

REPORT

Centre for
Mental Health



The future of the mental health workforce

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Mental Health Network
NHS CONFEDERATION



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Executive Summary

Centre for Mental Health was commissioned by the NHS Confederation Mental Health Network to explore what the mental health workforce of the future should look like. This report presents the key findings from a review of:

- The current workforce in specialist, NHS-funded mental health services in England;
- Current policy and its impact on the future workforce;
- The views of people who work in and use mental health services, obtained through a series of consultation events and roundtable meetings held across the country in early 2017.

Key policy developments

Mental health policy in England currently centres on *The Five Year Forward View for Mental Health* and the *Future in Mind* strategy for children and young people. Both documents have major implications for the mental health care workforce. The former is accompanied by a workforce development plan which sets out how an additional 19,000 posts will be created by 2020/21 to staff the new services it pledges.

The future development of the mental health workforce is also influenced by a wider range of policies and factors including:

- Education funding reforms;
- The creation of new professional roles (such as nursing associates) and routes into work (such as apprenticeships);
- The emergence of Sustainability and Transformation Partnerships and latterly Accountable Care Systems;
- The (as yet unknown) impact of Brexit.

The current workforce

The NHS mental health workforce comprises approximately 200,000 whole time equivalent (WTE) staff, including established professional groups (for example psychiatry, nursing and psychology) and a wide range of other workers in a variety of roles.

Key recent developments in relation to the composition of the workforce include:

- Little change in the number of psychiatrists – and growing concerns about attrition and the number in training for the future;
- A significant reduction in the number of nurses working in inpatient services (in line with falling bed numbers);
- A notable growth in the psychological therapy workforce resulting from the Improving Access to Psychological Therapies (IAPT) programme;
- A concern about the availability of mental health social care staff resulting from cuts to local government funding;
- A growth in the number of people working in peer support roles in mental health services;
- The development of a growing number of voluntary and community sector organisations as providers of mental health support.

Consultation findings

More than 100 people participated in consultation events and discussions for this report, bringing a wide range of personal and professional knowledge and experience. Key findings are summarised below under three major headings.

Recruitment, retention, training and skills

Attracting people to work in mental health is a major challenge, particularly in relation to nursing and psychiatry. Mental health is not routinely promoted as a career option for young people, and it is difficult to fill training places for some professional courses.

Attrition rates in mental health services are higher than for many other health services. Particular concerns were expressed about people leaving nursing after qualifying and the importance of retaining older staff members.

Mentoring and supervision are crucial for the mental health workforce but have been under-valued and given inadequate time and investment.

Concerns were expressed about the extent to which current training equips staff to work in changing mental health services and outside traditional settings.

Structure and roles of the workforce

Commissioning was seen as an important discipline in itself which is under-developed and which requires particular skills to meet future needs – for example to co-design mental health care with communities and service users.

Mental health professionals need to be able to reach out and share their expertise more widely with a range of other professionals – such as GPs, physical health care staff, and teachers in schools.

Greater focus is required on the workforce needed to provide mental health support in primary care and to create new opportunities for staff to work in this important environment.

Inpatient services were described as being under-valued as places to work, with low morale and high sickness rates and staff turnover.

Concerns were raised about growing fragmentation between the NHS and social care in mental health provision.

There was recognition that the voluntary and community sector is growing in importance, and that there is a need for future workforce planning to include VCS organisations more explicitly.

There was a desire for the voice of lived experience to grow in the future mental health workforce, through the creation of new roles and career opportunities in peer support and through increased coproduction at every level.

Communities and families need to be recognised as important partners in mental health support, with a greater focus on engaging with communities in the development of the future workforce.

Culture of the workforce

There was a widely expressed view that mental health services should move away from ‘traditional’ models of care and in the process create new and different professional roles to meet people’s needs in different ways. This

includes providing training in core skills that transcend professional boundaries, removing restrictive practices between professions and creating more flexible career pathways.

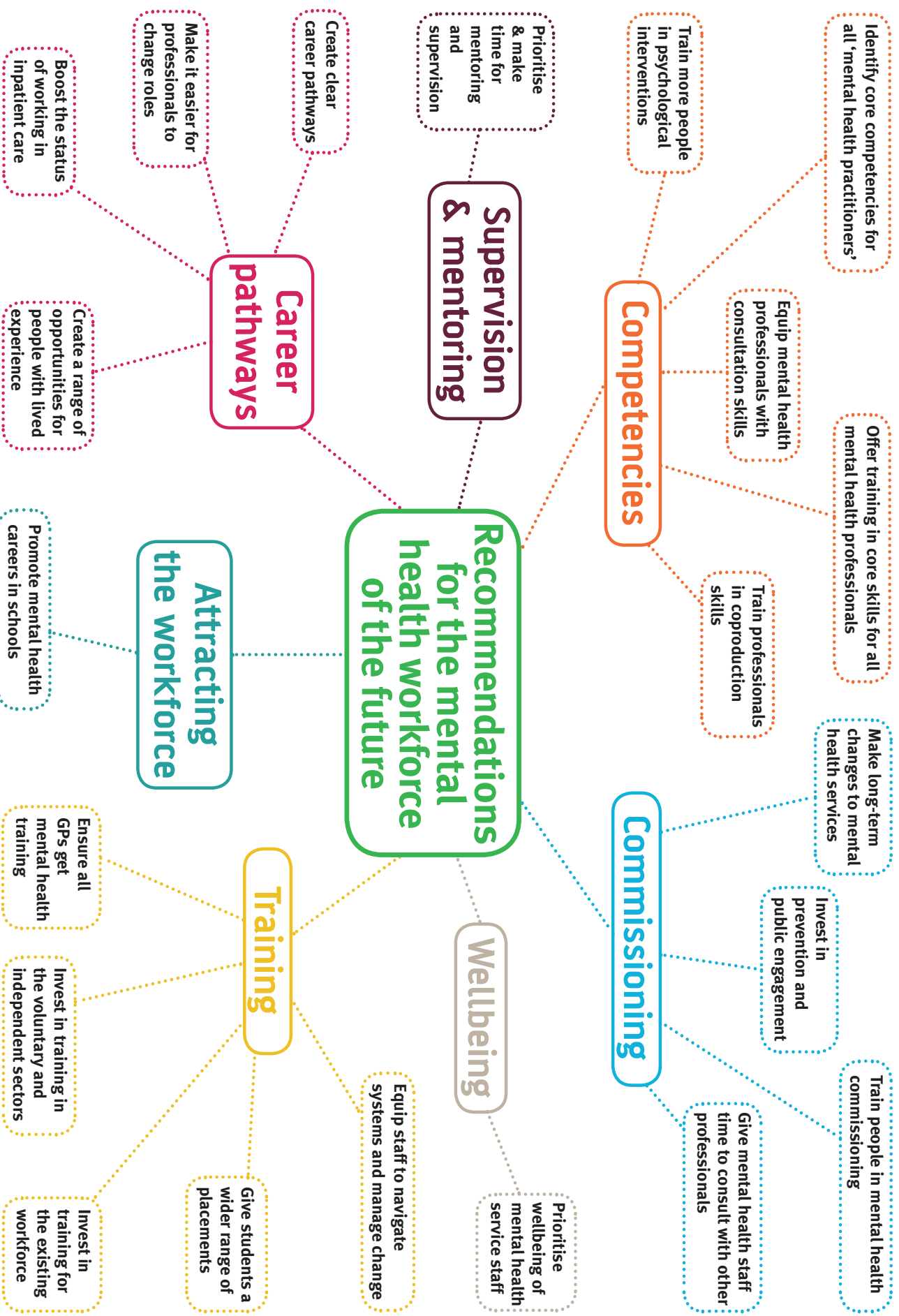
Participants wanted mental health services (and their workforce) to meet people’s needs in new ways, for example through the use of psychological formulation, through coproduced services outside conventional settings, and through focusing on people’s practical needs such as housing and employment.

There was a clear call for mental health services to become ‘compassionate organisations’ that prioritise the wellbeing of their staff, that enable people to work flexibly and in new ways, and that celebrate the difference mental health services make to people’s lives.

Recommendations

The report makes a series of recommendations for government, for the NHS, and for education and training providers. They include:

- Reaching out to schools and colleges to promote mental health career opportunities;
- Developing a wider range of career pathways for mental health professions and professionals, including for people with lived experience who wish to pursue careers in mental health support;
- Prioritising and protecting mentoring and supervision in mental health services, particularly for those in training;
- Developing new skills in training courses that will meet future demand – for example in consultation skills to support other health professionals and in psychological formulation, coproduction and outreach with communities;
- Promoting mental health commissioning as a skill set requiring specific training and development;
- Providing training and development opportunities to existing as well as new staff – particularly those reaching the ‘final third’ of their careers seeking new challenges and work roles;
- Ensuring that all mental health providers support the wellbeing of their staff.



Introduction

Over the last few decades, mental health services have experienced great change in the way that they are designed and delivered. More recent national developments, including *The Five Year Forward View* and the report of the Mental Health Taskforce, emphasised the need to adopt new models of care to meet rising demand, and to better integrate the way care is delivered to a population with complex physical, mental health and social care needs. However, resources are limited and workforce development takes time to achieve.

It is in this context that this report explores what the future mental health workforce should look like over the medium to long term (beyond the next five to ten years). It is based on research carried out by Centre for Mental Health in early 2017 on behalf of the NHS Confederation Mental Health Network, commissioned by NHS Employers and supported by Health Education England.

It presents data on the current picture of the workforce and findings from the Centre's research to identify the challenges and opportunities that lie ahead for the mental health workforce.

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.

Coverage of the report

Given the time and resource available, this project could not consider all the potential areas of the mental health workforce. It was agreed that the focus of this project should be on the workforce in secondary mental health services – whether they are employed by the statutory, commercial or not-for-profit sector. It concentrated on mental health services in England funded or provided by the NHS and where this provision links with social care.

The project did not include specific exploration of dementia, learning disability or substance misuse services, or general practice, though all of these arose as significant factors in the future of the mental health workforce during the project, and the themes explored in this report are broadly applicable to all such services. During the course of our research, we heard consistently about particular concerns regarding the workforces for learning disability services and addiction services, and about the ability of mental health services to meet the needs of people with autistic spectrum disorders. Each of these areas requires further exploration and examination building on the learning from this project.

It was also apparent throughout the project that the mental health workforce of the future will need to work in a wider range of settings and with workers in other sectors – such as primary care, schools and communities more broadly.

The policy context

Significant amongst those things required to improve access to, and outcomes from, mental health services is the right workforce. This is also a major theme in both the *Future in Mind* report for children and young people's mental health and *The Five Year Forward View for Mental Health* (FYFV-MH).

The Five Year Forward View for Mental Health

The Five Year Forward View for Mental Health set out the priorities for NHS mental health care and some wider recommendations for other government departments and agencies (Mental Health Taskforce, 2016). The strategy has major implications for every aspect of mental health service development but its success will depend on the availability of a workforce to implement its recommendations, including:

- A call for all NHS staff to have greater knowledge and awareness about mental health.
- The implementation of access and waiting time standards for adult Improving Access to Psychological Therapies services and for Early Intervention in Psychosis.
- Investment in new specialist perinatal mental health (community and inpatient) services.
- Investment in 'core-24' liaison psychiatry services in general hospitals.
- Expansion of the Improving Access to Psychological Therapies programme, with a particular focus on long-term physical conditions and medically unexplained symptoms.
- Improvements to community mental health care, including crisis resolution and home treatment, and Individual Placement and Support employment services.

