London's Mental Health Workforce
A review of recent developments

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This is one of a series of papers being produced in 2002/03 as part of the King's Fund Mental Health Inquiry. This Inquiry aims to assess whether London's mental health and mental health services have improved over the past five years. In 1997 the King's Fund produced a report entitled London's Mental Health, describing services in inner London 'that cannot be sustained'. The current Inquiry asks what, if anything, has changed since then, as well as tackling some new questions.

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The King's Fund Mental Health Inquiry (2002/3) revisits many of the issues covered in its previous inquiry of 1997. This identified several areas of concern about the mental health workforce, specifically:

- a crisis in recruitment and retention of mental health professionals of all disciplines in London
- among primary care staff, a lack of skills to effectively manage mental health problems
- high levels of organisational and job instability and poor cross-agency working.

The reasons for some of the difficulties identified were not well understood at the time. This working paper explores workforce issues in greater depth, to throw light on the challenges currently facing the mental health sector.

Terminology

The true 'mental health workforce' consists of a large and unboundaried population that crosses from formal and statutory services to voluntary, non-statutory and informal support and contributions. Within this working paper, the focus has been narrowed to concentrate primarily on people working within defined, formal mental health services. This includes:

- psychiatrists
- mental health nurses
- social care workers
- clinical psychologists
- counsellors
- psychotherapists
- occupational therapists
- support workers
- general practitioners (GPs).

The paper looks primarily at the workforce involved in adult mental health services, rather than services for children, adolescents or older people.

Compiling an accurate and contemporary profile of both the statutory and non-statutory mental health workforce in London is problematic. Data are patchy, inconsistent and incomplete, and definitional problems exist. Consequently, large swathes of the mental health workforce are unaccounted for and can only be described in relation to the services that employ them.

The emerging profile

Across the board, the NHS faces problems recruiting and retaining staff – the latter tending to be the bigger issue. Some of these problems are particularly concentrated in mental

health services. An ageing workforce, violence and harassment, stress, overburdening workloads and role boundary issues are just some of the challenges in this field. The problem of staff retention is particularly acute in London, which may be unattractive to employees with families, and where the cost of living is high. Staff shortages are much worse in the capital than in most other parts of the NHS, and the demand for staff is expected to grow markedly over the next few years as the population grows. London is also more reliant than the rest of the NHS on overseas-trained staff and temporary staff, employed to help fill gaps.

There are particular problems with inpatient nurses in terms of staff shortages, high staff turnover, overuse of bank and agency staff and low morale. This evidence was supported by interviews carried out with nurses working in acute mental health inpatient wards in London. The overwhelming message was that acute mental health units are challenging and stressful working environments in which morale is heavily influenced by staffing levels. The nurses identified considerable anxiety about personal safety at work, and provided examples of violence, intimidation and drug dealing on the wards.

Occupational therapists also have high turnover rates. Two explanations offered for this are isolated working practices and a sense of being marginalised within the mental health team.

The Government's response

Government policy to address generic workforce problems is characterised by a drive to:

- boost the numbers of key staff
- improve working lives
- develop career structures and opportunities (for example, through a 'skills escalator')
- implement radical pay reform.

A number of initiatives have emerged that are of particular significance to mental health, detailed in the chapter on mental health in the NHS Plan and the National Service Framework for Mental Health (see p 13). These have led to a bewildering array of working groups, taskforces, action teams and guidance documents on developing workforce issues.

Use of temporary staff

The number of agency staff currently employed within the NHS is difficult to quantify accurately. However, there is evidence to suggest that trusts are using an increasing number of temporary staff. London stands out from the rest of the NHS because of its very high use of temporary nursing staff, and its far greater reliance on external agencies than that in other parts of England.

The increased turnover and vacancies among nurses and the consequent high use of temporary staff can lead to a vicious circle of shortage, low morale, lack of support and

a feeling that working in ward environments is unsafe – for both patients and staff. Heavy reliance on temporary staff also raises issues such as:

- continuity of care
- availability of specialist skills
- the support and induction needs of agency staff
- increased costs in the overall staff bill.

The nature of acute mental health units means that temporary staff who are unfamiliar with the ward and its patients tend to be of limited use, and may even increase burdens on permanent staff. However, the need to actively manage temporary staff has led to a number of positive initiatives, including the NHS Professionals scheme (see p 36).

Employing service users in the mental health workforce

Mental health services are expected to recruit and train service users as part of their workforce. Quantifiable data on user involvement within the NHS workforce are difficult to gather, due to factors such as non-disclosure of mental health history to employers by employees. However, there is an increasing recognition of the value that qualified healthcare professionals with personal experience of mental illness can contribute.

For instance, the Department of Health's guidance on support, time and recovery workers states that a current or ex-user of mental health services could make an excellent candidate. Also, the number of contemporary projects within and around London in which good practice is being modelled suggests that slowly, more service users are being encouraged to bring their experience and insights into the NHS workforce.

Refugees and asylum seekers and the mental health workforce

Refugees have many urgent needs when they arrive in a new country, including food, shelter and safety. However, in the longer term, health problems (especially mental health problems) such as post-traumatic stress disorder, may also become apparent. Many of these problems are compounded by the effects of racism, poverty and social exclusion. Access to appropriate services and care are major issues.

Many refugees have relevant qualifications and skills that could prove useful to a health service beset by staff shortages and desperate to recruit new workers. Many projects are being developed to match skills to jobs and create pathways into employment, but there are still a number of barriers that prevent the health service from making proper use of this workforce resource. Targeting refugee populations means not only boosting labour market supply but also enhancing the competence of the mental workforce to provide culturally appropriate care.

Mental health services in prisons

The issues of staffing in prisons and the mental health services available to prisoners are important and complex. It is beyond the remit of this working paper to examine them in any depth. However, there is a need for an independent, in-depth study into the issues around health services available to prisoners, and also for reliable data on the profile of mental health staff employed in prisons.

Conclusions

There is no ready data that provides a benchmark against which to compare the mental health workforce today with that of six years ago. However, evidence suggests that progress to address the deficiencies highlighted by the 1997 King's Fund Inquiry has been variable.

Definitional and data limitations make it difficult to quantify recruitment and retention problems with any certainty. There is a serious need for better data, collected routinely and according to national standards. Until then, it is difficult to judge whether the contemporary workforce in London is better equipped than that of 1997 to cope with the health and healthcare needs of individuals in London with mental health problems. There is, however, evidence to suggest that the crisis in recruitment and retention of mental health professionals persists, and that it threatens to undermine the Government's plans for service reform. The problem is particularly acute in London.

Government policy increasingly recognises the challenges faced by the mental health workforce. The emphasis on tackling these by facilitating local responses within national frameworks is welcome. The workforce programme of the National Institute for Mental Health (England), in particular, offers the potential to bring coherence to the problems facing the sector.

More attention is required on the issue of retention. Poorly configured and managed services put staff under pressure. The demands on mental health service staff can be particularly challenging and stressful. Training and education needs to better prepare mental health professionals for theses stresses and equip them with the necessary skills.

The acute mental health sector requires particular attention and more specific policy interventions. A range of measures is needed to improve the working environment for acute mental health nurses in particular. Clearer policies about acceptable behaviour by patients and visitors on the ward, together with the authority to take action where these are violated, and greater cross-agency collaboration (particularly with the police), are required.

Increasing capacity while strengthening responsiveness

One way of helping to address the social and health needs of the refugee and asylum-seeker population is to increase their employment opportunities. Employing refugees and asylum seekers within the health service could help tackle staff shortages and enhance the

competence of the mental health workforce to provide culturally appropriate care. Similar issues apply to employing mental health service users. However, real barriers continue to prevent the health service from benefiting from the skills of individuals within these groups. Until these are confronted, the mental health sector will continue to miss out.

The function of temporary staff in the workforce is being legitimised by initiatives (such as NHS Professionals) that seek to actively manage these staff. By recognising that temporary staff are a permanent characteristic of the workforce, the health service should be able to make better use of this resource. This would have significant implications for the mental health sector, where reliance on temporary staff is high, but where the contributions they are able to make are often very limited.

Recommendations

- An in-depth study of the acute mental health ward environment should be undertaken to examine the extent to which problems of violence exist, and are caused or compounded, by the consumption and dealing by outsiders and visitors of illegal drugs and alcohol on the wards.

- Clear drug and alcohol policies are needed for acute mental health wards. They should be backed up with mechanisms to support staff when these policies are violated.

- Workforce Development Confederations should carry responsibility for compiling robust data specifically relating to the mental health workforce. The Department of Health should co-ordinate this activity and ensure that the data are able to support its workforce planning and design.

- A minimum dataset which informs the routine collection of workforce information across the spectrum of specialties should be developed and introduced urgently.

- Language support, better information to guide refugees and more streamlined and co-ordinated approaches to identify and assist those refugees with professional qualifications into the health workforce, are all needed. NHS staff should be trained to understand and meet the needs of refugees.

- An in-depth study into the mental health services available to prisoners should be conducted along with an evaluation of the impact of primary care trusts (PCTs) taking over the provision of health care for prisons. To facilitate this, reliable data on the profile of mental health staff employed in prisons is needed.

Introduction

The new King's Fund Mental Health Inquiry revisits many of the issues covered in the previous inquiry of 1997 (King's Fund 1997) but also attempts to find out whether the needs of Londoners have changed, and whether the services they receive have improved, as well as tackling some new questions.

One aspect of the current Inquiry – the subject of this working paper – is to examine the profile of the mental health workforce in London and related issues. It highlights significant changes over the past five years alongside government policy and action around recruitment and retention to in this sector. It pays particular attention to initiatives that are helping to address the shortfalls identified by the 1997 Inquiry.

The working paper looks primarily at the workforce involved in adult mental health services, rather than services for children, adolescents or older people. It also investigates the following issues in some detail:

- the use of temporary (agency and bank) staff in mental health services
- the involvement of users of mental health services in the workforce
- the recruitment of refugees and asylum seekers to the mental health workforce.

It also draws attention to workforce issues in relation to mental health in prisons. However, this is an area in transition and its investigation is beyond the scope of this working paper. Instead, it highlights a number of key issues for further consideration.

