2016 and reported concerns around recruitment. HEE will fill a further 230 places in 2017/18 to reach 3,250 trainees per year.
Peer workers: Few of these roles existed before 2010 but within three years mental health trusts were employing 20 or more each. HEE points to a planned growth in these numbers.[3]
Voluntary and Community Sector (VCS) provision: Health the third largest activity for the charitable sector. The growth of VCS providers has come about for a combination of reasons including cost saving and a drive for holistic services.

A series of **Consultation events** were run to understand perspectives. Around 100 people attended local events from a variation of backgrounds. There was **remarkable consistency** in the findings which are organised into three sections.

[1] pp. 9-10
[2] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[3] https://www.hee.nhs.uk/our-work/person-centred-care/mental-health/mental-health-workforce-plan
[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf
[5] pp. 11-13
[6] pp. 14-18

Findings part 1: Recruitment, retention, training and skills[7]

Entering the workforce

Attracting people who are new to mental health or working elsewhere is a challenge, especially in **mental health nursing**, due to less promotion and mature students. Nursing Associate roles and apprenticeships welcomed but concern there is no coherent plan. Entry into **psychology as a profession** has long been difficult – there were 595 training places for 3,730 applications in 2016. Sufficient numbers of psychologists trained at a high level is a concern. **Psychiatry** is not seen as an attractive career route and recruitment was difficult until recently. It also takes an unavoidably long time to train consultant psychiatrists. **Pharmacy** is sometimes regarded as a *peripheral service* in mental health – still an untapped resource.

Careers in Mental Health

Desire for **career structures** crucial for retention and allows for choice and different potential pathways. **Peer workers** want to develop but currently might need to go outside of mental health to do so.

Retention

Concerns that it is hard to retain mental health professionals, in particular nurses. Some areas struggled to keep those they **trained post-qualification** and some mental health nurses have the option to take their full **pensions at 55**. It is crucial to find ways to **retain workers aged 50+** through new roles and pathways.

Supervision and mentoring

Support for staff and learners was commonly discussed. The **allocation of adequate time** to provide mentoring is vital. Access to **clinical supervision variable** and needs more priority.

Training

Importance of **adequate, high quality training**. Demands facing the workforce need to be reflected in training. Training needs to **equip practitioners** to work in a **range of settings**. Quality of placements criticised and limited by locality. **Mentoring** needs to be considered in workforce planning and **more attention** needs paying to **existing staff**.

Findings part 2: Structure and roles of the workforce[8]

Commissioning

The **longer term** needs to be considered not just short-term goals. Commissioning impacts on **effective collaboration**. Stakeholders wanted mental health commissioning to be seen as a skill set that requires training. Competitions and market forces are potential barriers to sharing knowledge. Effective **workforce planning** and development is a crucial skill set.

Spreading skill in mental health more widely

There is a **shortage of mental health knowledge and skills in the wider public sector workforce** escalating mental health problems. Better mental health awareness training is necessary. **Open Dialogue** (mental health clinicians working collaboratively with patients) offers a potential solution but requires a different skill-set. Professionals working in **physical care** lacking the necessary mental health knowledge.

Primary Care

A **reform** and **rethink** around primary mental health care is **needed**. The **skills** of those in primary care need to **reflect the work they do**. Stakeholder listed **good practice example**s of this. GPs want **mental health advice** and help available to them but there is currently **no funding model** for this. **Prevention** and earliest intervention a theme and most **IAPT services are not able to accept clients** with any degree **of complexity**. Much discussion that a **'primary care plus'** type of service needed and greater integration between physical and mental health care across the board.

Inpatient services and staff

Often considered frightening, noisy and chaotic places by staff and patients – morale is low and sickness absence high. Inpatient care seen as the place you start working before 'graduating' to community services.

The role of VCS

Questionable whether the flexibility and accessibility of the sector can be maintained. There is a role for the statutory sector in supporting VCS organisations – much of the innovation of VCS is funded in the short-term.

[7] pp. 20-23

[8] pp. 24-36

The role of lived experience
Desire to boost the voice of lived experience through paid and volunteer opportunities – **co-production** much talked about. Peer support worked wanted career progression and pathways like other professionals.

The role of the community
Ideas about **encouraging genuine engagement** in communities were discussed. **Recovery Colleges** have a huge potential role. More **funding** should be placed in **community-based preventative work** but there are structural barriers.

The role of families as partners
Only marginal attention is given to families and carers. There is a need to develop models of embedding the support of families in services.

Findings part three: Culture of the workforce[9]

Moving away from traditional roles
The need for a new **mental health practitioner type role**. Regulators and government, as well as professionals, **uphold a traditional notion of the mental health team**. Service providers and commissioners need to **challenge inflexibility**. New roles welcome but need to **develop career pathways** for mental health professionals at every stage of their career.

Integrated and multidisciplinary workforce
Ongoing problems in integrated, joined-up working. The highly skilled mental health workforce is **not being utilised systematically**. A consistent message about **moving away from traditional medicalised model of mental health care**, and a desire to move towards more psychologically and recovery informed models.

Changing the nature of work
Need for staff to have **'more time to care'** – reducing administration could reduce this burden marginally.

Psychologically informed services
A shift to a more **psychologically informed approach** called for. Psychological formulations were seen by many as more useful in informing care than binary labels such as diagnoses.

Recommendations[10]

1. **Attracting the workforce** (reaching out to schools. Colleges etc.)
2. **Career Pathways**: range of clear pathways that reflect changing needs including specific pathway for inpatient care. Both volunteer and professional opportunities.
3. **Supervision and mentoring**: best possible resource and time invested, recognise mentoring as a core aspect
4. **Training** (all staff equipped to work flexibly in various settings, sufficient number and variety of placements, investment beyond the NHS, GPs and others in primary care have access to wide-raging training in mental health)
5. **Competencies** (develop a range of competencies that define the mental health practitioner, more postgraduate training, collaborative approaches, significant training in psychological intervention received)
6. **Commissioning:** include consultation in contract, training opportunities for mental health commissioners, work long-term, jointly invest in prevention and engagement)
7. **Wellbeing:** prioritise staff wellbeing in all mental health services to improve productivity and boost retention

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Please note this summary is for information purposes only; it does not include validation or critical appraisal of any content.

[9] pp. 36-39

[10] pp. 42-43