The Five Year Forward View for Mental Health was followed in July 2016 by an implementation plan which set out details of which of the report's recommendations for the NHS would

be delivered at what times up to 2021 (NHS England, 2016). The implications for workforce development include:

- **Children and young people (CYP):** an extra 1,700 therapists and supervisors by 2020/21 and all services working within the CYP Improving Access to Psychological Therapies (IAPT) programme.
- **Perinatal mental health:** new multidisciplinary teams providing evidence-based interventions and building relationships with other health services (for example, maternity and health visiting services).
- **Common mental health problems:** 3,000 additional psychological therapists working in primary care and focusing on the needs of people with long-term conditions and medically unexplained symptoms, and of older people.
- **Community, acute and crisis care:** developing a workforce to: meet new standards for Early Intervention in Psychosis; to deliver Individual Placement and Support; to provide more physical health checks and psychological therapies to people with severe mental illnesses; and to extend access to liaison services in acute hospitals, and to crisis resolution and home treatment services in the community.
- **Secure care:** developing a workforce capable of supporting people in the community for people who do not (or no longer) need to be in secure mental health care.
- **Health and justice:** expanding the liaison and diversion workforce, including a wide range of skills, backgrounds and competencies.

The Five Year Forward Views (both for mental health and the broader policy) place an emphasis on prevention and working 'upstream'. The Mental Health Forward View in particular places an emphasis on coproduction and working with those with lived experience.

Both these ambitions require a radical rethink of the skills and roles of mental health practitioners.

The implementation plan also notes the importance of supporting the mental health of the NHS workforce in order to improve quality and productivity, including initiatives such as line manager training, providing rapid access to psychological therapies, mindfulness exercises and regular health checks.

NHS England subsequently published a one-year-on review of progress towards meeting these objectives. It noted that significant progress was already being made in many aspects of their process, including in both adult and children's IAPT, perinatal mental health and early intervention in psychosis. Other areas, such as crisis care, employment support and liaison psychiatry, are at an earlier stage of development in line with the implementation plan (NHS England, 2017a).

More recently, since the research for this report was completed, Health Education England published its workforce strategy for the FYFV-MH, entitled *Stepping Forward to 2020/21* (Health Education England, 2017). The strategy sets out a range of measures that Health Education England and the other national Arm's Length Bodies will take to bring about a net 19,000 increase in the specialist mental health workforce in the next three years. The strategy identifies the need for an additional 11,000 staff in 'traditional' professional roles (such as psychiatry, nursing and occupational therapy) and 8,000 in newer roles such as Peer Support Workers and Psychological Wellbeing Practitioners. And it describes the ways in which this will need to be achieved through a combination of recruitment of new staff, retention of existing staff and changes in the way people work. The strategy also makes a number of changes that will have a longer term impact, for example to the number and scope of training places in professional roles.

Future in Mind

Future in Mind was the result of a Department of Health taskforce investigating how to improve child and adolescent mental health support (Department of Health, 2015). It set out a range of recommendations for improvement and required local areas to produce Transformation Plans in order to receive a share of £1.25 billion investment over five years that was allocated as part of the 2015 Budget.

Key features of *Future in Mind* with major workforce implications include:

- Creating "a [health, education and social care] workforce with the right mix of skills, competencies and experience" that can "promote mental health", "identify... problems early", "offer appropriate support", make referrals to targeted and specialist services and "work in a digital environment with young people who are using online channels to access help and support".
- Multi-professional training for all paediatric staff in physical and mental health "and the development of service models (such as paediatric liaison) which recognise the interaction and overlap between physical and mental health".
- Staff in targeted and specialist services "need a wide range of skills brought together in the CYP IAPT core curriculum". (This programme currently covers 68% of the population and is a Mandate commitment to roll out further.)
- A strategic approach to workforce planning: it proposes a "census and needs assessment" of the workforce "as the first stage in determining a comprehensive cross-sector workforce and training strategy".
- Accredited training in children's mental health "should be a requirement for all those working in commissioning of children and young people's services".

Wider developments

In addition to the impact of mental health service policy changes, the future shape of the mental health workforce will be affected by a range of wider developments and policies. Alongside uncertainty relating to the outlook for the UK economy and funding for public services, the following issues are highlighted.

1. Apprenticeships

The Government has announced measures to increase the number of apprenticeships, and included a target for public sector organisations and a levy of 0.5% of the total pay bill from April 2017. This is likely to create opportunities for mental health services, for example to create nursing associate roles for apprentices, but will also create pressures on already limited funding for the existing workforce. It is currently unclear how far mental health care providers are creating apprenticeship roles to ensure they recoup the cost of the levy.

The first nursing apprenticeships come into being in September 2017 and these provide an alternative route into nursing. The nursing degree course achieved through apprenticeship will normally be of four years duration, although those with previous experience (via Accreditation of Previous Experience) may be able to achieve the degree via an apprenticeship of shorter duration. Of significance is that the employer pays for the apprenticeship, rather than the learner. All employers with a wage bill of £3 million and above now contribute to the Apprenticeship Levy.

2. Education funding reforms

The move from bursaries to loans to fund most health professional training from September 2017 may impact the numbers of people choosing to train in these fields. There are concerns from some quarters that this could disproportionately affect numbers of student nurses choosing mental health careers.

The Government has committed to increasing the number of health professional training places by 10,000. If this is successful, this will increase demand on services to provide placement opportunities and offer supervision to trainees.

3. New roles

The nursing associate role is being piloted in a number of mental health services. It is unclear how far nurse associates will be additional to existing nurse roles or a substitute for some. The implications of this development for mental health services are not yet clear. Physician associates are also likely to become a part of the future mental health workforce along with other new or expanding roles such as peer supporters, navigators and mentors.

4. Flexible working

The Government is seeking to increase opportunities for NHS staff to work flexibly, for example having greater choice over shifts or to have term-time contracts. This could help to reduce the NHS's reliance on bank and agency staffing by enabling establishment staff to work flexibly.

5. Retention

A key element of the mental health workforce strategy (Health Education England, 2017) is an aim of reducing the vacancy rate in mental health services by retaining more staff. The strategy “assumes that although it may not be possible to fill all the vacancies by 2021, the ‘vacancy rate’ (20,000, 10% of the mental health workforce) will reduce as we shift people onto substantive contracts in line with national policy” (p20).

A number of existing initiatives are already in place to support NHS organisations to retain staff. NHS Employers is currently working with 100 NHS providers (including 12 mental health

trusts) to support them to retain staff. The scheme includes examining why staff choose to leave or stay in their organisations and then helps them to develop, deliver and evaluate plans for improved retention. Learning from this initiative should help health care organisations to retain staff more effectively.

More recently, NHS Improvement has launched a programme of support to NHS provider organisations that will include “targeted support for all mental health providers to improve the retention rates of all staff groups” with a particular focus on those with “above average leaving rates for all clinical staff”¹.

6. Sustainability and Transformation Partnerships

Many Vanguard sites, including those focused on mental health, are developing new approaches with implications for the future workforce, for example increasing capacity in community services to reduce demand on inpatient care or developing alternative crisis pathways. This direction of travel is strongly supported in most Sustainability and Transformation Plans, some of which include specific pledges to develop improved mental health services (including prevention and earlier intervention) that will have a significant impact on the workforce. As these evolve into Sustainability and Transformation Partnerships, Accountable Care Systems and, eventually in some areas, fully fledged Accountable Care Organisations, they will exert a powerful influence on the shape and the priorities of the mental health workforce in the years to come.

An analysis by the Nuffield Trust (Imison *et al.* 2016) concluded that the whole of the NHS faces a “huge organisational development challenge” in reshaping the workforce to implement new models of care. It notes that while training new staff will be crucial, “the biggest opportunity to reshape the workforce lies in developing the skills of the current workforce, particularly the non-medical workforce” for example in supporting people managing long-term conditions.

7. The ‘Brexit’ effect

There are more than 161,000 people from the European Economic Area (EEA) working in social care and health care in England (Cavendish Coalition, 2017). While these are not disproportionately employed in mental health care, there are significant numbers of people working in NHS, local authority, voluntary sector and independent mental health providers from the rest of Europe.

It is as yet unclear what impact Britain’s future relationship with Europe will have on this section of the workforce long-term, although in the short-term there is evidence of uncertainty about the future for those working in the UK and there is a possibility that potential future recruits will be reticent about coming to Britain.

8. The Carter Review

NHS Improvement’s review of efficiency and productivity in the NHS, led by Lord Carter of Coles, is currently investigating mental health and community trusts in England. The report, due to be published in late 2017, is likely to have a significant impact on working patterns and financial management in mental health services.

9. Inequalities in access and outcomes

A continuing concern for mental health services is the ongoing need to ensure the right workforce is in place to tackle inequalities in access and outcomes. Such inequalities are particularly marked for people from some Black and Minority Ethnic communities, who are less likely to access mental health treatment through primary care but more likely to be detained under the Mental Health Act. Higher rates of poor mental health are also found among children in care and care leavers; people with physical, sensory and learning disabilities; lesbian, gay, bisexual and transgender people; and people in contact with the criminal justice system.

¹See <https://improvement.nhs.uk/news-alerts/securing-sustainable-nhs-workforce-future/>

It is vital we see a much greater focus at a national level in tackling these inequalities and ensuring everyone can access high quality, appropriate care and support. Meeting the needs of marginalised and vulnerable groups requires the workforce to operate in different, flexible, and creative ways (Khan *et al.*, 2017).

10. Access and waiting times

In recent times there has been a greater focus in national policy on the issue of improving access and waiting times for mental health services, with the introduction of a number of specific new waiting time targets.

For example, new national standards state that over 50% of people with first episode psychosis should be treated with a NICE-approved package of care within two weeks of referral. Provisional, experimental data (NHS Digital, 2017a) shows that in a three-month period between the beginning of September and the end of November 2016, across English trusts there were 2,283 referrals on the Early Intervention Psychosis (EIP) pathway for treatment. Of these, 65.9 per cent (1,504) waited less than two weeks to begin treatment.

There were, however, 12 trusts where over 50% of referrals on the EIP pathway had to wait more than two weeks.

Should new waiting time standards be introduced across more mental health services, these will have implications for the workforce required to deliver them.

11. Reducing inappropriate out of area placements

The Government's national ambition of eliminating inappropriate Out of Area Placements (OAPs) for adults is being measured through a new dataset of Out of Area Placements in Mental Health Services. Data from NHS Digital indicates that at the end of October 2016, there were 7,161 open ward stays in adult acute inpatient mental health care. Of these, where distance travelled could be calculated, 284 people (4%) were receiving care at least 50 kilometres away from their home postcode (NHS Digital, 2017a). Ensuring more people have access to appropriate services closer to home has implications for future workforce planning.

The current mental health workforce

This section gives an overview of a selection of key available statistics relating to the current clinical mental health workforce. This draws largely on data from the World Health Organization and NHS Digital. It should be noted that NHS mental health services are delivered by a wide range of organisations from the statutory, commercial and voluntary sectors. National workforce datasets, such as those outlined below, largely derive from employment statistics within statutory organisations, rather than those employed within independent organisations providing NHS treatment, and therefore should be interpreted with care.