Terminology

The mental health workforce extends across a wide range of professionals and non-professionals. For the purposes of this report, however, the 'mental health workforce' is limited to people working in mental health services, including:

- psychiatrists
- mental health nurses
- social care workers
- clinical psychologists
- counsellors
- psychotherapists
- occupational therapists
- support workers
- general practitioners (GPs).

The 1997 Mental Health Inquiry

The 1997 King's Fund Inquiry (King's Fund 1997) identified several areas of concern about the mental health workforce:

- A crisis was reported in recruitment and retention of mental health professionals of all disciplines in London. Many services were reported to have levels of agency and other non-permanent staff making up over 20 per cent of their total complement, with shortages of psychiatric nurses, psychologists, occupational therapists and psychiatrists of all grades. Evidence suggested that levels of staff burnout were high.

- GPs and practice nurses often appeared to lack the necessary skills to diagnose and manage mental ill health. Further, the distribution of mental health professionals in primary care was found to be patchy.

- The management structures of London's mental health services were characterised by high levels of organisational and job instability. The Inquiry identified problems in joint working with other agencies and also with medical colleagues. In many parts of London, there was evidence of a lack of management capability to manage change in a highly complex service system.

Workforce issues were not examined in any great depth. Also, the reasons for some of the difficulties identified were poorly understood at the time. However, the Inquiry made a number of recommendations around workforce, specifically:

- 'that a review should be carried out of the causes of difficulty in recruiting and retaining staff, and of ways of improving working conditions and attracting adequate numbers of appropriately qualified staff to work in the capital'

- that the training of primary care staff should 'become a high priority, with a focus on developing the detection and management skills of GPs and practice nurses.' Also, that ways should be found of making the availability of counsellors and psychologists in primary care more equitable, and that community mental health teams should consider ways of increasing integration with primary care services

- that managers should 'be provided with adequate training, support and guidance in policy implementation, comprehensive service planning and the management of change'. Also, that the 'impact on morale and staff effectiveness of repeated organisational restructurings need to be considered', and that ways 'be found of improving inter-agency working and communication'.

King's Fund (1997), p 371

Methods

Data for this paper was gathered through a literature review, interviews and surveys.

- Literature review A review of literature about recruitment and retention issues provided the context for this paper. Particular attention was paid to data relating to the use of service users, temporary staff, refugees and asylum seekers in the workforce.

- Interviews Semi-structured interviews were conducted with key stakeholders, employers, civil servants, health employment agencies and mental health professionals to explore views on recruitment and retention problems, and to scope other essential issues.

  Separate to this, interviews were conducted with a handful of nurses working in acute units in mental health trusts across London. The aim was to compile a snapshot of experiences of mental health nurses in these settings to provide a 'reality check'. Particular attention was paid to ward environment, the use of temporary staff, and staff safety.

- Surveys All 13 mental health trusts in London were asked to provide information about vacancy and turnover rates among specific workforce groups (see p 26).

Limitations of the data

Compiling an accurate and contemporary profile of both the statutory and non-statutory mental health workforce in London is problematic for a number of reasons. Firstly, data are patchy, inconsistent and incomplete. Moreover, where data do exist, these are only collected routinely within the NHS and social services in relation to mental health workers with a recognisable mental health qualification. This includes psychiatrists, mental health nurses, occupational therapists and so on. Categorisation is often crude, with all non-medical mental health staff lumped together as one homogenous group.

This means that large swathes of the mental health workforce – for example, in the voluntary and private sectors – are unaccounted for, and can only be described in relation to the services that employ them. Finally, it is difficult to map all the voluntary and private mental health services that exist in London as no coherent list exists.

Background and policy context

Across the NHS, the ability of health services to recruit and retain skilled health care staff sufficient to meet the health needs of the population is an increasingly pressing and complex issue. London's health care workforce faces particular challenges, with higher staff turnover and vacancy rates, within the context of a patient population that is growing faster in the capital than in other parts of the country. Against this backdrop is the mental health workforce in London.

The recruitment and retention crisis

There is evidence of a shortage of staff across all the professional groups working in mental health. The Sainsbury Centre for Mental Health (2001) maintains that about one in eight consultant psychiatric posts are unfilled at any one time, and there is heavy reliance on agency nurses to cover shortfalls in nursing. The problem is particularly acute in areas like such as London, which may be unattractive to employees with families and where the cost of living is high. This echoes a wider problem for London's health services in recruiting, retaining and motivating workers.

This problem is not new. Gournay et al (1998) found that one-third of mental health wards in London were routinely using agency nurses to maintain a full complement of staff. That same year, the Nursing Times reported that understaffing was the main reason that one in four wards in London were not able to admit severely disturbed patients, despite beds being available (Gullan 1998). There is anecdotal evidence that the problem has grown over the last five years and that it will continue to escalate.

There are a number of possible reasons for this, for example:

- an ageing workforce
- violence and racial harassment
- perception and stigma of the mental health sector
- cost of living
- work–life balance
- stress
- workload
- boundary problems with subspecialties
- training and career management.

These issues are examined in more detail below:

- An ageing workforce Studies predict that the number of 35–59 year olds will increase over the next four years, in contrast with the expected shortfall in younger professionals (25–34 year olds). This will have significant consequences for the workforce, particularly given that about 150,000 of the 1 million employed by the NHS are aged 50 or over and therefore eligible for early retirement (Meadows 2003).

- Violence and racial harassment A survey carried out by the NHS Executive in 1998/99 found that there were approximately 65,000 violent incidents against NHS trust staff in England each year. The average number of incidents was more than three times higher in mental health/learning disability trusts compared with the average for all trusts (NHS Zero Tolerance Zone website, details on p 56). Such incidents resonate both for the individual and for the organisation as a whole.

- Perception and stigma of the mental health sector There is evidence that coverage of mental health issues by the media has helped to discourage younger people from joining mental health services and has created a negative image of what a career in the service would be like. It may also have enhanced the stigma surrounding mental health illness (Health Education Authority 1999).

- Cost of living There is growing disparity between the cost of living in the capital and the earnings of key public sector workers. Many of those who train in London cannot afford to stay after completing their training. In August 2002, the average cost of a flat or maisonette in Greater London was £176,800 – twice the cost of the next most expensive region (the south east). Assuming a 100 per cent mortgage on three times average earnings, the salary required to buy into the London housing market at this price is almost £60,000 (Buchan et al 2002).

- Work–life balance Employment in the mental health services would be more attractive, to women and people returning from a career break in particular, were they to offer more flexibility and shorter working hours (Sainsbury Centre for Mental Health 2000).

- Stress Research has shown that approximately 20 per cent of professionals caring for people with dementia suffered from psychological distress. However, the levels of stress in staff working in NHS care homes were lower than those working in private homes, at 16 per cent and 22 per cent respectively (Margallo-Lana et al 2001).

- Workload When Kennedy and Griffiths (2000) examined the concerns of consultant psychiatrists, they found that the majority were experiencing increasing workloads. Overall, there was a feeling that only a few chief executives and trust boards were interested in monitoring their workloads and taking action when they were excessive.

- Boundary problems with subspecialties The Royal College of Psychiatrists (2001) has blamed recruitment problems on a lack of clarity about the roles and responsibilities of psychiatrists for causing recruitment problems. Some consultant psychiatrists report feeling like 'dustbins' into which the other subspecialties dump the people that they are reluctant to treat (Kennedy and Griffiths 2000).

- Training and career management Heavy workloads, combined with staff shortages knowledge and training by going on courses (Sainsbury Centre for Mental Health 2000). This, combined with unclear structures for career progression, has served to make a career in mental health less attractive than other specialties.

Some of the key motivators and demotivators for staff across the health service as a whole are summarised in Table 1.

Table 1: Motivators and demotivators in the NHS

Motivators	Demotivators
- hands-on management - appropriate delegation - stability - financial security - job satisfaction and training - acknowledgement of effort and good work - peer and inter-professional support - pleasant and safe environment	- poor leadership - inability to delegate - mistrust - instability - financial insecurity - destructive stress and burnout - job dissatisfaction - being taken for granted - workload and lack of training - no support - shortages and high turnover - poor environmental conditions and safety issues

Statistics compiled from Finlayson (2002)

Government policy on workforce

Since 1997, the Government has developed a number of policy initiatives designed to address recruitment and retention problems across the NHS generally, and specifically in mental health.

One of the Government's key objectives has been to build capacity in the health service by boosting numbers within the workforce. The NHS Plan (Department of Health 2000) promised by 2004:

- 20,000 more nurses
- 2,000 more GPs
- 6,500 more therapists.

More recently, Delivering the NHS Plan (Department of Health 2002a) promised a net increase by 2008 of:

- 15,000 consultants and GPs
- 35,000 nurses.

The extra staff will be made up of UK-trained graduates and topped up with staff recruited from overseas, at least in the short term.

However, there is evidence to suggest that these targets may be unrealistic. Gray and Finlayson (2002) argue that if the number of GPs and consultants continue to rise at past rates, it is unlikely that the Government will reach its targets for 2008. Between 1991 and 2001, the number of GPs employed in England increased by only 10 per cent, and the number of consultants employed by the NHS in England has risen by only 4 per cent per year since 1994.

Further, a significant recruitment and retention problem persists among some staff groups (especially radiographers, nurses, general practitioners and medical consultants). Additionally, increasing numbers of staff are approaching retirement age, particularly in community nursing and medicine (Finlayson et al 2002). That said, the Government claims to have reached its target for nurses ahead of schedule.

As well as boosting numbers, The NHS Plan contained a number of initiatives to improve the working lives of staff. For example, it announced £30m by 2004 for additional childcare schemes to support flexible working patterns, as well as £140m by 2003/4 for personal development and training, and plans to modernise pay. Improving Working Lives (Department of Health 1999a) also included plans to provide training and development opportunities. It also sought to increase options for flexible working, to introduce a 'zero tolerance' campaign against violence, and to better manage discrimination and harassment.