The recently published mental health workforce strategy (Health Education England, 2017) notes that the overall specialist mental health NHS workforce comprises a total of approximately 214,000 whole time equivalent (WTE) posts, of which about 20,000 are vacant at any time, giving a current workforce of 194,000 WTE. It also notes that NHS mental health services lose some 10,000 staff a year through attrition.

Psychiatry

The World Health Organization (2015) estimates that, across the whole of the United Kingdom in 2014, 14.63 psychiatrists were working in the mental health sector per 100,000 people in the general population. This compares to 14.1 in France, 20.1 in the Netherlands, 18.31 in Sweden, 13.42 in Canada, and 12.4 in the United States.

According to NHS Digital (2017b) provisional statistics covering English NHS Trusts and CCGs, in October 2016 there were 8,819 psychiatrists (full time equivalent, total number across all grades).

While the overall number of psychiatrists in England has not changed significantly in recent years, there are challenges facing the profession. Firstly, attrition rates amongst consultant psychiatrists aged 53 or less have been substantially higher than the attrition of NHS consultants as a group (Centre for Workforce Intelligence, 2014). Secondly, there have been lower rates of trainees progressing with their training. Nearly one in five doctors in training in 2014 failed to progress from core psychiatry training into higher specialty training (Centre for Workforce Intelligence, 2014 in Addicot *et al.*, 2015).

Table one: FTE Psychiatrists in England NHS Trusts and CCGs (October 2016, provisional statistics, NHS Digital 2017b)

Psychiatrists	09/2016
Child and adolescent psychiatrists	967
Forensic psychiatrists	549
General psychiatrists	5709
Old age psychiatrists	1090
Learning disability psychiatrists	421
Psychotherapy psychiatrists	83
Total psychiatrists	8,819

Mental health nursing

The World Health Organization (2015) estimates that, across the whole of the United Kingdom, 67.35 nurses were working in the mental health sector in 2014 per 100,000 people in the general population. This compares to 90.86 in France, 52.9 in Sweden, 53.31 in Canada, and 70.91 in Australia.

Provisional data from NHS Digital (2017b) showed that there was a total of 35,943 full-time equivalent (FTE) mental health nurses in October 2016. This number fell by over 10% from October 2009, when there were 40,862 FTE mental health nurses in post. Over this period, there was a small increase in the overall numbers of community psychiatry nurses but sharp reductions elsewhere: most notably in inpatient settings (which is likely to be due to bed closures).

The Royal College of Nursing (RCN, 2014) has highlighted concerns about the “downbanding” in the mental health nurse workforce, in which higher banded nurses are replaced by those from lower bands.

Additionally, RCN research reported in The Guardian (2016) highlighted high numbers of vacancies among mental health nurses. Their research found that London hospitals had 10,000 nursing vacancies and that NHS mental health trusts were among the worst affected by shortages of nurses.

In response to these vacancies, there has been a greater reliance on temporary and agency staff. According to The King’s Fund, by 2014 requests for temporary nursing in mental health services had increased by two-thirds (Addicot *et al.* 2015).

Nursing support staff

Provisional data from NHS Digital (2017b) showed that there were a total of 1,611 nursing support staff (nursing assistants/auxiliaries, and nursing assistant practitioners) in the community psychiatry group in post in October 2016. These numbers have decreased since October 2009, when 1,979 staff were in post.

Table two: FTE mental health nurses in English Trusts and CCGs (October 2016 provisional data, NHS Digital 2017b)

	October 2009	October 2016
Community Psychiatry	15,295	16,350
Nurse Consultant	33	53
Modern Matron	48	44
Nurse Manager	647	945
Other 1st Level Nurse	14,450	15,172
Other 2nd Level Nurse	116	136
Other Psychiatry	25,387	19,592
Nurse Consultant	109	97
Modern Matron	550	395
Nurse Manager	1,060	1,095
Other 1st Level Nurse	23,230	17,901
Other 2nd Level Nurse	438	104
Total	40,682	35,943

By contrast, in the “other psychiatry” staff group (predominantly those working in inpatient settings) numbers have remained largely stable, albeit with some shifts in the types of role being used. In October 2016, 19,149 FTE nursing support staff were in post, compared with 19,337 in October 2009. Within that category, the number of nursing assistant/auxiliary staff decreased from 13,727 in October 2009 to 8,296 in October 2016; while the number of healthcare assistants increased from 2,747 to 6,824 over the same period. Similarly, staff numbers employed under the “support worker” label have increased from 2,841 to 3,739 FTE (NHS Digital, 2017b).

Psychology and psychological therapy

The World Health Organization (2015) estimates that, across the whole of the United Kingdom, 12.8 psychologists were working in the mental health sector in 2014 per 100,000 people in the general population. This compares to 10.77 in France, 47.42 in Canada, 12.78 in Denmark, and 16.68 in Australia.

Provisional data from NHS Digital (2017b) shows that in October 2016 a total of 7,057 FTE staff were in post within clinical psychology roles, a slight increase on October 2009 when 6,797 professionals were in post.

From the same dataset, the number of psychotherapists has increased significantly over the same period. In October 2009 provisional data from NHS Digital (2017b) indicates that 1,214 FTE staff were in post in psychotherapy roles, rising to 4,341 in October 2016.

Within clinical psychology support roles, there were 1,221 assistant practitioners in post in October 2009, rising to 1,825 in October 2016. Numbers of trainees and students however has reduced over the same period, from 1,832 in October 2009 to 1,305 in October 2016 (NHS Digital, 2017b).

In the psychotherapy support group, there were 133 assistant practitioners in post in October 2009, rising to 750 in October 2016. There were 201 trainees and students in post in October 2009, and 287 in October 2016 (NHS Digital, 2017b).

Further data on the workforce relating to talking therapies is provided by the 2015 IAPT workforce census (NHS England and Health Education England, 2016), which achieved a 90% return rate from services. Data from this report indicated that, as at April 2015, there were 6,897 FTE therapists and practitioners, 780 trainees and 127 employment support advisors. The 2015 IAPT workforce comprised 36% Low Intensity (Step 2) workers, 62% High Intensity (Step 3) workers and 2% Employment Support workers.

IAPT provides not only a significant career pathway for psychological practitioners (it has nearly doubled the NHS psychological practitioner workforce); it is also a significant entry point for a career in mental health practice. The IAPT workforce is predominantly female (79%), White British (83%) and relatively young (66% are under the age of 46 years), and thus is not always representative of local populations and service users. The census also highlighted that the majority of therapy capacity within IAPT services related to cognitive behavioural therapy (CBT) and counselling,

with an “under-representation of brief dynamic interpersonal therapy, interpersonal psychotherapy for depression and couples therapy”. The census report recommended that “increasing capacity for the full range of NICE approved therapies for depression will improve patient choice and may lead to increased treatment take-up and recovery rates” (NHS England and Health Education England, 2016).

Social care

Social workers delivering statutory adult mental health services are currently most often employed or funded by local authorities. Mental health social work has a particular statutory role, for example providing the majority of Approved Mental Health Practitioners under the Mental Health Act 1983. There is also a wider mental health social care workforce providing support with independence and daily living for people with long-term mental health needs.

Skills for Care’s (2016) national minimum dataset for social care estimates that there are 1.55 million jobs in the social care sector in England across the independent and statutory sectors. Across the workforce, 83% of workers are estimated to be British, 7% from the European Economic Area (EEA, non-British) and 10% from non-EEA countries.

The national minimum dataset for social care estimates that 28,500 jobs in the sector are concerned with exclusively providing care and support to people with “mental disorders or infirmities”. 1,500 of these are within local authorities, 15,000 in the independent sector and 12,500 through direct payment recipients (Skills for Care, 2016). Some 483,500 jobs provide care and support to people with

“mental disorders or infirmities” combined with other care and support provision. Of those, 56,000 roles are through local authorities and 428,000 within the independent sector (Skills for Care, 2016).

Between 2009 and 2015 the total social care workforce increased by some 18% (Skills for Care, 2016). The number of adult social care jobs increased between 2014 and 2015 for independent employers by around 2% (20,000 new jobs). But while the number of adult social care jobs in the NHS increased by 6% (5,000 jobs), the number of local authority jobs decreased by 8% (10,000 jobs) over the same period. Skills for Care (2016) reports that commonly cited reasons by councils for reductions in staff were restructures, service closures and the outsourcing of services.

Primary care

In March 2016, there were 34,914 FTE General Practitioners, an increase of 0.9% since September 2015 (NHS Digital, 2016). There have been reported concerns around recruitment, with a 2013 survey finding average vacancy rates of 7.9% (Kaffash, 2013).

The Government has set an objective of an extra 5,000 doctors working in general practice by 2020. NHS England reports that numbers entering GP training are up by 10% since 2015 and that Health Education England will fill a further 230 places in 2017/18 to ensure they reach 3,250 trainees per year (NHS England, 2017b).

There is no data about the extent or nature of the workforce offering mental health support within primary care.

Peer workers

There is a long history of mutual support being provided by people with mental health problems (see pages 7-9 of Mind, 2013), and service user representation at different levels supporting mental health service development has been evident since the 1990s. However, the employment of people within specific peer support roles is relatively recent in the UK. Very few such roles existed in England prior to 2010 (Repper, 2013), but within three years some mental health trusts were employing 20 or more each. The adoption of recovery orientated services has been the spur for the development of many new salaried and volunteer peer worker opportunities. Repper provides a useful guide to types and functions of peer support (2013). It is not clear what the size of the peer worker workforce is, but it is at least in the many hundreds. And the recent mental health workforce strategy (Health Education England, 2017) points to a planned growth in these numbers over the next three years.

Voluntary and Community Sector (VCS) provision

Health as a whole is the third largest activity for the charitable sector (Bull *et al.*, 2014) and it is estimated that 9.3 million adults were provided with emotional support or counselling by charities in 2015/16 (Guardian, 2016). The Association of Mental Health Providers (a VCS membership group) has over 50 members across England and Wales and this is a fraction of the groups out there when taking into account the number of medium and small providers. VCS organisations are significant providers of mental health services and their growth has come about through a combination of factors, including changes in mental health commissioning, enabling a greater diversity of provision; a need to drive down costs; and a desire to offer more holistic and engaging services than have traditionally been available.

Similar to the previous section it is difficult to establish the numerical contribution to the mental health workforce made by the VCS.

Consultation events

In order to understand the perspectives of people who use, work in or have a stake in mental health services to construct a vision for the future of the workforce, we ran a series of consultation events in different areas of England. Local consultation events were held in:

- Bradford;
- Middlesbrough;
- London (Centre for Mental Health attended a Sustainability and Transformation Planning meeting);
- Nottingham;
- Birmingham;
- Leatherhead.

Two national events were also held. These were attended by representatives from unions, Royal Colleges and other professional organisations, charities and service user networks.

Coverage

Around 100 people attended the local consultation events representing a variety of backgrounds including:

- Service users;
- Carers;

- Those with peer engagement lead roles and support worker roles;
- Executive level NHS managers;
- NHS human resource management;
- Psychological leads and practitioners;
- Social work leads and practitioners;
- Occupational therapy leads and practitioners;
- Nursing leads and practitioners;
- Pharmacists;
- Education providers;
- Voluntary and community sector providers.

There were representatives of those working in older adult, working age adult and children and young people's services, both in inpatient and community settings. We sought to ensure that at each event there was a diversity of voices, including people with lived experience as users of services or carers, people working outside the NHS (including in education, policing, housing and social care) and people providing a wide range of mental health services. Psychiatrists were not present at any of the local consultation events but were well represented at national events and on the project's expert reference group.

Consultation findings

The findings from these consultations and events provide a concise summary of the views about which there was consensus across the events. While each event had a varied focus according to the expertise in the room at the time, there was remarkable consistency in the direction that stakeholders wanted mental health services and their workforce to take.

The findings are organised into three sections: part one looks at recruitment, retention, training and skills; part two looks at the structure and roles of the workforce and part three discusses the culture of the workforce. Building the workforce of the future will require concerted action across each of these domains.

Findings part one: Recruitment, retention, training and skills

Part one outlines the current dilemmas and changes to the workforce, and future considerations in relation to entering and leaving the workforce. It also highlights what training needs to be in place to equip individuals with the necessary skills to be a mental health practitioner in light of the changing demands we can expect in the future.

It was stated by participants across all events that the demand for mental health services had increased significantly in recent years, and that national campaigns such as Time to Change had played a significant part in this, as perhaps had austerity. However, this has come at a time when the staffing of mental health services has become more challenging, and is set to become more so over time.

Entering the workforce

Attracting people who are either new to mental health or who are working elsewhere but have relevant skills and experience for the mental health workforce was consistently cited as a challenge. This was in part due to the great deal of uncertainty about the future of several mental health professions and sub-specialties.

Nursing

Understandably these concerns were most pronounced with regard to mental health nursing, the largest group of mental health professionals. There was a particular concern that nursing now had to compete with other degrees as a result of the replacement of the bursary.

Stakeholders reported that most people get into mental health by chance, circumstance or as a result of personal or family experience. It is not routinely promoted in schools as a career option. Moreover, it was common for nurses to be mature students who already had a degree: in one area it was noted that 40% of those entering a nursing degree course had already completed a previous degree. These entrants were seen as more mature with more life experience. However, this has also been noted

to make mental health nurse training more vulnerable to the loss of the training bursary from this year onwards.

“I can't see many people coming into nursing this way...why would you want to double your debt?”

“...when I entered nursing, most of my colleagues had done other jobs and had other life experience...I think we understood better what we were entering and have stayed in the profession...”

“...there are 10 applicants for every IAPT training place whereas universities can't fill all their places for nursing. Yet IAPT gives no career structure and many could have gone into nursing and had one...”

While some questioned whether there was a career path in nursing it was accepted that IAPT and the voluntary sector offered less, yet they were more attractive to some potential nurse recruits and some trained nurses migrated into the voluntary sector in particular.

There were other changes that stakeholders commented on with regard to nursing: the nursing apprenticeship and nursing associate posts in particular. Both were viewed as positive and offering potential opportunities. But there was a concern that their introduction and the changes in nurse training were not necessarily part of a coherent and coordinated plan; for example, at one event it was reported that the introduction of the nursing associate role had “scuppered” local planning and thinking about more general mental health associate roles.

Psychology

Stakeholders see the contribution of psychology to mental health services as crucial, but entry into psychology as a profession has long been difficult. Psychology as a choice of undergraduate degree is popular, with over 100,000 registered on full or part-time undergraduate programmes in the UK in 2014 (Study International, 2016).

There are of course several psychology career paths to follow but the number of clinical psychology training places has long been seen as a bottleneck. Across the UK there are just 595 training places, with 3,730 applications for these in 2016 (see <http://www.leeds.ac.uk/chpccp/numbers2016.html>): a recruitment rate of 16%. Counselling psychology requires self-funding and thus was seen as an option for primarily “white middle class” individuals, resulting in a less diverse workforce.

These are not the only routes to becoming a psychological practitioner: many nurses train to develop skills in this area and the Improving Access to Psychological Therapies (IAPT) programme has introduced two new types of practitioner, the Psychological Wellbeing Practitioner and the High Intensity CBT Therapist. Entry to the latter requires a mental health qualification while entry to the former is much more open and psychology graduates can apply, though a degree is not necessarily required. The central issue for psychology is one of having sufficient numbers of psychologists trained at the highest level, who might offer supervision and consultation.

Psychiatry

We heard that psychiatry is not seen as an attractive career route for many of those entering medicine and 20% of trainee psychiatrists do not finish core training:

“No one wants to do mental health...[it’s] for second rate medical students”

Psychiatry training places have until recently been hard to fill, though it was noted at one of our events that this has improved of late. It was also pointed out, however, that some trainees find working in inpatient settings off-putting and that this reduces the number who will eventually become consultant psychiatrists. We were also told that there is a risk that government attempts to increase the number of new GPs could place further pressure on the numbers training in psychiatry.

Moreover, through current routes it takes some nine years to train a consultant psychiatrist:

speedy solutions are simply not possible, and decisions made today can have ramifications decades ahead. Physician associates are not widely used in psychiatry, however, and those attending our events felt there was potential for meeting current shortages through developing physician associate opportunities. And there were examples given of programmes in some trusts to expand the number of non-medical Responsible Clinicians in relation to the Mental Health Act.

A number of participants also remarked that recent changes to mental health provision and commissioning may have “sounded the death knell” for some sub-specialties of psychiatry, including consultant level psychotherapy and addiction psychiatry. Only 17 of the 55 English mental health trusts have specialist drug and alcohol services, many of which have seen significant cuts in funding which makes it difficult to train a new generation of addiction psychiatrists.

Pharmacy

Pharmacy is sometimes regarded as a peripheral service in mental health and many perceived pharmacy simply “as a supplier”.

“...in general healthcare ward settings, we are very much part of the team, but not so in mental health...”

Yet examples were given where pharmacy and psychology had collaborated to produce local guidelines on managing anxiety and depression. Overall, during the consultation, pharmacy was felt to be an untapped resource and that both pharmacists and pharmacy technicians had much to offer. Associate roles for the former were seen as potentially plugging gaps in psychiatry.

Careers in mental health

A theme that emerged across the events was the desire for career structures. This was felt to be crucial to the retention of the existing workforce but also for recruitment and making ‘mental health’ attractive to those considering entering. The desire for a career structure was

in part about people being able to continue in clinical or part clinical roles, but also about having choice and different potential pathways. At the events it was felt by many that career development in nursing often in effect “...meant ceasing to be a nurse...”.

The desire for career structure was also present amongst those in peer support worker roles. Peer workers reported that they had just as much desire to develop and progress, but that at the present this might mean transferring the knowledge and skills they acquired outside of mental health and to other sectors, rather than retaining this within mental health but nevertheless progressing. Some ideas about roles that might be open to peer support workers are discussed elsewhere.

Retention

We were told about concerns that it is hard to retain mental health professionals and in particular nurses. Such concerns are also noted in the mental health workforce strategy (Health Education England, 2017) which notes that mental health trusts’ attrition rates have risen – from 10.5% in 2012/13 to 13.6% in 2015/16 – and are significantly higher than those observed in secondary physical health services (where they are 8.6%).

Some areas struggled to keep those they trained post-qualification, and at the Surrey event it was reported that often those they have invested in training move to posts in London when they qualify; this may be related to ‘London Weighting’. In another local area, it was reported that services struggle to retain lower paid staff in competition with other sectors, for example the ‘tourist economy’ and catering, many of which offer more flexible working arrangements (for example giving a choice of shift patterns) than the NHS.

Some mental health nurses (who joined the NHS pension scheme prior to April 1995 and who continue to meet a set of criteria) retain mental health officer status and have the option to receive their full pension at 55 years of age

rather than wait till retirement age. This does not, however, explain the majority of attrition in NHS mental health nursing, and it will be rarer as time passes.

At several of the events, it was noted that when nurses leave the NHS they are not necessarily moving out of mental health care. Examples were given where people had left the NHS and moved into employment with voluntary and community sector services and so were still contributing to mental health service provision.

Stakeholders felt that it was crucial to find creative ways to keep workers aged 50+ in the workforce through new roles and career paths. It was discussed that changing pension arrangements can have perverse effects, potentially encouraging workers to leave the service to avoid getting ‘stuck’ in their jobs until they can retire in their late 60s. Creating opportunities for a ‘meaningful final third’ of a person’s career may be critical to retaining and making the best possible use of older workers. As one participant noted: “careers matter as much as jobs and roles”. And for many, having a ‘route map’ was important to create a sense of ‘structure and certainty’ to careers in mental health, especially where traditional professional boundaries become more pervious and job security is hard to achieve.

Supervision and mentoring

Support for staff and learners was commonly discussed across the events. The quality of learner placements is often determined by the quality of mentoring and a significant part of this is the importance given to mentoring by employers providing placements. The allocation of adequate time to provide mentoring was seen as vital, but was perceived as often being an issue. Mentoring of course is not just something that supports learners, but also those new to post and especially less qualified workers. Likewise, good quality supervision, both management and clinical, of those working in mental health roles requires sufficiently budgeted time for it to be useful and genuinely supportive. Access to clinical supervision was

deemed as variable and there was a desire for it to be given more priority in practice.

Supervision was seen as critical in the retention of staff who “...often hear of and see quite harrowing things...” and in roles where there was “...huge potential for burnout...”.

Training

Participants highlighted the importance of adequate, high quality training in developing a workforce that was skilful, flexible and competent. The demands facing the workforce were cited as growing in complexity, which needed to be reflected in the training provided:

“...We need people who understand complexity and comorbidity...and with an ageing population we need people who understand the needs of older people...”

Stakeholders reflected on how training needs to equip practitioners to work in a range of settings to echo the growing focus on mental health practices “moving out from traditional settings” into places that individuals felt more comfortable accessing. Participants felt that practitioners needed to be trained in how to cope with and manage working in complex mental health systems, for example the constant experience of organisational change:

“The one constant in my three decades of working in mental health has been ‘change’... we should train trainees in managing ‘change’...”

There was concern that newly qualified nurses were not being adequately trained and did not have the capability and competence required to do the role. Participants said that nursing was particularly difficult at this time due to the “shrinking workforce, growing expectations and exhausting demands” and it therefore required competencies and skills which were not being observed among students. Participants discussed how training needed to have more emphasis on the practical as well as clinical aspects of nursing: for example, knowing how to assess and manage a risk situation.

The quality of placements for those studying to be nurses was also criticised and it was noted that it was often hard to pair a placement with the particular learning required at different points in the course. More specifically, it was noted that placements were limited to where mentors (qualified nurses) could be provided, which made it difficult to arrange placements outside the NHS that could offer valuable experience to trainees.

Related to this was the need for mentors to have the time to work with and support students and trainees. Student nurses reported that mentors often struggled with the daily demands of their nursing role and found it hard to find time to adequately mentor them. One stakeholder explained:

“I’ve had to cut students in the team because of the number of mentors...you can’t always expose them to what they need to be exposed to. They are with us 37½ hours per week. One will end on the Friday and the next will start on the Monday. Mentors don’t have time to breathe, reflect, evaluate or even think about their own work.”

Thus, mentoring needs to be considered in workforce planning as it represents a time-consuming but essential part of the work. This was perceived to be important to reduce the risk that mentors might sign off students who were not competent due to unmanageable time constraints.

Additionally, there were concerns that although a new workforce was being trained and new roles developed, little attention was given to existing staff. For instance, the ‘imposition’ of the nursing associate role was said to have “ridden roughshod” over the existing cohort of support workers who could have benefited from something similar yet who get little training and few development opportunities: “why not up-skill the existing workforce rather than creating a new one?” And concerns were expressed about reductions in funding for Continuing Professional Development (CPD) in the NHS as a result of broader financial pressures.