Priority has also been placed on developing career structure and opportunities for career progression. This is reflected in HR in the NHS Plan (Department of Health 2002b) and the promise of a 'skills escalator'. The Department of Health states:

> For staff it provides opportunities to develop their careers at any time of their working lives. Employers benefit from a structured programme of skills development and acquisition that supports recruitment and retention of staff, developing them to fill posts traditionally hard to fill
>
> Department of Health (2002b), p 4

The Government has also attempted to address staffing concerns about pay. It has set about changing the NHS pay system by focusing on ways of breaking down barriers and rewarding workers according to the responsibilities they undertake rather than the titles they are given. Agenda for Change (Department of Health 2002c) set out the frameworks for pay reform, the key elements of which include a clearer connection between rewards and responsibilities, incentives to change traditional ways of working to improve patient care, and greater flexibility for employers to pay more locally to recruit and retain staff.

Twelve sites have been selected to test the new pay deal from Spring 2003. London stands to gain the most initially, from enhanced regional pay, with more than £110 million being invested in the capital's workforce. One aspect of the reforms that could potentially be of particular benefit to mental health is the facility for NHS organisations to make additional payments to particular staff groups (over and above the basic pay), where these payments are needed to recruit or retain sufficient members of staff.

These reforms tend to mean compromises, which are not always welcomed by the workforce. For example, the promise of a higher basic salary and the removal of income restrictions on private practice for new consultants were not sufficient to convince the profession to accept extra on-call duties and other restrictions around private work. Medics expressed concern that managers would have too much control over consultants' pay, working hours, career progression and time spent in private practice (Gray 2002). In October 2002, consultants voted to reject the contract, and negotiations continue.

Government policy on the mental health workforce

The importance afforded mental health is reflected by the inclusion of a specific chapter on mental health in the NHS Plan. This showed that expanding the workforce by 2004 is a priority. Among the pledges was the promise to create:

- 1,000 new graduate mental health staff to work in primary care
- an extra 500 community mental health team workers
- 50 early intervention teams to provide treatment and support to young people with psychosis and their families
- 335 crisis resolution teams
- an increase to 220 assertive outreach teams
- 700 extra staff to work with carers.

These targets reflected the additional staff, across all groups, required by the standards and service models of the National Service Framework. Most government initiatives in relation to mental health services originate from the National Service Framework for Mental Health, published in 1999 (Department of Health 1999b). This is a major piece of policy, which sets national standards, puts in place underpinning programmes to support local delivery, and has established milestones and performance indicators against which progress within agreed timescales will be measured.

In terms of workforce, the framework highlighted the following critical challenges:

- recruiting across the range of mental health disciplines
- building a workforce that represents the community it serves
- staff retention
- enabling staff to develop modern mental health skills and competencies
- leadership.

A number of principles and aims were identified in order to meet these challenges; specifically, the need to:

- agree clear inter-agency workforce plans
- create workforces that represent the communities they serve
- ensure that education and training emphasise team, inter-disciplinary and inter-agency working
- provide professional development for staff
- enable strong leadership.

The overall aim was:

> ... to enable mental health services to ensure that their workforce is sufficient and skilled, well led and supported, to deliver high quality mental health care, including secure mental health care.
>
> Department of Health (1999b), p 3

At national level, the changes initiated by the National Service Framework for Mental Health and NHS Plan are overseen by the Mental Health Taskforce Board. This includes representatives of Government, the NHS and social services, service users and voluntary groups. At local level, each health and social care community has a local implementation team to plan and deliver change. These also comprise the statutory services for the area, together with service users, carers and local voluntary groups.

Each local implementation team produces a local implementation plan setting out how the National Service Framework standards, the NHS Plan and other changes will be translated into new local services, and how resources provided to achieve these aims will be spent. The local implementation plan should reflect progress in all of the underpinning programmes, of which workforce is one.

The Workforce Action Team was established to co-ordinate work in this area and support implementation of the National Service Framework for Mental Health and the NHS Plan. It produced a final report in 2001 (Department of Health 2001), describing its work and suggesting potential solutions to problems of recruitment and retention, poor workforce planning and poor education and training. The Workforce Action Team has initiated a number of important pieces of work. Two of the most significant are a framework of capabilities and the creation of a new staffing role.

- Framework of capabilities This framework, known as 'The Capable Practitioner', set out the knowledge, skills and attitudes required by the workforce to deliver the National Service Framework for Mental Health and the NHS Plan. The work was carried out by the Sainsbury Centre for Mental Health (2001) and will enable the skills, knowledge and competencies of the entire mental health workforce within adult mental health services to be assessed and developed.

- New staffing role Known as 'support, time, recovery' (STR) workers (WAT 2003a), the role of these staff is to support service users with mental health problems by spending more time with them and helping them to cope with daily activities and access services. They are not responsible for delivering treatment or care co-ordination.

   The Workforce Action Team estimated that 10,000 STR workers will be needed in England and expects some will convert from existing non-professionally affiliated roles, such as support workers in community mental health teams and acute ward nursing assistants. This should provide job opportunities to new populations of workers (particularly those who suffer from mental health illness). Also, other staff will be able to gain the knowledge of what users need from people with hands-on experience (Healy 2001).

The National Institute for Mental Health

On the back of these initiatives, the National Institute for Mental Health (England) – known as NIMHE – was launched in July 2001. Working with all agencies, the institute aims to develop a co-ordinated programme of research, service development and support for local services (Department of Health 2001a).

A small administrative centre oversees and supports the work of NIMHE. Eight regionally based 'mental health development centres' build on and sustain the work of pre-existing regional centres and local networks. The mandate of the centres is to drive change and help facilitate organisational development. They have strong links with the workforce development confederations and operate to given targets from the National Service Framework for Mental Health – although the way they respond to these will vary according to the needs of local organisations. The Department of Health reports that some of the NIMHE offices are already very developed, while others are confronting issues for the first time (personal communication 2003).

The workforce programme is split into five components:

- workforce design and development
- education development and training
- recruitment and training
- skill-mix and competencies
- leadership.

Progress within each of these areas is outlined briefly below.

- Workforce design and development Work here is conducted through the local implementation teams. The local implementation plans provide a good picture of progress. However, in 2001, 84 per cent of teams admitted that they were not there yet, and rated their progress under the traffic light system as either amber or red.

  A working group on workforce design and development has been established to advise local implementation teams, and the Department of Health is about to publish a practical guide to assist on implementation issues. This will be explicit about where responsibility for workforce planning lies and will provide a model for such planning, to help local implementation teams define demand for local mental health services and estimate the workforce needed.

- Education development and training A subgroup of the Mental Health Care Group Workforce Team has been developing a strategy to provide a sense of purpose to this programme. Many different agencies are responsible for implementation of National Service Framework targets in this area, although workforce development confederations are the focal point. The strategy aims to assist by being explicit about the roles and responsibilities of the various players.

- Recruitment and training There are two working groups in this area – one looking at psychiatrists and another on all other professional groups. The latter group is seeking to launch a national recruitment campaign to help drive local or regional campaigns. Engaging local communities is the centrepiece of work in this area.

- Skill-mix and competencies Developments here include the 'Capable Practitioner' document (mentioned on the previous page) and the national occupational standards for the mental health workforce, due to be published in Spring or Summer 2003. Headline standards will be launched in May. An implementation guide will follow soon after.

At the beginning of 2003, the Department of Health published best practice guidance on new graduate workers in primary health care, which addressed planning, training, recruitment and retention issues (Department of Health 2003b). A month later, it published a guide on STR workers that provided a framework for local agencies to introduce these new workers into the mental health workforce. The guidance is prescriptive around issues such as what an STR worker should not do, but in other respects allows for local application and decision making (Department of Health 2003a). Other guidance aims to facilitate the appointment of at least 500 community mental health staff or 'gateway workers' (Department of Health 2002d).

Work is also underway to look at new ways of working for consultant psychiatrists, with the aim to ease workload burdens. This working group is not expected to report until 2004. Finally, under the Mental Health Bill, the role currently undertaken solely by approved social workers will not be limited to this group in the future.

Leadership

This element of the programme is led by the Leadership Centre, at the Modernisation Agency.

An overarching strategy on workforce for mental health, which ties together the various initiatives described above, is due to be published by the Department of Health in Spring 2003.

Summary

Across the board, the NHS faces problems recruiting and retaining staff – the latter tending to be the bigger issue. Some of these problems are concentrated in mental health services. An ageing workforce, violence and harassment, stress, overburdening workloads and boundary issues are just some of the challenges needing to be addressed.

The Government has responded with a variety of initiatives. Expanding the size and skill-mix of the workforce are key features. With so much ground to cover, given the array of targets contained in the National Service Framework for Mental Health and the NHS Plan, co-ordination at a national level and support to local teams is vital. The National Institute for Mental Health in England, and its regional outposts, are therefore key.

Profile of the mental health workforce

Key points

- More consultant psychiatrists are opting for part-time posts. This trend may be suggestive of more women entering the profession and an increased desire for part-time work or of deliberative moves to balance the work–life balance.

- The number of general practitioners in London fell between 1999 and 2001.

- The number of psychiatrist consultants in England rose between 1997 and 2001.

- Despite a lack of adequate training, large numbers of practice nurses report seeing, and being involved with, patients with mental health problems.

- Turnover rates for registered mental health nurses in London are lower than that of registered adult nurses.

- Turnover rates for clinical psychologists are relatively high.

- There are high turnover rates among occupational therapists in comparison to other professions.

Mental health services in London

The mental health workforce within the NHS in London (excluding primary health care and prisons) is mainly employed within:

- NHS mental health trusts. Following the break up of combined community and mental health trusts in 2002, there are now 13 mental health trusts in London.

- Mental health nursing homes. The number of mental health nursing homes in England rose by 17.02 per cent between 1997 and 2001. In London, the number of nursing homes varies between North and South Thames. In North Thames, there was a 49.12 per cent increase between 1997 and 2001, while in South Thames during the same period, the number fell by 6.3 per cent (Department of Health 2002e).

The number of registered mental health beds in the NHS has risen since 1997. In England, the increase has been 2.14 per cent. In North Thames, the increase has been considerably more (28.20 per cent), but in South Thames the increase fell below England's growth, at 1.24 per cent (Department of Health 2002e).

The general health workforce

In spite of an increase in the total number of people within the health workforce in the past seven years, shortages of staff persist across all sectors of the health and social care workforce in England (Genkeer et al 2002). Further, the gap in the demand for, and supply of,

health care staff is growing. The situation for individual positions is examined in more detail below:

- Doctors. The overall number of medical registrants and doctors joining the register in the UK has increased over the past 10 years. By 2001, there were 73,850 (head count) medical staff employed in the NHS, a 17.5 per cent increase since 1995 (Department of Health 2002e).