Findings part two: Structure and roles of the workforce

In this section we consider the structure of the workforce; what it looks like and the roles it requires. It highlights the role of commissioning in structuring the workforce and outlines the crucial (but often neglected) role of the mental health workforce in training and consulting for the wider public, voluntary and community sectors in providing preventative support. It also considers how wider resources such as primary care, the voluntary sector, community and family need to be recognised and utilised.

Commissioning

Our stakeholders felt that policies and commissioning need to consider the long term, but are too often driven by shorter term goals. One example given was outcome measures that force staff to work on getting someone out of hospital and that this "drive" often discourages longer term and more strategic thinking and stifles more holistic approaches:

"...it incentivises the ticking of boxes over what might be more helpful..."

Commissioning has an impact on effective collaboration, for example psychiatrists meeting with GPs to advise on patient care. This is problematic when it's not a commissioned service and its impact cannot be captured on the outcomes measures by which staff and organisations are judged.

Our stakeholders wanted mental health commissioning to be seen as a skill set and set of competencies that requires training and ongoing development. In practice, mental health commissioners often have other responsibilities and were noted often to be more junior than those for other services. And our stakeholders felt that commissioning is fragmented between organisations, making partnership working more difficult for providers.

"Commissioners need to be seen as a part of the workforce... It is currently a fundamentally weak profession..."

Competition and market forces in particular were seen as potential barriers to increased

sharing of knowledge and skills across organisational boundaries.

It has been noted during the production of this report that the nature of commissioning may be changing, for example with the arrival of Accountable Care Systems and Organisations. While such changes may in future change the way services are planned and contracted for, they will not avert the need for people with commissioning skills – who are able to understand the needs of a population and secure the best value support available.

It was also noted that one of the most important skills in future commissioning will be the ability to coproduce and engage with communities – drawing on the expertise of people who have used services (and those who have not) to redesign support that people would find more helpful and responsive.

Finally, it was pointed out that effective workforce planning and development is another crucial skill set in itself, and one that needs to be valued by mental health commissioners and providers alike, to ensure that decisions made about the future shape of services can be implemented in practice.

Spreading skill in mental health more widely

There was broad discussion of the fact that the mental health workforce had huge skill and the potential to enable other services and professionals to provide more preventive mental health support and enable earlier identification when people need help. Our stakeholders told us that there is a shortage of mental health knowledge and skills in the wider public sector workforce, which results in mental health problems escalating and individuals needing more acute support when they reach a crisis. Currently, this also means that some public sector workers, such as teachers, have to provide support beyond their competence:

"...they are 'crying out for support' and we need to create a common language and greater understanding..."

Our stakeholders thought that better mental health awareness training was required for workers across the public sector. Participants cited the role of mental health practitioners working with schools to train teachers in mental health awareness and provide preventive support and signposting to services. Other participants referred to their work in primary care, for example in aiding GPs to make more informed referrals. This was seen as a hugely important part of mental health work, with wide ranging impact, yet is rarely acknowledged as a core aspect in workforce planning:

“...There is a huge amount of knowledge locked up in an ever decreasing workforce...we have to think about how we can get the best out of it [the workforce]... Outreaching to the community and voluntary sector and providing consultancy are ways forward...”

Open Dialogue was seen to offer this potential, but like the case studies that follow, requires a different skill-set, and one which involves genuine collaboration with the service user, their carer and their community. Open Dialogue involves mental health clinicians working in collaboration with patients, their families and wider social networks and was first developed in the 1980s in Western Lapland. Its central aim is the development of a shared understanding of ‘the problem’. It has reported considerable success in working with people with severe mental illness, both in symptom reduction and in accessing employment. (An accessible description of Open Dialogue is provided <https://www.psychologytoday.com/blog/hide-and-seek/201507/open-dialogue-new-approach-mental-healthcare>). Open Dialogue was seen as having potential to help a wider group than specifically those with psychosis, and it was also seen as a means of moving skills out from clinics for greater engagement with the community.

Professionals working in physical health care were also seen as lacking in mental health knowledge, and this was viewed as particularly crucial given that many of the people who present to primary care and other health services may have a mental health problem as the root cause or concurrent with their physical complaint. Increasing the necessary knowledge

through medical training can be a slow process. The Royal College of Psychiatrists is currently developing training for qualified doctors in mental health and aims to include mental health in all specialties.

Primary care

Although the consultation was primarily concerned with the specialist and secondary mental health care workforce, there was a recognition that there needs to be a reform and rethink around primary mental health care. Our stakeholders felt that the skills of those working in primary care need to reflect the work they do: if one in three GP appointments concerns mental health, why do only 46% of GPs do a mental health placement in their training? All should receive a significant amount (and range) of training in mental health.

Stakeholders gave examples of work with primary care, which increased GPs’ capacity and skill in addressing mental health needs. One participant described how they had ongoing dialogue with GPs through regular phone calls, surgery visits and consultations. This helped GPs to understand better when to make a referral, which enabled primary care partners to use mental health systems more effectively. Participants discussed how trusts were trying to work better with primary care, for example by working with GP practices with high levels of referrals, in order to understand what drives the level of referral and what they needed. Several participants discussed the benefits of GP surgeries where psychiatric nurses were embedded to provide effective care at the right level.

GPs want mental health advice and help available to them but currently there is no funding model to support this. Stakeholders told us that the Welsh Mental Health Measure had helped to improve this for GPs in Wales (see box overleaf).

Participants discussed the common myth that primary care is deskilling for mental health practitioners, and suggested that it actually requires very skilled clinicians because it will determine an individual’s future care and support:

“It’s actually very skilled, you need to think diagnostically, about possible interventions, formulate, lots of what ifs and ‘maybes, you need to be able to conduct a comprehensive assessment because you will be determining their care pathway...”

Prevention and the earliest intervention were a theme at events and some models were described. There was a recognition that secondary care thresholds have risen in recent times and continue to do so, meaning fewer people with marked need meet the criteria for services. This is especially the case in relation to adult social care, where there have been marked reductions in funding.

There is perceived to be a “huge gap” between primary and secondary mental health care, and Improving Access to Psychological Therapies (IAPT) services as currently commissioned do not fill that gap:

“...IAPT....its targets and KPIs and ‘one model’ fits all...”

Stakeholders reported that most IAPT services are not able to accept clients with any degree of complexity (e.g. having traits of personality disorder or misusing substances). Centre for Mental Health conducted a review of publicly available sources for this consultation, looking at entry criteria for IAPT services, which confirmed that such complexity often led to exclusion from IAPT.

There was much discussion of the need for a ‘primary care plus’ type of service and it was noted that there were some primary mental health care teams that included psychiatry, psychology and nursing, but also that there was a need to test and evaluate these services. Such services should not simply transplant secondary care work into primary care settings but offer a distinctive alternative.

Stakeholders wanted to see much greater integration between physical and mental health care across the board in the NHS and pointed to some limited examples of mental health nurses being employed within hospital medical and surgical wards to advise and support those teams.

The Welsh Mental Health Measure

The Mental Health Measure is legislation passed by the Welsh Assembly in 2010 that seeks to improve access to mental health care. There are four parts to the measure:

- Part 1 seeks to ensure more mental health services are available within primary care.
- Part 2 gives all people who receive secondary mental health services the right to have a Care and Treatment Plan.
- Part 3 gives all adults who are discharged from secondary mental health services the right to refer themselves back to those services.
- Part 4 offers every inpatient access to the help of an independent mental health advocate.

The measure has a number of guiding principles and these are:

- Patients and their carers should be involved in the planning, development and delivery of care and treatment to the fullest possible extent;
- Equality, dignity and diversity;
- Clear communication in terms of language and culture is essential to ensure patients and their carers are truly involved, and receive the best possible care and treatment;
- Care and treatment should be comprehensive holistic, and person-focused;
- Care and treatment planning should be proportionate to need and risk;
- Care and treatment should be integrated and coordinated.

*This is adapted from
www.mentalhealthwales.net/mental-health-measure/*

Case Study one: Catterick's GP-based psychological service

The event in Middlesbrough offered an example of an innovation that Centre for Mental Health was able to follow up. A psychological practitioner was based in a GP practice, enabling earlier intervention, preventative working, more open access and flexible service provision (compared to secondary care). It also reduced the need for referral to secondary care. A clinical psychologist from Tees, Esk & Wear Valleys NHS Foundation Trust is based within a general practice in Catterick. Catterick is a 'garrison town' where the infantry basic training school is based. There are service personnel living in the town, many of whose families receive their care from the NHS. Many veterans and their families have also based themselves within Catterick. The level of mental health need at the practice has been perceived as high.

The psychological service is open to all and GPs and primary care staff make patients aware of the service. Reception staff can book people into the service and anyone registered with the practice can self-refer either through an online booking system or requesting an appointment at the practice reception.

The psychologist offers up to 20 15-minute appointments during the day. Some people will receive double appointments, particularly when they are receiving a guided psychological intervention.

The service was established to:

- Provide advice and reassurance for those with mild emotional/psychological needs;
- Provide evidence-based interventions for those with moderate or more marked needs;
- Improve the quality of referral to secondary care;
- Reduce referrals to secondary care.

There are no entry criteria and the service is open to all ages: the youngest client was just under two years of age and the oldest in their eighties.

After six months of operation, the service had seen around 260 individuals and offered nearly 800 appointments. In addition there have been over 100 case consultations with professionals both within and outside of the practice.

Early data suggested that referrals to secondary care had reduced, though the service had been in operation for just over six months at the time. The psychologist providing the service had expected that they could 'upstream' some of the assessments that would normally be conducted in primary care but also found that they were:

"...upstreaming the therapeutic provision...so for people who do need to be seen in secondary care, I can provide lots of assessment information, but also they are 'hitting the ground running' because they know what CBT is, they know how their behaviour is impacting on their emotional wellbeing and how unhelpful thinking patterns are making things worse..."

At the time of the interview the service was exploring how a second year might be funded. The current practitioner felt that clinical psychologists and others such as nurse psychological practitioners could deliver this type of service.

Inpatient services and staff

Sometimes, in order for people to be safe, they need to be supported in inpatient care. However, our stakeholders told us that often current acute inpatient units do not provide a safe space. These are often, from the view of the patient (and staff, too), frightening, noisy, chaotic and stressful places to be in.

The morale of staff is often low and acute inpatient services have high sickness absence rates and staff turnover; as a consequence they rely on bank and agency staff. We were told that most new nurses want to move from inpatient posts to a career in the community and few seem to find the inpatient environment an attractive one.

Our stakeholders felt that staff working in acute inpatient settings can often do little more than contain people. Access to opportunities for meaningful activity and therapy can be very limited. It was felt by some stakeholders that inpatient wards, in spite of having multidisciplinary teams, often felt the least multidisciplinary of mental health settings because in practice it was largely nursing that was visible and present on a ward.

“...We put the least able and least qualified staff with the most ill people...”

Inpatient care is viewed as the place you start working in before ‘graduating’ to community services where pay, status and opportunities are perceived to be better. This is in contrast to what happens in physical health care where hospitals are often valued above community services. And there is a risk that current policy exacerbates this, creating new opportunities in community services and leaving inpatient care behind and stigmatised even more.

“Do we need to make inpatient care a multidisciplinary speciality in itself?”

Children’s services

Centre for Mental Health visited an innovative project in Birmingham, which has been making mental health support more accessible to children and their carers and is described in the box adjacent.

The role of social care

Some of those we spoke to suggested that mental health is increasingly on the fringe of social care, even though most Approved Mental Health Professionals are social workers. Social care has begun to withdraw from partnership agreements with the NHS as meeting the obligations of the Care Act 2014 is viewed as difficult by local authorities unless they have direct management control of social work staff. This is leading to more fractured working relationships and may contribute to additional and duplicated processes for assessment and service delivery.

The role of voluntary and community sector (VCS)

The VCS is a significant provider of mental health services and is often more able to be innovative and accessible than statutory services. More often than not it provides services without the traditional structures of the statutory sector. However, as some charities become more mainstream providers of NHS care, it was questioned whether the flexibility and accessibility of this sector could be maintained. There are perceived threats to the VCS, which our stakeholders thought were often more accepting of and accessible to many service users. VCS organisations are increasingly playing a major role in mental health provision, but NHS organisations sometimes struggle to work well and flexibly with them. Risk aversion in the NHS was seen to be contributing to this, making it difficult to work with outside providers. This means VCS organisations end up adapting to fit a system (often the one they offered a healthy counter to) and potentially lose the uniqueness of what they offer.

Case study two: children's mental health: Pause, Birmingham

Pause is a drop-in mental health and wellbeing service for children and young people aged 0-25 in Birmingham. Its practitioners provide a very different culture of provision to that of traditional services. It is part of the Forward Thinking Birmingham partnership between Worcestershire Health and Care NHS Trust, Birmingham Children's Hospital, Beacon UK, The Children's Society and The Priory Group. Pause aims to improve access to emotional health and wellbeing services and advice, reduce risk of escalation by providing timely and preventative support, reduce avoidable referrals to specialist services, increase access to other services, reduce stigma of mental health services and raise awareness of wellbeing across Birmingham.

Pause is delivered in a very accessible and flexible way by its multidisciplinary team of mental health clinicians, youth workers and volunteers. The practitioners provide support through a drop-in facility. No appointment is needed and the team provide support and advice to those dropping in seven days a week. Pause adopts a tiered approach, ranging from an informal chat, one-off advice, short therapy and triaging to more intense support, signposting to other services, and making emergency referrals. Pause provides confidential, flexible and individualised support and advice to children, carers and professionals (e.g. teachers). Designed in collaboration with young people, Pause is relaxed, friendly and comfortable, described as somewhere between a "Costa Coffee and Apple shop". Pause uses a "meet and greet" approach to introduce the service as individuals arrive, to assess what the person would like and need. There is no pressure to talk – children can sit and have a drink, use the computers and read user-friendly information, and are welcome to do so more than once.

Young people, carers or teachers can have an informal conversation with staff or can access one-to-one consultations, assessments or brief therapy. There are creative workshops which focus on positive wellbeing, for example mindfulness, relaxation and art. Pause also has designated days where specialists in employment and housing are located onsite to provide specific support.

A formal evaluation of Pause is under way and friends and family have reported high levels of satisfaction. Young people and carers have reported the benefits of using Pause in providing immediate support without needing a referral and have highlighted the non-judgmental, welcoming and individualised approach as key to what makes it accessible. Approximately 1,000 individuals access Pause per month, with about 50% of those being first-time users. The majority of individuals accessing Pause are young people aged 11-25. Pause estimates that in its first year it will see 8,000 people, which will add 50% to the capacity of the Forward Thinking Birmingham partnership.

Pause and Project Future (see case study three) involve practitioners being engaged in more service user- and needs-led services than 'traditional' mental health services. Scaling up such services requires some radical rethinking of staff training and preparation.

Stakeholders discussed the role of the statutory sector in supporting VCS organisations and their staff. VCS organisations often do not have the resources of the statutory sector, an example being lack of an infrastructure for training and upskilling. Bradford participants gave examples where places on NHS training programmes have been offered and taken up by local VCS providers.

A key question seems to be whether training strategies for mental health care should feature the VCS more prominently given the significance of their provision.

In addition it often seems to VCS organisations that knowledge is "locked up" in the statutory sector:

"...as we take on more and more care it would be great to access this knowledge and for mental health practitioners to see it as a key part of their role to come out to us and provide consultancy and even supervision..."

Some commissioners were able to give examples of more substantive and longer term contracting of VCS organisations, but by and large our stakeholders felt that much of the innovation of the VCS was funded in the short term and through non-recurring grants. It was questioned why, if the VCS was a real partner in providing mental health care, it is not currently given a strategic voice – and its absence from Sustainability and Transformation Planning fora was given as an example.

The VCS could also have a role in changing the 'traditional culture' in mental health services by being enabled to provide secondment experiences for mental health professionals and placements for students and trainees, if there was more flexibility in the ways placements were determined.

The role of lived experience

There was a desire across events for boosting the voice of lived experience, through a combination of paid and volunteer opportunities. Genuine coproduction was much talked about and there were several examples given, among which Recovery Colleges were prominent. Coproduction, where genuine, could play a significant part in engagement which in turn can have an impact on wellbeing and recovery.

Coproduction was operating to different extents across different trusts but was seen as crucial to providing people with accessible and enabling support. It was noted that coproduction should be built into service design and delivery, as well as training for new members of staff. One participant described involving carers and service users in the training of new staff to help them understand their experiences better. There are examples of innovative projects, which are genuinely underpinned by coproduction, such as Project Future (see case study three).

Case study three: Coproduction at Project Future

Project Future is an award-winning youth-led wellbeing project that works with a community of young men aged 16 to 25, who are often labelled as "socially excluded", "offenders" and "gang members". The team, just like that for Pause (see case study two) is multidisciplinary and works incredibly flexibly and out of the normal 'comfort zone' for mental health practitioners. A key facet of this service is that it is coproduced with the young people who use it, (including the name, function and activities of Project Future), and this has been the case from the very outset. As is described below, some young people form part of the multidisciplinary team.

The young men accessing the service have historically had poor and limited access to services including mainstream mental health. It is a partnership project between Barnet, Enfield and Haringey Mental Health NHS Trust, Haringey Council and the charity MAC-UK, which has been funded for three years by Big Lottery. Project Future is based on INTEGRATE principles (Durcan *et al.*, 2017) developed by MAC-UK.

Project Future uses a holistic approach to mental health and wellbeing, recognising that the young men that access the service have complex and multiple overlapping risk factors linked to wider health, social and racial inequalities (e.g. poor education, deprivation, lack of opportunities, unemployment). Therefore, Project Future offers young men whatever support they ask for, e.g. with employment, justice or housing, and wraps the mental health care around such support. Project Future seeks to address inequalities by intervening at individual, peer, community and organisational levels to increase social inclusion and reduce marginalisation.

Project Future uses a team approach and is run by a multidisciplinary team of clinical psychologists, community members, youth employees and youth workers, bringing diverse expertise to the service. The project uses evidence-based psychological approaches in a way that is accessible and empowering to young people (i.e. at their pace, in a space that they are comfortable in). Underpinned by evidence-based theories, Project Future has created a safe and therapeutic environment and provided holistic support to 155 young people. And it has adopted a strengths-based approach where young people are not viewed as the 'problem' but rather as capable and resourceful young men: experts in their own lives.

The project was coproduced by young people from the community who have been instrumental in setting up and advising on all aspects of the project. Young people are involved in everything from co-designing the space, interviewing new staff and managing risk, to operating a peer referral system, where the young people refer others to the project.

An independent evaluation of Project Future by Centre for Mental Health is in process and interim findings have demonstrated significantly improved mental health and wellbeing of individuals involved as well as increased access to mainstream services and education, employment and training. Young people described its impact on their wellbeing:

"At Project Future you can get a bit of headspace...for me personally there's a lot going on and this is somewhere to go when you need time out..."

"Project Future is a safe space that has an impact on your wellbeing. And from safe you can advance and do what you want to do. Until you've got the basics met you can't advance..."

Peer support workers are increasingly being seen as a core part of the mental health workforce and there was discussion about needing to see peer support workers as equal staff members who brought invaluable expertise to the workforce. Part of this was ensuring that there were career pathways for peer workers so that they could progress in the same way as other staff. But there was also discussion about how the role of peer support continued to stigmatise and mark out individuals with lived experience as “different” from other staff:

“Professionalised peer support is a stigmatised role. It’s like you’re not really a serious mental health professional. Peer means ill, so you’re an ill person playing professional. It’d be better to scrap the peer tag and make them a mental health professional. Help them gain access to working in these roles but don’t mark them out as anything different. A support worker is a support worker, whether you have lived experience or not.”

Peer workers at events wanted career progress and pathways just as other professionals did and there were discussions about important roles in mental health teams (such as care coordination). Participants felt that training towards them should not be closed to peer workers or indeed other professionals.

Equally the role of peer working in the peer worker’s own recovery was seen as important. As a consequence, opportunities to provide peer support as a volunteer were regarded as

helpful as an alternative to paid roles:

“...not everyone who uses their lived experience to help others wants a career in it... but some do...we need both opportunities... but we need to think about both...”

Embedding coproduction also changes the skills and capabilities required of existing professional groups, for example to support shared decision-making with individual service users and to work in partnership with families and social networks as well as individuals. This is likely to include the ability to communicate effectively with individuals through digital media and confidently making use of new forms of communication as they emerge in the future.

The role of the community

Various ideas were discussed about encouraging genuine engagement with communities. In part this was a recognition that as demands for support were increasing while services were shrinking, new models of care were needed, and volunteering and genuinely community-embedded services should be a part of this.

The discussion on Open Dialogue (previously described) was part of this. But other models were mentioned too, one being the Trieste Model. Though well established in Trieste in Italy, the model was seen as providing a guide to new service design. It was highlighted that spending on inpatients in the Trieste community was 6% (far lower than in the UK) and that there were fewer issues in accessing care in the community.

Case study four: The Trieste Model

Although Trieste offers a whole service model, at the events where it was described, it was given as an example of how a workforce with quite traditional roles can still deliver a service with a markedly different culture and one that is more readily accessible than many of our community services.

The Trieste Model represented a radical departure from the previous asylum based system of care, with a move to a 'minimum dosage' inpatient service, featuring full integration within a community and full citizenship for people using the service. Italy, unlike the United Kingdom at the time of its hospital closure programme, had virtually no tradition of community care.

Trieste's mental health service has low thresholds for access, and essentially operates an open door policy. The model in Trieste (population approx. 240,000) has developed from the early 1980s and currently consists of four community mental health services, which are open 24 hours a day and 7 days a week, each serving a population of 60,000. The services have small inpatient units of around six beds each and there is a central inpatient unit, also of six beds, based in a general hospital. The latter are primarily used for night time admissions; stays are usually less than 24 hours. Teams are multidisciplinary with each consisting of nurses, psychiatrists, social care specialists, psychologists, rehabilitation specialists and support workers (around 200 mental health workers in all). The teams all see in the region of 1,000 people each year. These teams work in close collaboration with NGOs who provide some of the wider rehabilitation service elements and supportive housing.

Supported housing is a key part of the model and consists of:

- Rehabilitative housing for people with severe mental illness and no family networks - 42 places in 7 group homes
- Transitional housing - 18 places in 7 group homes
- Supported housing provided at different levels of intensity - 64 places in 20 apartments

The aim is for independent living for all that can attain it. And community engagement is an important part of this: for example the community mental health services will work with neighbours to provide housewarming parties for those moving onto independent living.