- Nurses and midwives. Latest figures from the Department of Health (2002e) show that qualified nurses, midwives and health visitors currently employed in England make up the biggest staff group within the NHS: 266,170 whole-time equivalent (WTE); 330,540 headcount. Overall, this represents an increase in the total nursing population since 1997, when the number of qualified nurses employed in the NHS fell to a low of 246,010 whole-time equivalent (Department of Health 2001b).

- Social care workers. Since 1996, there has been a 9 per cent increase in the number of whole-time equivalent social work staff providing services for children and adults or elderly client groups, as well as those working in specialist teams. However, there has been a fall in the number of day care staff – for example, those working with adults with learning disabilities, the elderly or mentally infirm and adults with physical disabilities and mental health problems.

  The number of residential care staff has also decreased (by 21 per cent between 1996 and 2001), with most of this decrease in those working with older people and those who have dementia and/or Alzheimer's disease. The number of residential care staff working with adults with mental health problems fell from 2,100 in 1996 to 1,700 in 2001 (Department of Health 2001c).

- Allied health professionals. The NHS in England employs 40,530 whole-time equivalent allied health professionals, of whom the largest groups are:

  – physiotherapists (12,510 WTEs)
  – occupational therapists (11,190 WTEs)
  – radiographers (9,170 WTEs) (Department of Health 2001b).

  There has been a steady increase in the number of allied health professionals registered with the Health Professions Council (formerly the Council for the Professions Supplementary to Medicine, or CPSM) from 1988 to 2000. Between 2000 and 2001 the total number registered increased sharply, partly as a result of three new staff groups (speech and language therapists, clinical scientists and paramedics) joining the register for the first time (Finlayson 2001).

London's health workforce

A recent report by the King's Fund has shown London to be markedly different from other parts of the country in terms of health care workforce (Buchan et al 2002). The NHS in London employs more than 175,000 workers (NHS Confederation 2002), but NHS Plan targets and service needs indicate this number will have to grow over the next decade.

Staff shortages are much worse in the capital than in most other parts of the NHS, and the demand for staff is expected to grow markedly over the next few years. The population of London is likely to increase by 700,000 by 2016 (Greater London Authority 2002a) and health services in the capital have to ensure they deploy enough skilled health care staff to meet the health and health care needs of this population. Employers are already facing recruitment and retention problems, and motivation and morale among staff remains low.

The following situation is emerging in London:

- There are higher staff vacancy and turnover rates than the England average, especially among inner city and teaching trusts. Turnover rates are highest among allied health professionals. Vacancy rates are highest among allied health professions, doctors and dentists, and lowest among support workers.

- Despite being a training ground for health care professionals from across the UK and abroad, London struggles to retain staff within a few years of qualification, due to high living costs.

- The NHS in London is more reliant than the rest of the NHS on overseas-trained staff to help fill vacancies, and may be more vulnerable to international competition for them.

- London's NHS is much more reliant on temporary staff – and the external agencies that supply them – than elsewhere in the UK. Within London, there are marked variations in the use of temporary staff.

- The capital has an older general practitioner workforce than the England average. However, for most other groups, such as allied health professionals and nursing staff, the age profile in the capital is younger than the national average.

- The NHS workforce in London is more ethnically diverse than the England average. However, it is still not representative of the ethnic diversity of the local population.

The mental health workforce

This section looks at the situation for the following members of the mental health workforce:

- general practitioners
- psychiatrists
- nurses
- counsellors
- occupational therapists
- psychotherapists.

General practitioners

General practitioners tend to see a substantial number of patients with mental health problems, as they are the first point of contact for care, and serve as 'gatekeepers' to wider services. As such, the primary care setting provides the greatest opportunities both for detecting and preventing mental illness. And yet many GPs lack confidence in managing and

treating mental health illnesses, which may reflect that less than 30 per cent of GPs have held a postgraduate psychiatric post (Department of Health 2001d). Moreover, GP shortages in some areas of London are acute, particularly in inner and east London, and many GPs are already over-burdened by large caseloads.

The table and figures below show that the number of unrestricted GP principles and equivalents between 1999 and 2001 has risen very slightly in England as a whole, by 0.13 per cent, and has fallen in London, by -0.13 per cent.

Table 2: Number of unrestricted principles and equivalents, 1997–2001*

	1997	1998	1999	2000	2001	Growth rate (%)
London	-	-	3,739	3,174	3,734	0.13
England	25,678	25,831	25,902	25,922	25,938	1.01 (0.13)

* WTE

Statistics compiled from Department of Health (2002e)

Figure 1: Number of unrestricted principles and equivalents in England, 1997–2001
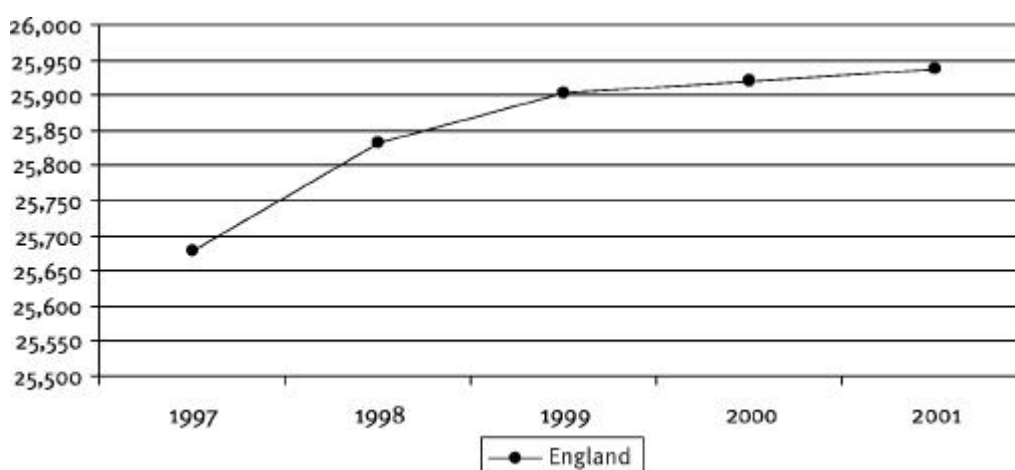
Statistics compiled from Department of Health (2002e)

Failure to detect some early mental illness, such as depression, and treat it appropriately within primary care may lead to progression to serious mental illness (including an increased risk of suicide and para-suicide), ultimately requiring more intensive treatment and resources.

Jenkins (1992) highlighted the importance of using secondary care staff to provide an educational and supportive role to the GP and others in the primary care trust in order to treat individuals with depression appropriately. Jenkins also encouraged the employment of practice nurses, counsellors and health visitors to work within the mental health domain to support GPs and enhance their capacity to treat patients with depression and prevent the illness from progressing. However, while there is evidence of some improvements in the overall quality of primary care mental health services, questions remain as to the long-term effectiveness of counselling services provided within general practice.

Psychiatrists

Table 3 shows that the overall number of psychiatric consultant posts has risen between 1997 and 2001 by 13.13 per cent, as has the number of consultants in posts (12.81 per cent, whole-time equivalent).

Table 3: Consultant psychiatrists in England, 1997–2000

	1997	1998	1999	2000	2001	Growth rate (%)
Total consultant posts	2,872	2,971	3,050	3,187	3,249	13.13
No of consultants in post	2,486	2,552	2,696	2,816	2,861	15.08
No of consultant vacancies	386	419	354	372	388	0.52
Vacancies filled by locums	248	278	207	232	211	-14.92
WTE consultants in post	2,316.3	2,362	2,471	2,587.4	2,612.91	12.81

Compiled from statistics supplied by the Royal College of Psychiatrists (2001)

Table 4 shows that the overall number of part-time posts for general psychiatrists has increased by 70.6 per cent. There is a greater rise among female psychiatrists, reflecting the increased number of women entering the medical workforce generally.

Table 4: Gender of general psychiatrists in England, 1997–2001

Year	Total posts (including vacancies)	Full time		Part time		Vacancies filled by locums	Vacant posts	Locum posts
		Male	Female	Male	Female			
1997	1,321	784	210	72	70	129	56	N/A
1998	1,368	797	187	89	96	147	52	N/A
2000*	1,482	848	237	99	110	130	58	29
2001	1,525	854	235	112	130	119	75	50
Growth rate (%)	15.44	8.93	11.90	55.56	85.71	-7.75	33.93	72.41**
* Data not available for 1999 ** Growth rate calculated using 2000 and 2001 data								

Compiled from statistics supplied by the Royal College of Psychiatrists (2001)

Table 5, over the page, shows the number of consultants in forensic psychiatry in England in full- and part-time posts between1997 and 2001. These have risen by 30.6 per cent and 53.8 per cent respectively. Overall, the number of consultant posts (whole-time equivalent) also increased, by 34.8 per cent, which may be due to the increase shift to part-time working and increase in activity. This trend may be suggestive of more women entering the profession and an increase desire for part-time work, or of deliberative moves to address the work–life balance. However, there has been a 34.7 per cent increase in activity (in sessions per week) in the last five years. So, despite the increase in consultant numbers, there may still be a feeling of acute shortage.

Table 5: Consultants in forensic psychiatry in England, 1997–2000

Year	Full time	Part time	Vacant	Total posts	Vacancy rate (%)	WTE cons posts	Total sessions per week
1997	111	13	25	149	16.8	113.3	1,246.5
1998	118	12	23	153	15.0	118.6	1,305
1999	144	13	17	174	9.8	146.5	1,611.5
2000	152	21	17	190	9.0	157.6	1,733.5
2001	145	20	16	184	8.7	152.7	1,679.5
Growth rate (%)	30.6	53.8	-36.0	23.5	-48.2	34.8	34.7

Compiled from statistics supplied by the Royal College of Psychiatrists (2001)

Table 6 shows that the number of general adult psychiatry consultants in part-time posts has risen by almost 59.15 per cent between 1997 and 2001. Again, this trend may be suggestive of more women entering the profession and changes in working patterns. There was also an increase in activity of nearly 1,904 sessions per week between 1997 and 2001 – which equals a 17.28 per cent rise in workload.