Access to employment is also a key part of the model and patients can move initially into a number of social cooperative workplaces (there are currently 15 such cooperatives). Around 13% people in the cooperatives move into mainstream employment each year.

In recent years personalised health care budgets have been utilised, particularly for those with the most complex needs. Around 160 people receive these per year and they account for just over 20% of the mental health budget.

(Source Mezzina, 2014; Portocolone, 2015; and stakeholders at events who had visited Trieste)

Recovery Colleges (and peers) were seen as having a huge potential role in training significant numbers of volunteer champions (perhaps in collaboration with other educational providers), with ambitious targets for training people in the community in mental health first aid and other such courses. Recent conversations with the West Midlands Mental Health Commission have indicated a desire to promote such wider training in mental health awareness.

Stakeholders emphasised the importance of communities as the preventative component of the mental health system, which has been overlooked in traditional medical models. Stakeholders discussed how peer support ought to be seen as the informal support in the community between friends, neighbours and community groups. They called for a “mass movement as part of the preventative agenda” to connect communities in providing informal support.

One stakeholder highlighted the impact of the Hearing Voices Network, a community-based group which provides the opportunity to share experiences and offer informal support.

Means of engaging communities (and people with lived experience) in more genuine ways were seen as routes to providing earlier help. For example, in Camden, barbers completed a mental health first aid course, which has enabled men who are experiencing poor mental health but who do not access any support, to

start talking about it. This has been important in reducing stigma in accessing professional support. Burgess and Ali (2015) reported on an evaluation in Wandsworth, where Black pastors have been trained in family therapy to address socio-cultural factors that contribute to the poor take-up of mental health services among Black Caribbean and African groups.

Stakeholders discussed that more funding should be invested into community-based preventative work, which would prevent a huge number of people from needing services:

“If there was that support, where you call each other up, chat about your mental health, then you wouldn’t need the services so much... but you get more and more ill because there’s no support in the community...”

However, there were significant structural barriers in the ways that mental health services are set up and funding is allocated that make it difficult to transfer resources into communities.

Stakeholders also suggested that local service providers should seek to make their workforce ‘a slice of the local community’, creating ‘broad entry points’ that enable a diverse range of people from the local area to become a part of the workforce. This could include creating more opportunities to coproduce new service models. And it should start young, encouraging young people who have been in contact with CAMHS, for example, to get involved in coproduction activities and enable them to find roles in the workforce of the future.

The role of families as partners

Our stakeholders felt that mental health services give only “marginal” attention to families and carers, and need to use and develop models of embedding the support of families. An example of one such service was provided, the Meriden Family Programme, which provides training to support services in developing more family-sensitive mental health services. It uses Behavioural Family Therapy with families to support positive communication, problem-solving and stress management within the family (Birmingham & Solihull Mental Health NHS Foundation Trust, 2017). Mental health services were encouraged to provide support to families and carers, to use them as a resource, and to find some way of genuinely embedding this in all that they do.

“The role of family... [is a] big resource to us, traditional adult mental health services just see individual but the family is not involved...”

“The whole family suffers; confidentiality is a challenge that we need to think about. At the end of the day your family care for you, when you’re not in hospital. But then they get shut out when you’re in hospital... ‘sorry, we can’t tell you anything’...”

At one of our events the Triangle of Care was cited as an example of an approach that can reduce silo working and make better use of families and carers. The challenge is that

professionals are not trained to work with families or social networks and find it difficult in practice to deliver genuine family and carer engagement. The Triangle of Care approach² encourages professionals to acknowledge they don’t have all the answers and they can share knowledge and responsibility.

The six key elements state that:

1. Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
2. Staff are ‘carer aware’ and trained in carer engagement strategies.
3. Policy and practice protocols regarding confidentiality and information sharing are in place.
4. Defined post(s) responsible for carers are in place.
5. A carer introduction to the service and staff is available, with a relevant range of information across the acute care pathway.
6. A range of carer support services is available.

The Open Dialogue approach has something to offer here too, as it actively seeks for professionals, patients, families and wider social networks to seek a shared understanding of the need and how it can be met.

² Learn more about the Triangle of Care at <https://carers.org/triangle-care>

Findings part three: Culture of the workforce

The culture of the future workforce was repeatedly highlighted as key to this discussion. It was regarded as being central to creating a genuinely compassionate and healthy workforce that delivered effective care with sustainable impact.

Moving away from traditional roles

“...Why are we still talking about nurses, social workers, OTs and so on?”

There were voices in the events with competing views, but a great many of those we heard from described the need for a new mental health practitioner type role. Some saw this replacing basic qualification training for nursing and allied mental health therapists, and viewed the current professions as being ‘specialisms’ within a single mental health practitioner profession. Others were in favour of more merging of skills as a result of postgraduate training.

An example of the latter concerned a course in dementia diagnostics provided by the University of Bradford and offered to people from a range of clinical disciplines at postgraduate level. It is a part-time course, lasting a year which offers a postgraduate certificate³. Significantly, it helps spread knowledge that would traditionally have been seen as the domain of medicine among a range of practitioners. The aim was to speed up the time it takes to make a “...life-changing diagnosis...” and ultimately to offer support and care to those diagnosed with dementia.

“...there is a strong culture of service that needs to be challenged for new ways of thinking and innovation to thrive...”

Our stakeholders felt that many professionals were imbued with this ‘culture’. However, as stated previously it was not only professionals

who upheld traditional notions of the mental health team or service, but also regulators and government that often reinforce traditional notions of a ‘mental health team’. This thereby creates risk aversion and stifles innovation in service provision.

Risk aversion in the NHS was seen as a barrier to change. This was in part fuelled by recent crises, such as the review of deaths of patients while under the care of Southern Health. This has hampered positive risk taking and considering creative solutions. Regulators were seen as having a hand in this:

“...we need to rethink what we mean by ‘mental health team’: the mental health teams of the future will have to have different composition to what we have now...but we can’t get to that point if regulators have a fixed idea of what they are ...that you need to have a doctor doing this and so on...”

It was also noted at one event, however, that services can ‘too often hide behind regulators’ as an excuse to avoid making changes in anticipation of disapproval. It is up to service providers and commissioners to challenge inflexibility rather than simply to accept it.

The events listed many examples of successful non-traditional mental health care approaches, such as crisis cafes, outreaching to barber shops to access young black men, recovery colleges, coproduced projects with young people who were gang-involved, and Individual Placement and Support (IPS):

“...IPS is a really good example... we’ve trained lots of non-professional folk to deliver a successful and evidence-based non-traditional mental health service ... It should be a template for the development of other services...”

³ See www.bradford.ac.uk/study/courses/info/dementia-for-practitioners-with-a-special-interest-pgcert-part-time

However, much innovation was possible through “under-spends” and short term grants, and it was felt that commissioners and mental health providers needed to work together, to take more risks and to commit funding when pilots proved a success. In addition, it was noted that most of the new roles being created in mental health have been at the lower end of the career ladder (e.g. apprenticeships and associate roles). Our stakeholders stated it had long been a challenge in some mental health professions to develop a long-term career:

“...it’s a real shame, but if you don’t make people want to stay in mental health by having a career path for them to follow, then you end up losing lots of experience...”

While the new roles were welcome, there was also a need for developing career pathways for mental health professionals at every stage of their career. And some participants spoke of the need to challenge restrictive practices, for example to allow clinical psychologists to prescribe medication and some pharmacists to become Responsible Clinicians (under the Mental Health Act).

Integrated and multidisciplinary workforce

Stakeholders described ongoing problems in joined-up, integrated working, where individual staff members remained in silos, in part due to traditional professional badges. Stakeholders described the potential impact of better integration on both “the health care system as well as the individual”. Stakeholders discussed how there was an extremely highly skilled and diverse workforce in mental health which is currently not being utilised systematically. They discussed how joined-up working currently relies on personal relationships between practitioners, i.e “calling each other up”.

An example of the potential for greater integration was the huge challenge for mental health services relating to supporting people with medication. They described how pharmacy and psychology could be working more collaboratively to understand why people were not taking medication and what would help. Stakeholders highlighted the need for a multidisciplinary workforce, which did not work in professional silos but used each other’s expertise. This needed to happen throughout the system from management all the way to practitioners working on the ground.

There was a consistent message in all of the consultation events about moving away from the traditional medicalised model of mental health care, and a desire to move towards more psychologically and recovery informed models. The contribution of psychiatry was recognised, but notions that only a psychiatrist can be a Responsible Clinician were challenged. Forensic services in Nottinghamshire, for example, had had a non-medical in such a role for quite some time, and at the time of the event several more such roles were about to be rolled out. Whilst it has been possible to develop such roles for a number of years, our stakeholders told us that non-medical Responsible Clinicians were still quite rare.

Stakeholders described the experience of professions such as occupational therapy and clinical psychology not being considered “core” or essential to the mental health system:

“We’re always defending why we should be there. Why is there no national understanding of what these professions bring to the table?”

Traditional notions of a mental health team were felt by our stakeholders to be “steeped in” the ‘medical model’, for example in workforce planning focused solely on the medical and nursing professions:

“...Traditional narratives paralyse the system...”

There was consensus that this traditional model did not result in the best care for individuals as it located mental health problems and solutions within individuals (requiring treatment through medication) and neglected broader issues and protective factors (i.e. community, family) affecting their health. This model has also meant that the mental health system has been focused around diagnoses and professional labels, which individuals had to fit into, rather than services which flex around their needs. Stakeholders called for a radical change from the current way of working, which was perceived to stigmatise and not address needs:

“Why do we accept growing use of the Mental Health Act and traditional professional labels based on the asylum?... Let’s think about how things could be...”

“Why fix a system that’s unfixable? We currently fail to meet people’s basic needs.”

“What we do now is barbaric.”

Stakeholders described an “inner system prejudice”, where there was significant stigma within the mental health service system and stereotypes about people with mental health problems. Professional stakeholders described how it was still common to “distance and distinguish” themselves from mental health service users, even though many practitioners themselves have lived experiences of mental health difficulty.

Changing the nature of work

We heard a number of calls for change to the way work is organised in and around the NHS, in particular to give staff ‘more time to care’. We were told that many clinicians spend less than half of their time providing direct patient care; and that even reducing their administrative

burden marginally (for example by limiting data collection requirements) would free up significant amount of time for staff to spend with patients. It is also, however, important to build time into professionals’ routines for supervision and reflective practice as well as protected time to provide mentoring for those in training.

Psychologically informed services

Stakeholders called for services to shift to a more psychologically informed approach. Centre for Mental Health, in a report for another consultation, summarised what might constitute the elements of a psychologically informed service, and this is highly consistent with what was described at these consultation events, as described adjacent. A variety of psychological services were represented and discussed at the events. Across the events the contribution that psychological understanding and knowledge could make was acknowledged. Psychological formulations were seen by many as more useful in informing care than binary labels such as diagnoses.

There were mixed views on IAPT. For some, it was seen as a success story allowing several hundred thousand people to get access to evidence based care. But it was also seen as excluding many people who might benefit from psychological intervention, particularly those who fall below the threshold for secondary care and might benefit from an approach other than CBT or require a more adapted form, such as non-English speakers and those with more complex problems.

Psychological interventions were also felt to be sparsely available in secondary care, in inpatient settings, and for older adults, although we encountered examples of professionals who provide these services across the events.