Table 6: Consultants in general adult psychiatry in England, 1997–2000

Year	Full time	Part time	Vacant	Total posts	Vacancy rate (%)	WTE cons posts	Total sessions per week
1997	994	142	185	1,321	14.0	1,001.3	11,014.2
1998	984	185	199	1,368	14.5	1,019.8	11,218
1999	1,044	199	175	1,418	12.3	1,089.36	11,983
2000	1,085	209	188	1,482	12.7	1,145.9	12,605
2001	1,055	226	194	1,525	12.7	1,174.4	12,918
Growth rate (%)	6.14	59.15	4.86	15.44	-9.29	17.29	17.28

Compiled from statistics supplied by the Royal College of Psychiatrists (2001)

The Royal College of Psychiatrists (2001) points out that a continuing steady growth in non-consultant career grades has major implications for consultant staffing. The figures suggest that women are choosing to divert to this grade rather than move into higher psychiatric consultant grades, possibly demonstrating a need to balance home and work life demands. Given the numbers of women in the workforce, this could have serious long-term impact on the numbers of consultant psychiatric staff.

Nurses

Since the late 1980s and the development of Project 2000 education programmes for pre-registration nursing, mental health training has been a pre-registration specialisation of nursing. That is, nurses can choose to become qualified within mental health at the outset of nursing training, though others can undertake further training following their qualification as nurses. These nurses then register as mental health nurses with the Nursing and Midwifery Council.

Figure 2, below, shows the total number of qualified mental health nurses in relation to the nursing workforce as a whole.

Figure 2: Number of qualified nurses, midwives and health visitors in England in psychiatry and all other areas of health care, 1997–2001
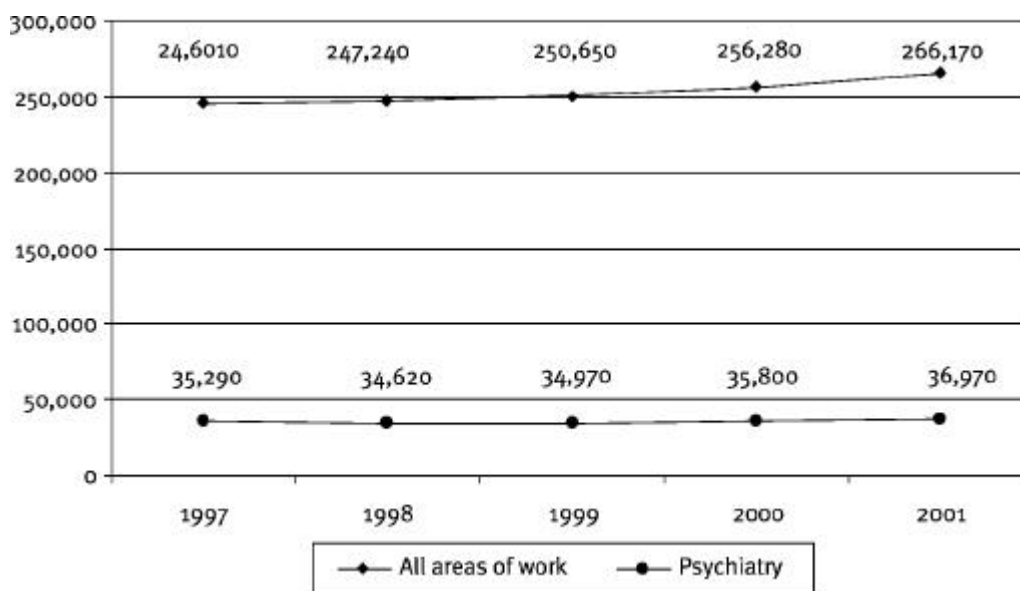
Compiled from statistics from Department of Health (2002e)

While the nursing population has increased slowly over the last few years, the nursing workforce with mental health qualifications has not kept pace. Within primary health care only 2 per cent of practice nurses have undergone formal mental health training and yet 43 per cent report being involved in early detection of depression and anxiety. Eighty-nine per cent report regularly seeing patients with mental health problems while at the same time 87 per cent felt they had inadequate training (Department of Health 2001e).

Counsellors

Although mental health patients tend to seek advice initially from GPs, GPs usually lack the time or training to conduct long therapy sessions. In such cases, counsellors are employed to help treat these patients. There is a lack of available data relating to the number of counsellors working in NHS mental health services. However, research by the King's Fund suggests that access to counselling has increased since 1997, with the majority (80 per cent) of a 20 per cent sample of London GP practices having access to counsellors in their own or neighbouring practice. Nevertheless, two-thirds of counsellors were available for only one to two hours each week (Rosen and Jenkins 2003).

Occupational therapists

The College of Occupational Therapists has about 23,000 full members, of whom 30 per cent (roughly 6,900 occupational therapists) work in mental health (personal communication

2003). As the data in Table 7 show, between 1997 and 2001 the number of occupational therapists employed in the NHS gradually rose from 9,790 to 11,820 respectively (whole-time equivalent) – a 21 per cent increase over the five years from 1997 up to and including 2001.

One study (Lynam and Walker 1999) found that the largest area of practice for occupational therapists employed within mental health services was general adult psychiatry, and that most of these staff worked in the community. The largest area of specialism within mental health was forensic psychiatry.

Table 7: Therapeutic staff (WTE) by area of work in England, 1997–2001

	1997	1998	1999	2000	2001	Growth rate
Occupational therapy	9,790	10,190	10,790	11,190	11,820	20.7
Psychotherapy	320	350	370	410	470	46.9

Statistics compiled from Department of Health (2002e)

Figure 3: Number of occupational therapists and psychotherapists in England, 1997–2001
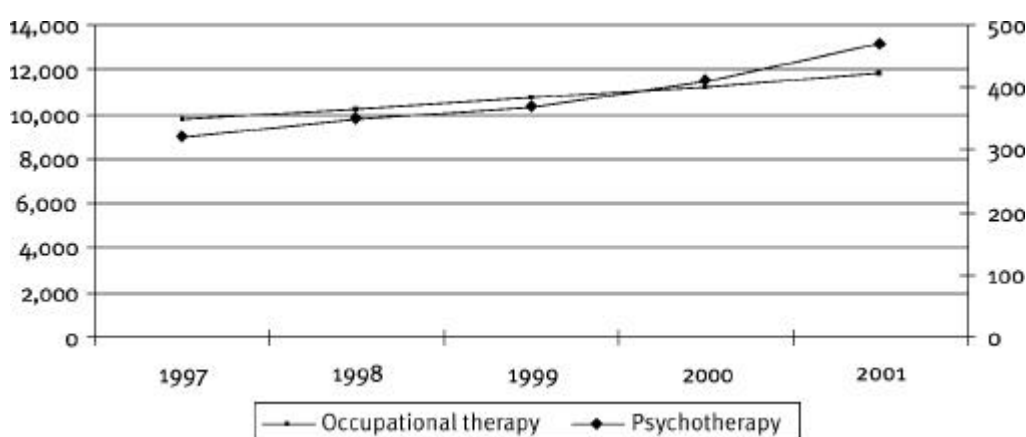
Compiled from statistics from Department of Health (2002e)

Psychotherapists

Over the past five years, the number of consultant psychotherapists (psychiatrists who work in psychotherapy) has risen by 47 per cent. Obtaining more information about other groups of psychotherapists is extremely difficult as they are not regulated by statute. The British Psychological Society holds the register for chartered psychotherapists. The United Kingdom Council for Psychotherapy holds the register for psychotherapists who meet its standards. However, some psychotherapists are not registered with either of these bodies.

Table 8: Consultants – psychotherapy in England, 1997– 2001

Year	Full time	Part time	Vacant	Total posts	Vacancy rate (%)	WTE cons posts	Total sessions per week
1997	49	68	11	128	8.6	89.2	981.5
1998	50	68	8	126	6.3	88.8	976.5
1999	48	63	6	117	5.1	83.9	923
2000	56	63	8	127	6.3	90.6	997
2001	61	57	6	125	4.8	92.3	1,015
Growth rate	24.49	-16.18	-45.45	-2.34	-44.19	3.48	3.41

Compiled from statistics from Royal College of Psychiatrists (2001)

Vacancy and turnover rates

Vacancy and turnover rates are commonly used to measure recruitment and retention:

- Turnover rates represent the number of staff who have left a post and moved to another NHS organisation or have left the NHS altogether, over one year.

- Vacancy rates are the number of unfilled established posts at a particular point in time (typically 31 March). They may be calculated from the first day a post becomes vacant (the definition used by the Royal College of Nursing) or limited to posts that have been vacant for three months and that trusts are actively trying to fill (the definition used by the Department of Health). Because vacancy rates represent a 'spot-check' on a particular day of the year, turnover rates tend to be the more reliable indicator of recruitment and retention (Finlayson et al 2002).

Table 9 shows the turnover and vacancy rates for five staff groups employed in mental health trusts in London:

- registered mental health nurses
- community psychiatric nurses
- psychiatrists
- clinical psychologists
- occupational therapists.

These categories are examined in more detail from p 27.

Table 9: Turnover and vacancy rates for mental health trust staff in London, 2001–02

	Registered nurse (mental health)			Community psychiatric nurse			Psychiatrist			Clinical psychologist			Occupational therapist		
	Staff in post 31/03/02	Turn-over	Vacancy	Staff in post 31/03/02	Turn-over	Vacancy	Staff in post 31/03/02	Turn-over	Vacancy	Staff in post 31/03/02	Turn-over	Vacancy	Staff in post 31/03/02	Turn-over	Vacancy
		31/03/02 (%)			31/03/02 (%)			31/03/02 (%)			31/03/02 (%)			31/03/02 (%)	
Trust															
1	858.40	20	14	99.55	24	3	81.00		3	58.40	41	14	58.77	30	12
2	652.00	21	14	224.64	11	9	69.00		0	81.00	18	14	54.33	45	0
3	550.74	7	25	86.97	14	5	48.01	8	0	82.65	3	21	65.06	9	31
4	432.58	16	17	87.39	15	3	7.18	13	5	111.30	7	0	49.77	28	27
5	570.00	14	17				57.00		13	47.00	21	20	51.00	27	22
6	471.00	17	15	57.00	4	-14	46.00		8	60.00	19	1	36.00	37	57
7	320.98	11	13	112.38	7	4				51.96	6	11	41.19	34	27
8	1,232.36	13	15	253.00	0	0				184.30	33	5	143.61	28	11
9	649.60	16	23	113.60	13	5	70.80		13	136.50	12	5	90.90	24	22

King's Fund (2003)

The data in Table 9 were obtained by contacting London's mental health trusts. Not all of the trusts had figures available for all the professions involved in mental health, so the data should be treated with some caution, given that trusts may collate data differently. In this respect, the following should be noted:

- Staff in post are expressed as whole-time equivalents.
- Staff in post rates, for all staff groups except psychiatrists, are taken from trusts' returns to the workforce development confederations.
- Staff in post rate for psychiatrists is taken from the Department of Health medical and dental workforce census, and are accurate as at 20 September 2001.
- Psychiatry statistics supplied from the Department of Health, except for those relating to South West London and St George's Mental Health Trust.
- Psychiatry statistics from South West London and St George's Mental Health Trust include psychotherapists.
- Figures on community psychiatric nurses for Trusts 3 and 4 are taken from the previous year – 31 March 2001.

The turnover and vacancy rates for each group are discussed in the sections following.

Registered mental health nurses

- Turnover rate: 11–21%
- Vacancy rate: 13–23%

Turnover rates for registered mental health nurses are at between 11 per cent and 21 per cent. The rates for Trusts 1 and 2 are slightly higher than those in other trusts in London. Turnover rates for registered mental health nurses working in London appear to be lower than the rates among registered nurses (adult) working in London, which range from 11 per cent to 38 per cent.

One explanation may be that turnover rates for registered mental health nurses were high several years ago as a result of organisational changes, such as mergers between trusts. Turnover rates have stabilised at an overall lower rate in subsequent years. Furthermore, a merger between two organisations with disparate turnover rates is likely to produce a more moderate turnover rate in the new organisation. Vacancy rates among registered mental health nurses are at between 13 per cent and 23 per cent.

The Department of Health recognises particular problems with inpatient nurses. It has identified shortages of staff, high staff turnover, overuse of bank and agency staff and low morale (Department of Health 2002f). A further problem is that whereas community mental health nurses are recognised as specialists, there may be less recognition of the specialist skills, knowledge, expertise and attitudes required of nurses working in acute settings.

Interviews with nurses working in acute mental health inpatient wards in London provided some insight into why retention of nurses in this area might be a problem. The overwhelming message was that acute mental health units are challenging environments in which to work and can be extremely stressful. Morale tends to be variable and is heavily influenced by how short-staffed a unit is. One staff nurse reported 'lots of arguments' over staff shortages in the unit in which she works.

One ward manager said that senior staff tended to be older and to stay in post, while there was a transient population of staff nurses. He believed that nursing training inadequately prepares nurses for acute mental health, which means they quickly become disillusioned once in the job. While an older workforce may be more stable in terms of mobility, it brings problems of its own: another ward manager said that six or seven nursing staff in his unit would be retiring within the next two years.

Flexibility (around working patterns, in particular), autonomy and control appear to be key in dictating job satisfaction and morale. The nature of acute mental health wards means that nurses are not able to pre-assess patients or control admissions. One nurse said 'We get whoever comes through the door.' A recurring theme was patients being admitted when the purpose of admission was unclear or inappropriate. Upward slippage from community teams was also a problem: 'We're still taking what no one else wants,' said one nurse.

Boundary problems are also manifest in the way that nurses in acute units feel they have to deal with the social needs of their patients, such as rehousing, because no other agency addresses these needs. One nurse explained: 'We can deal with the psychiatric issues – what we can't cope with are the complex social needs that patients come in with.'

Safety is also a major issue for acute mental health nurses. All of the nurses interviewed said they had felt concerned for their personal safety at work. Many had been personally threatened, or had witnessed threatening behaviour. One observed a nursing colleague get badly beaten by a violent patient a few weeks previously. This nurse described how she no longer liked to be in the office alone and often felt frightened. Another said he and two other colleagues had themselves suffered mental health problems as a result of verbal and physical abuse.

A distinction was often made between patients who were violent or aggressive because of their mental health condition and those who were violent because of alcohol or drug use – and the latter group were thought to be behind most violent confrontations. Many mental health patients on acute wards were reported to have substance misuse problems and there were anecdotal accounts of drug dealers coming onto the units to supply illegal drugs. One nurse described the problem of illegal drugs on his unit as 'phenomenal'. Another said patients would often be the ones dealing drugs.

Nurses tried to assert control in these situations, but cited occasions where patients or drug dealers had threatened them as a result (threats included 'coming after' the member of staff on their way home or once they got home). Some described situations in which they had sought support from the police, but this had not always been effective, and some felt the police simply were not interested. The availability of psychiatric emergency teams helped, but for units that were geographical isolated, such support was at a distance.

Two nurses also mentioned that guns had been brought on to the ward, and in addition to physical violence, a high level of verbal abuse was reported. Although these accounts were anecdotal, the same story was repeated time and again by the nurses interviewed. The overall picture was one in which staff were working in conditions that would be considered unacceptable in any other field, and which undoubtedly had major implications for the recruitment and retention of nurses to the acute mental health sector.

Community psychiatric nurses

- Turnover rate: 0–24%
- Vacancy rate: 0–9%

Turnover rates among community psychiatric nurses are at between 0 and 24 per cent. Apart from Trust 1, which has a rate of 24 per cent, turnover rates among this staff group are generally lower than among registered mental health nurses. Vacancy rates for community psychiatric nurses are at up to 9 per cent.

Psychiatrists

- Turnover rate: 8–13% (estimate)
- Vacancy rate: 0–13%

Turnover rates are not generally available for psychiatrists. This is because the figures for psychiatrists are collated by the Department of Health rather than the Workforce Development Confederations, and it uses three-month vacancy rates as its indicator of retention. However, one Workforce Development Confederation has collated turnover rates for psychiatrists and reported rates of 8 per cent in one mental health trust and 13 per cent in another. Vacancy rates for psychiatrists are at between 0 per cent and 13 per cent.

According to the Royal College of Psychiatrists (2001), locums occupy two-thirds of consultant vacancies for psychiatric staff, although the pattern varies across different specialties and regions. For example, in Northern Ireland no vacancies were reported, while significant recruited problems were identified in Wales. In England, there are high vacancy rates in Mersey, Trent, North West and West Midlands.

Clinical psychologists

- Turnover rate: 6–41%
- Vacancy rate: 1–21%

Turnover rates for clinical psychologists are at between 6 and 41 per cent. Of the seven trusts that employ clinical psychologists, five have turnover rates of 18 per cent or more, and two have turnover rates of more than 30 per cent. One reason for the comparatively high turnover rates may be that there are currently fewer clinical psychologists than available posts. Vacancy rates for this staff group are at between 1 and 21 per cent.

Occupational therapists

- Turnover rate: 24–45%
- Vacancy rate: 0–57%

Turnover rates for occupational therapists are higher than the preceding four staff groups, ranging between 24 per cent and 45 per cent. Of the eight trusts employing occupational

therapists, seven recorded turnover rates in excess of 25 per cent and five had turnover rates of 30 per cent or higher. Further, the figures suggest that turnover rates are higher in mental health trusts than in acute trusts.

Vacancy rates for occupational therapists are also higher than in any of the four preceding staff groups, at 0–57 per cent. Other figures have put the vacancy rate for occupational therapists at 7 per cent in London and 4.1 per cent for England as a whole (Lim 2002).

A number of factors may explain the high turnover. Usually just one occupational therapist will work on a mental health ward, or as part of a mental health team in the community. Without proper support and supervision from their professional colleagues, they can become isolated. There is some evidence that occupational therapists working in mental health experience more stress than those working in other areas. As the sole occupational therapist on the mental health team, they can sometimes feel marginalised within that team (personal communication 2003).

These sentiments are reinforced by the fact that nurses in mental health qualify for a mental health allowance to which occupational therapists in the sector are not entitled. Furthermore, money allocated to trusts for staff training and development often goes through nursing budgets, making it difficult for occupational therapists to access further training, develop their skills and progress their careers. Additionally, few postgraduate courses meet the specific needs of occupational therapists working in mental health.

These factors are compounded for occupational therapists in London, who must meet the higher housing and living costs associated with the capital on a limited salary. (A newly qualified occupational therapist can expect to earn £18,400–£21,000 in a London trust.)

Lynam and Walker (1999) claimed that occupational therapists in mental health were being promoted to aid retention levels, sometimes without necessary experience. The main concerns of occupational therapy managers within mental health services were problems of recruitment and retention of staff in inner city or remote areas. Other concerns included poor response to advertisements and attracting staff with sufficient experience, as well as support and development of staff. Some managers said that basic-grade occupational therapists were not well-prepared for working in mental health. The study also pointed towards relatively low numbers of newly qualified staff entering the mental health field.

General practitioners

- Turnover rate: Not applicable
- Vacancy rate: 0–9%

In the 1970s, a number of GPs from south Asia were recruited to the UK to plug gaps. A significant number of these are now nearing retirement, and in some areas – particularly in London – this could mean the loss of one in four GPs in the next few years (Taylor and Esmail 1999). London has significantly fewer GPs aged 35–49 than in England as a whole, and significantly more GPs aged over 50 than the England average (Department of Health, 2001f).

Another study, conducted as part of the 2002/03 King's Fund Mental Health Inquiry, found that fewer than half the London practices contacted contained a GP with a particular interest in mental health (Rosen and Jenkins 2003). Staffing and skills shortfalls within practices (GPs, counsellors and lack of practice-based community psychiatric nurses) were among the most pressing problems faced by these practices.

A survey by the London Evening Standard (Frith and Wilkinson 2002) found that in all 32 primary care trusts in London, 197 GP posts were vacant for three months or more. This represented nearly twice the national average vacancy rate (4.9 per cent of London GPs). This finding throws doubt on whether the Government will be able to meet its targets for 2004, which it set out in the NHS Plan. In addition, in some parts of the capital, one in six GP posts was empty – eight times the national average of 2.7 per cent.