Psychologically informed care

A psychologically informed approach can be seen as one which seeks to understand the motivations and thinking of the person, and where such knowledge informs how staff members react and respond both through day-to-day communication and through specific therapy. Developing such an understanding can allow workers to be proactive.

Psychological informedness is often used specifically when discussing people with personality disorder, and specific environments such as the Enabling Environment concept (developed by the Royal College of Psychiatrists and described by Johnson & Haig, 2012) and Psychologically Informed Planned Environments (developed by Department of Health, NOMS and NHS England). However, a psychologically informed approach also involves using formulations to understand the individual. Formulations can be described as having the following characteristics:

- A summary of the service user's core problems;
- A suggestion of how the service user's difficulties may relate to one another, by drawing on psychological theories and principles;
- The aim to explain, on the basis of psychological theory, the development and maintenance of the service user's difficulties, at this time and in these situations;
- Indication of a plan of intervention which is based on the psychological processes and principles already identified;
- Being open to revision and re-formulation.

(Johnstone & Allen 2006, cited in British Psychological Society (BPS) 2011, p. 6)

Formulations are an attempt to understand an individual in their context, and to do so using 'plausible account' (Butler, 1998 cited in BPS, 2011) in the form of a shared narrative, rather than a categorical diagnosis. The formulation provides a hypothesis to be tested and its narrative changes as the individual does.

Aspects of a psychological approach, such as formulations, lend themselves particularly well to working with people with complex and multiple needs.

Conclusion

Developing a mental health workforce to meet the needs of the future is a challenge for the whole of the NHS and its partners in local government, education and other public services. Without the right workforce, no national strategy or local plan can be implemented successfully. Yet the time it takes to develop a workforce can often be far longer than any single policy directive, strategy or plan.

This report has sought to take a longer term view in order to understand the likely direction of travel for mental health services and the people who work in (and increasingly with) them, to inform workforce development planning now so that it will be better able to meet people's needs over time. By changing the way we plan, recruit, train, retain and develop the mental health workforce in the short-term, we can bring about large scale change and make it possible to meet people's needs more effectively in the future.

The consultation findings reveal that the people we spoke to across the country want to see our mental health services radically reformed. As they often pointed out, many of the ideas that were discussed were not necessarily new: for example Open Dialogue and the Trieste model both have their origins in the very early 1980s. The potential role of peers, the benefits of coproduction and a desire for genuine community engagement were stressed at all events. So too were challenges to 'traditional' thinking around what is a mental health team and how we might train mental health practitioners.

There was optimism that the current challenges facing the mental health workforce (e.g. shortages in branches of psychiatry, the predicted negative impact of the loss of the nursing bursary, and a lack of career structure in some disciplines) create a real opportunity for introducing some of these proposed radical challenges. New associate roles offer the

potential to fill current gaps and these are being developed across the country. However, there was a concern that there was a 'piecemeal' nature to these developments and innovations. There is a need for a more systematic and strategic underpinning to proposed changes to the mental health workforce.

Although this review set out to explore options for the secondary care mental health workforce, those responding to the consultation stressed the need to make changes to primary care, not least of which being that all primary care practitioners should have significantly more mental health training. There was a recognition that thresholds for secondary care have always been high but that these have risen in recent times and that many people with quite complex needs fall below the threshold of secondary care and yet are too challenging for primary care. There were examples given of services both in the public and voluntary sectors that set out to meet the needs of people caught in this gap, but these were seldom suitably funded.

It is very clear that there is an increasing need for mental health practitioners to develop new skills and that these include the ability to offer consultation and thereby spread their expertise further than to just those they can provide direct care for. There is both a need and increasingly an expectation that mental health practitioners will work collaboratively with service users, carers and whole communities and that services are coproduced with those they are intended for. Supporting a workforce to make this change requires leadership and direction nationally, and bodies like Health Education England, NHS England, NHS Improvement and the Care Quality Commission have a role here. Those providing leadership need to work in collaboration with professional bodies and others to provide this and to support local leadership to ensure that these developments are always needs-driven. There is a clear role for Sustainability and Transformation Plans (STPs) in enabling such change to take place in local

areas, as part of the wider sustainability and transformation agenda.

Our respondents felt that commissioners needed to invest in reformed services, but recognised that widespread risk aversion – for example to changing established ways of working and patterns of provision – made that more challenging.

Commissioning itself was seen to be in crisis, with mental health commissioners not always having the status of other commissioners. There was a recognition that it is a discipline in its own right which requires a robust and rigorous knowledge base and therefore training. There was also a concern about the degree to which commissioning was done in ‘silos’ when effective mental health commissioning relies on effective partnerships between sectors and organisations. While the way health and care services are commissioned is likely to change in the coming years, the importance of the discipline of commissioning will not diminish and the need for skilled, capable people in these roles will be as great as ever.

We also heard significant concerns about services for people with learning disabilities and autism within mental health trusts, where pressures may be greater still and the need for a thorough review of the workforce is considerable. Similarly we heard about the loss in skills and knowledge on substance misuse, due to changes in the commissioning of these services, such that only a minority of mental health trusts still provide these services. This may and perhaps already does impact on the ability to deliver services for those with dual diagnosis and multiple and complex need.

As we ask mental health practitioners to work in new ways and settings and to develop and deploy new skills, there also needs to be attention given to helping providers with workforce planning capacity and capability. As the workforce strategy (Health Education England, 2017) acknowledges, it is up to NHS employers to develop their workforce, to create posts to meet changing needs and to implement

the changes set out in *The Five Year Forward View* and any future policies. And it will be essential for employers to establish what roles are required collaboratively with their own workforce.

The multidisciplinary nature of many of our mental health teams was valued by those attending the consultation events. It was seen to have much to offer in providing a broader understanding of need. But many of those who attended felt that mental health services were too “medical model dominated” and this was to their detriment. Psychologically informed thinking was highly valued, as were psychological interventions. So too was social care, and yet social work was seen as gradually being withdrawn from mental health care despite the continued need for its distinctive contribution to care and support.

Services must also be needs-driven; a much clearer assessment of local needs is required for a comprehensive offer and this must inform training plans and the development of the workforce.

The vision set out in this report will take many years to bring about. It requires major, and in some cases, fundamental changes to the way the mental health workforce is developed, recruited, trained, employed and supported. It implies major changes to the way services operate and work with those who use them, as well as their interactions with the rest of the NHS, local government and other public services. It builds on but looks beyond the current Five Year Forward View and its recently published workforce strategy, recognising that workforce development cannot be done quickly but that changes are needed now in order to bring about benefits in the future. And this report emphasises that the mental health workforce cannot be taken for granted – that mental health services need to show compassion to their workforce as well as the people they serve, and that nurturing people with the skills and capabilities to meet future need is a long-term investment that cannot be left to chance.

Recommendations

Attracting the workforce

1. Mental health service providers, training bodies and professional associations should reach out to schools and colleges advertising mental health career opportunities to young people when they are thinking about their futures.

Career pathways

2. Professional bodies, Department of Health and Health Education England should join together to develop a range of clear career pathways for mental health professions and professionals.
3. Service providers should develop career pathways that reflect their changing needs. This may mean creating opportunities for careers that go across professional and agency silos, and offering support and training in order for people to move on to different career routes. Career development should also reflect the stage in life each employee is in, for example this might mean roles appropriate to someone reaching retirement as well as support for retirement as they approach it. This all requires recognition from those with a national leadership role around the mental health workforce (including Health Education England, NHS England, NHS Improvement, Care Quality Commission and professional bodies).
4. Professional bodies and service providers should create a specific career pathway for inpatient care. This could be linked with crisis care in other settings to give staff a wider range of opportunities and to boost the status and profile of working in inpatient services.
5. Service providers should develop both professional and voluntary opportunities for those with lived experience. They should recognise that some people may wish only to volunteer as part of their own recovery journey, whereas others may have much more to offer long term and to develop

careers and take up training in a wide variety of roles at every level of the system.

Supervision and mentoring

6. Mental health service providers should provide the best possible management and clinical supervision and this should have both resource and time invested in it.
7. Service providers should recognise mentoring for students and trainees as a core aspect of work for mental health professionals, with sufficient time scheduled for mentors to perform these duties.

Training

8. Training providers and commissioners should ensure that training in all mental health disciplines equips new staff to develop skills to work flexibly in various settings and in multidisciplinary teams, with recovery and psychological underpinning. Training should focus on and enable practitioners to navigate complex health and care systems and to manage change.
9. Service providers and training bodies need to ensure that there is a sufficient number and variety of placements available to students and trainees for them to develop necessary skills.
10. Training bodies should ensure that all new training frameworks consider and invest beyond the NHS, including in the voluntary and community sector, in the independent sector, in health and social care more broadly and beyond.
11. Investment in training needs to be directed towards the existing workforce and in helping them to achieve the shifts in focus and expectations.
12. The General Medical Council, Royal College of GPs and education providers should ensure that all general practitioners and other practitioners in primary care have

significant and wide-ranging training in mental health. Similar approaches should be taken with other professions in building up their knowledge about mental health.

Competencies

13. Health Education England, the Department of Health and professional bodies should work together to describe the range of competencies that define 'mental health practitioner' and design a number of routes to achieve this or parts of this that go beyond 'traditional professional boundary' thinking, e.g. pharmacists in prescribing roles, peer workers as care coordinators.
14. Education and training providers should develop more postgraduate training for mental health service competencies that are open to a wide range of disciplines. An example currently is the University of Bradford postgraduate certificate in dementia diagnostics, which is open to a wide range of health professionals.
15. Education and training providers should develop training in consultation skills for mental health professionals. Consultation is an increasingly important means of spreading limited skills more widely.
16. Education and training providers need to develop training for collaborative approaches to service provision. Coproduction with service users and carers requires preparation and training for professionals.
17. Education and training providers and service providers should ensure that all mental health practitioners receive significant training in psychological intervention, for instance doing psychological formulations. The mental health service model of the future should be one that gives a greater role to psychological thinking and being psychologically informed. This needs to be reflected in the training of all professionals and in the development of mental health practitioner competencies.

Commissioning

18. Commissioners should include consultation in contracts with mental health providers to enable staff to share their expertise, for example with colleagues in primary care, the voluntary and community sector and more widely in schools and general health care and other settings. Consultation within primary care in particular should be a core duty and not an 'add on' for mental health services.
19. Education and training providers should develop specific training and development opportunities for mental health commissioners. Mental health commissioning must be recognised as a skill set in itself that requires specific training and continuing development.
20. Commissioners and providers of mental health services should work long-term to develop needs-led, holistic support services that are embedded in the community, that are coproduced with the people who use them, that are psychologically informed, and with a sufficiently skilled workforce.
21. Commissioners of mental health services and public health should jointly invest in prevention and engagement (for example with communities, families, schools and workplaces).

Wellbeing

22. Service providers and commissioners should prioritise staff wellbeing in all mental health services. Investing in staff wellbeing will improve productivity, boost retention and encourage more people to develop their careers within 'compassionate organisations'. All mental health service providers should aim to provide comprehensive support for their workforce's wellbeing. The 2009 Boorman Report on the health of the NHS workforce sets out a range of actions that all NHS employers should take to support health at work which should be the starting point for all organisations working in this sector (Boorman, 2009). Commissioners should seek evidence of this from the organisations they contract for mental health services.

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