Summary

Developing a coherent picture of London's mental health workforce is difficult for a number of reasons. Most data exist for England alone and are not broken down. The data that do exist are patchy. However, a recent report by the King's Fund demonstrates that many of the trends and issues in the health workforce for England as a whole are also true for London. However, these problems are greater and more complex within the capital. This is for a variety of reasons:

- Staff shortages in particular are much worse in the capital than in most other parts of the NHS.
- The demand for staff is expected to grow markedly over the next few years.
- Employers are already facing recruitment and retention problems.
- Staff motivation and morale remains low.

Within the mental health workforce a number of trends can be identified at a national level, namely:

- an increase in women in psychiatry and a move towards part-time work
- an increase in the number of consultant sessions, which may outweigh the overall increase in consultant staff
- an ageing workforce of general practitioners, with many retiring over the next five years, therefore exacerbating shortages.

Within London, there is a lower turnover of mental health nurses than there is in adult general nursing. This could be due to a variety of reasons, but it suggests that there may be an older and more stable workforce in mental health nursing. However, this can present problems of its own. In the longer term, vacancies may increase as staff retire. Additionally, younger staff can find it harder to progress their careers where the workforce is top-heavy of more senior staff.

Temporary staff

Key points

- NHS trusts are increasingly using temporary staff to cover vacancies and shortages.

- The number of registered bank nurses employed by the NHS has doubled in the past ten years.

- The number of agency staff currently employed within the NHS is difficult to quantify accurately.

- An increase in the use of agency nurses within the mental health sector raises issues of continuity of care, availability of specialist skills, the support and induction needs of agency staff, as well as increased costs in the overall staff bill.

- The need to actively manage temporary staff has led to a number of initiatives, such as NHS Professionals.

Temporary staff in the NHS

The NHS uses temporary staff, not only to provide short-term cover for permanent staff who are on leave or off sick, but also to cover for long-term vacancies. The extent of temporary staff usage can therefore be related to the level of vacancies, and can indicate problems with recruitment and retention of permanent staff.

There has been significant growth in expenditure on temporary staffing in the NHS in recent years. Complete data on temporary staffing in the NHS is not held centrally, but some statistics are available on expenditure on agency nursing staff and medical locum staff. A study published by the Audit Commission (2001) reported that on a typical day, approximately 20,000 bank and agency staff provide temporary cover in the NHS in England and Wales, at a cost of about £810 million a year –around ten per cent of the nursing pay bill.

By the end of September 2000, the NHS in England was using approximately 9,560 whole-time equivalent registered bank nurses: twice as many registered bank nurses as were used over the same period in 1990 (Audit Commission 2001).

There are various problems in determining the overall numbers of bank and agency nurses within the UK as the boundaries between NHS employment and agency work are diffuse. The Audit Commission (2001) found that one in four agency nurses is registered with at least two agencies, and one in six has an NHS job or undertakes agency work during time off in order to earn extra money. Similarly, six out of ten bank nurses also have full- or part-time contracts in NHS posts. The Audit Commission estimated that about 185,000 nursing staff in England are on NHS banks and that there are about 46,500 registered with agencies. It suggested that staff shortages, vacant posts and permanent staff off sick or on leave explain the increasing reliance on temporary and agency staff.

London stands out from the rest of the NHS because of its very high use of temporary nursing staff, and its much greater reliance on external agencies. The Audit Commission (2001) found that expenditure on agency staff alone accounted for an average of 11 per cent of the total nursing bill in non-teaching trusts in London – more than three times as much spent in equivalent non-London NHS trusts (3 per cent). Over half of all nursing agency expenditure was in London, partly because NHS employers in the capital made relatively less use of in-house nurse banks. One reason given for the greater use of agency staff was a higher rate of vacancies, and rates of pay for agency nurses were higher in London than they were elsewhere.

In 2001, a Royal College of Nursing membership survey found that half of NHS nurses working in the capital had a second job – a higher proportion than nurses working outside of London.

Temporary staff in the mental health sector

The use of temporary staff within the mental health sector in general, and specifically within London, is difficult to ascertain as data are rarely compiled by specialty. What little data there are point to increasing use of temporary staff.

In 1998, Gournay et al found that one-third of mental health wards in London were routinely using agency nurses to maintain a full complement of staff. In acute mental health hospitals in inner city London, at least 30 per cent of staff in 26 wards were agency or bank nurses. The proportion increased to 50 per cent at night; one-third of wards were staffed entirely by bank and agency staff at night.

Conversations with a handful of nurses working in acute mental health in-patient wards reinforced the belief that reliance on temporary staff continues to be high. A couple of nurses said that bank and agency staff were used every day. One nurse said her unit of 29 patients was staffed by five nurses each shift, of whom only two or three would be permanent staff and the rest were agency or bank nurses. One ward manager said his unit had been running at 85–90 per cent staffing levels for the last couple of years. He had used 130 hours of agency nurses and 100 hours of bank nurses in January, compared with 420 hours of overtime for staff.

In fact, all the nurses interviewed said that, where possible, extra shifts were given to permanent staff. However, limits on the amount of overtime that staff could take on, and moves to get rid of overtime arrangements altogether, threatened these arrangements and will necessitate greater use of agency and bank staff.

Implications of reliance on temporary staff

Relying on temporary staff to fill gaps in care has cost and quality implications for the service in the following areas:

- continuity of care
- safety
- quality
- cost.

Continuity of care

For the most part, bank and agency nurses are employed within the NHS in clinical areas that reflect their area of skill and expertise. However, there are times when temporary staff work in unfamiliar areas, or only on an occasional basis, making it difficult to provide the same standard and continuity of care for patients.

Continuity of skilled care is paramount within acute mental health care. Over the past decade, more and more patients who would previously have been treated on an in-patient basis now receive care within a community setting. Many of the new crisis intervention and home treatment teams prevent the hospitalisation of acutely ill patients. In turn, the level of acuity of need within inpatient care is now critical. People within acute mental health wards require consistently skilled and expert care. Perversely, this is where continuity and skill appear to be at their most scarce.

The nurses interviewed placed great emphasis on using temporary nurses who were known to the ward and familiar with the patients and ward routine. Ward managers said they did not have time to provide induction to agency staff who were not familiar with the unit and so they tried to keep 'new faces' to a minimum.

Safety

The lack of induction for temporary staff has safety implications. The Audit Commission (2001) found that where temporary staff are brought in at short notice, induction may be inadequate or non existent. They may be unfamiliar with the patients under their care, with local procedures, practices and equipment, with their surroundings and their colleagues. Moreover, it may mean temporary staff are given more restricted duties and require extra supervision, with the knock on effect this has for the workloads of permanent staff (Allan and Blair 2002).

Certainly this was the case for the nurses interviewed. One ward manager said he used agency and bank staff 'when we're short-staffed and the staff are stressed, to give the shitty jobs to.' This often included one-to-one observations of patients – a task disliked by the patient and the member of staff alike.

Another ward manager said that very few tasks could be allocated to agency staff and that this increased the burdens on permanent staff. In this respect, mental health acute wards were considered very different to general acute wards, where it could be easier for nurses unfamiliar with a ward or its patients to perform a variety of tasks. The manager said that many of the permanent senior nurses would prefer to be short-staffed than have 'three strangers' on the unit and have to spend time explaining things to them.

The number of hours covered by temporary staff can affect the standard of care. Some trusts have attempted to minimise the risks by setting a limit on the number of hours temporary staff can work. This is likely to be unpopular where the main incentive for doing agency work is 'moonlighting' for extra money.

Quality

All the nurses interviewed had concerns about the calibre of agency and bank staff. Surprisingly, bank staff seemed to attract the most concern, even though hospitals might be expected to assert greater control over the calibre of the nurses that join their own banks. The ward managers preferred to develop their own list of nurses whom they could contact directly as needed.

These concerns reflect the fact that many bank and agency nurses do not have permanent posts within the NHS or the independent sector and are therefore less likely to maintain their technical competence and knowledge, or to address changes in skill needs. Yet there is some evidence to suggest differences between agency and bank staff. The Audit Commission (2001) found that agency staff were more likely to take advantage of training opportunities within trusts than bank staff were – which may go some way to explain why the nurses interviewed had some concerns about the quality of care offered by bank nurses.

Cost

The Audit Commission (2001) reported that in 1999/00, approximately 4 per cent (£743 million) of pay by NHS trusts in England and Wales was spent on non-NHS staff. More than half of this was on agency nursing staff. Eight out of ten trusts had spent more on agency nursing staff than they had in the previous year, and three out of four trusts had increased their expenditure on bank staff.

In 1999/00, the average NHS trust spent just under £2.5 million on bank and agency nursing with some trusts spending two or three times this average. Moreover, agency rates of pay for a nurse are higher (by 5–18 per cent) than bank staff fees and the cost varies between agencies (Audit Commission 2001).

Within specialties – such as mental health – the rates for agency nurses increase again. The Audit Commission (2001) reported that a junior grade mental health nurse (D grade) can earn between £10.26 and £24.00 per hour, compared with a range of between £8.95 and £23.40 for a general nurse at the same grade.

Addressing the issues

The Government has come under increasing pressure to find solutions to boost staff numbers across the service. It will take time before the measures it has introduced begin to make a measurable difference to recruitment and retention rates. In the meantime, trusts continue to employ large numbers of agency and bank staff. This is particularly evident in the nursing profession and especially important as they deliver the bulk of patient care.

Two initiatives that aim to ensure that the use of temporary staff is more structured and quality driven are NHS Professionals and London Agency Project. A further initiative worth mention is the Rotation Scheme. These are outlined briefly below:

- NHS Professionals is an NHS-led 'agency' aiming to increase the number of temporary staff working in the NHS, manage vacant posts and become the primary source for temporary staff in the NHS by April 2003. People who register are either currently working in the NHS or thinking about returning to the service. The agency has been developed on a London-wide basis, and to date incorporates two call centres (Paddington and Ilford). Ten London trusts are signed up to the scheme (NHS Professionals website, details on p 56).

- London Agency Project aims to achieve new working arrangements with agencies. A framework agreement for the supply of specialist nurses for A&E, critical care and operating theatres went live in September 2001. Of the 45 agencies that originally bid for the contracts, 29 were selected, and these are now the only agencies able to supply nurses into the areas specified. The selection was made on the grounds of cost, ability to supply staff and their treatment of nurses. In March 2002, a framework agreement for the supply of nurses, midwives, health visitors and healthcare assistants was launched (London Agency Project website, details on p 56). The agencies have been contracted for three years, and will be monitored to ensure they offer nurses regular appraisal and career development programmes to match those of their colleagues in the NHS.

- The Rotation Scheme (see Nurse Rotation website, details on p 56) is one of only a few schemes that specifically address mental health. Developed by the Nursing Rotation Co-ordinating Centre, one of its main objectives is to provide nursing staff with three eight-month placements in numerous service-delivery areas as part of their career development programmes.

  The two-year scheme aims to increase the average length of stay within the trust of newly registered D- and E-grade nurses, reduce turnover and nurse vacancies, and provide for greater continuity of care. It is particularly useful in 'hard-to-staff' areas within the NHS. A survey into the effectiveness of the scheme found that 25 nurses had been recruited and, as a consequence, 18 service delivery areas had been able to replace temporary staff with regular nursing staff (Coyne and Beadsmoore 2001). Four mental health trusts in London are signed up to the scheme.

Summary

The overall picture is one of increasing use of temporary staff across the country as a whole, but particularly within London. Within mental health services in London, evidence suggests that the use of temporary staff in large acute hospitals is at an all-time high.

Anecdotal information collected both from staff and from service users during the scoping phase of this paper suggested that increased turnover and vacancy among nurses, and the consequent high use of temporary staff, becomes a vicious circle of shortage, low morale, lack of support and a feeling that working in ward environments feels unsafe – for patients and staff alike.

Other work by the King's Fund (Buchan et al 2002) suggests that the use of temporary staff within London's NHS is a permanent characteristic of the capital's health workforce and should be more actively managed rather than treated as a problem or denied. NHS Professionals and the London Agency Project are two approaches that attempt to do this. Other local initiatives, such as the Rotation Scheme, have been successful within the mental health arena and deserve further examination and duplication.

User involvement in the workforce

Key points

- Data on service user involvement within the NHS workforce is limited.

- User involvement in the workforce has a number of advantages, both to employing organisations and to the individuals themselves.

- Perceptions of the value of involving users in the workforce are mixed. The stigma of having mental health problems persists.

- Service users have a variety of obstacles to overcome before they are truly assimilated into the health workforce and able to improve its cultural competence.

- A number of schemes have been developed within London to involve users meaningfully, not only within service planning stages, but also as part of delivering care.

The concept of user involvement within the NHS is not new. However, it is only recently that all mental health services have been expected to recruit and train service users as part of the workforce (Department of Health 2001g).

Employing mental health service users in the NHS

It is well established that employment, or the lack of it, can have an effect on mental health. Yet people with severe and enduring mental health problems – those, in many ways, with the most to gain from employment – are the least likely to be employed. In fact, people with mental health problems have the highest rate of unemployment among people with long-term health problems. In the current climate of workforce shortages, encouraging users into the mental health workforce is a valid way of increasing both the quality and the quantity of the workforce.

A lack of available data makes it very difficult to quantify the number of service users currently employed by the NHS. There may be a number of reasons for the shortage of ready data, including the fact that trusts may not collect such information or may feel that asking individuals about their mental health is controversial. What is more, staff may feel uncomfortable admitting to having suffered from mental illness.

Barriers to employing mental health users

A number of hurdles continue to obstruct the recruitment of health professionals with a history of mental illness. NHS employment policies and occupational health procedures have a tendency to screen out people with mental health problems from the recruitment process – a factor that also affects students with mental health problems in pre-registration and undergraduate training programmes (Buckmaster 2001, Truman and Raine 2002).

People with mental health problems experience major hurdles in the workplace as a result of ignorance, apathy or discrimination. Wright and De Ponte (2000) found the workplace to be the second most common source of discrimination, and 37 per cent of people with mental health problems reported facing discrimination when searching for employment. Such stigma and discrimination causes stress and anxiety, and can prevent individuals from using their experiences to help patients.

Mental health users and the mental health workforce

There is increasing recognition of the value that can be contributed by qualified health care professionals with personal experience of mental illness. More trusts are employing individuals because of their experience of mental illness, recognising the potential of service users as employees. The Department of Health's guidance on support, time and recovery workers states that a current or ex-user of mental health services could make an excellent candidate (2003b). This might take two forms:

- developing the STR role specifically for service users, who could us it as a way of stepping into employment (what the Department calls the 'Pathfinder' model).
- employing as STR workers people who also happen to have first-hand experience of mental distress.

Either way, appropriate support mechanisms will be needed, particularly where the individual has ongoing care needs.

A number of organisations in London have adopted progressive user involvement schemes, particularly in the primary care sector. Some of these focus on helping service users gain employment within mental health services. For example:

- South London and Maudsley NHS Trust has developed a service-user support strategy and is working towards a new project to support people with mental health problems gain employment (see Annual Report 2001 on the South London and Maudsley website, details on p 56).

- Camden and Islington Mental Health and Social Care Trust has established a service-user employment programme (Buckmaster 2001).

- South West London and St George's Mental Health Trust has established a supported employment programme whereby service users are employed to work within the trust. The programme comprises three main components, including:

  - a supported employment programme, to help people who have experienced severe mental health problems gain and maintain employment in the trust
  - a volunteer programme, to provide people who have experienced severe mental health problems with the skills, training and references needed to apply for posts within and outside the trust
  - a charter for the employment of people who have experienced mental health problems, to reduce discrimination of mental illness.

Summary

Quantifiable data on user involvement within the NHS workforce are difficult to access, for reasons such as stigma, the duty of confidentiality on employers in relation to divulging medical history and non-disclosure of mental health history to employers by employees. What is available is anecdotal, and there is no way of accurately identifying any trends. However, the number of contemporary projects within and around London in which good practice is being modelled suggest that slowly more service users are being encouraged to bring their experience and insights into the NHS workforce.

Mental health and refugees

Key points

- The majority of refugees and asylum seekers that come to the UK head to London. Most are young males aged 35 years and under.

- Refugees and asylum seekers have a number of pressing needs once in the UK, including safety, food and shelter. Long-term health needs may be given a low priority.

- Mental health problems among refugee and asylum seekers are common (particularly depression and post-traumatic stress disorder) but they can take a long time to appear in health services, and service take-up is low.

- High unemployment among refugees and asylum seekers can further compound these problems.

- The refugees are possible candidates to recruit to the health and social care workforce – their qualifications and skills are diverse.

- Key challenges include providing language support, better information to guide refugees and training to enable NHS staff to understand and meet the needs of refugees and asylum seekers.

Refugees are among the most vulnerable and excluded groups in society, not only suffering from problems from their past, but also having to deal with the stresses associated with building a new life in a different country. The rising numbers of arrivals in London, combined with increasing pressures on the health service in the capital, have made the health of refugees and asylum seekers an issue of increasing concern.

London's refugee and asylum-seeker population

London has a long history of providing sanctuary to refugees and asylum seekers. Around 85 per cent of those who come to the UK head to London. It is estimated that within London, around 240,000–280,000 people have been through the process of applying for asylum within the past 15 years (Greater London Authority 2001). Unfortunately, there are limited data on the number of refugees within individual London boroughs.

The term 'refugee' is defined here as someone whose application for asylum has been recognised by the Home Office as fulfilling the terms of the 1951 UN Convention relating to the status of refugees. The term 'asylum seeker' relates to a person who has applied for refugee status (Greater London Authority 2002b). Sixty one per cent of refugees and asylum seekers in England, Wales and Scotland are single men aged 35 years and under, as compared to just 18 per cent of women in the same age group (Refugee Council website, details on p 56). These young men tend to have more skills and qualifications and are better placed to gain employment in a new country, and perhaps to provide economic support to those left at home.

The health needs of refugees and asylum seekers

On arrival in England, refugees have a number of pressing needs in relation to food, shelter and safety. Long-term health needs may be afforded low priority. According to the London Health Observatory (2002), the average physical health status of refugees on arrival in the UK is not particularly poor – most are young and physically fit. However, significant numbers exhibit particular health problems including:

- physical conditions as a consequence of war, torture, displacement and their journey to the UK
- communicable diseases endemic in their country of origin (most commonly tuberculosis)
- mental health problems, especially following trauma, as well as more widespread social and psychological problems where individuals have to cope with a new culture, separation from their family, and loss of status. Uncertainty around the process of claiming asylum can exacerbate these problems.

Many refugees and asylum seekers perceive that their health deteriorates after arrival in the UK. Psychological distress, including anxiety and depression, is reported to be common (Burnett and Fassil 2002). Pinning down the incidence of mental health problems among refugees and asylum seekers is difficult – little research has focused on the health problems of refugees in the UK, or in London in particular. Mental health problems may not become apparent within the health service for some time. Also, refugees and asylum seekers are likely to have very complex mental health needs.

Watters (2000) has suggested that mental health problems among the refugee population come in three episodes:

- traumatic conditions – as a result of war, famine and persecution in their home countries
- flight from home country – in some cases, refugees may have to pay extortionate amounts of money to illegal operators to take them across the borders, during which time they may be subjected to physical or sexual abuse
- the effects of detention – once in the country in which they wish to seek asylum, refugees may be detained in camps or prisons, where mental health has been shown to decline and is often accompanied by feelings of despair and hopelessness.

One of the most commonly diagnosed mental health illnesses among refugees and asylum seekers is post-traumatic stress disorder (Aldous et al 1999, Muecke 1992).

Take-up of health services by refugees

Access to health services is a problem for the population as a whole. Also, the mental health needs of the general population are often not well met. These problems are compounded for refugees and asylum seekers. There are few evaluations that examine the effectiveness of refugee-specific services. What data are available suggest that the level of health service engagement with these groups is relatively low (Aldous et al 1999).

There are a number of possible reasons for this, including:

- fear of discovery and deportation
- cultural and language barriers
- lack of awareness and sympathy on the part of health professionals
- lack of knowledge among refugees about their rights to health care.

Yet the health needs of refugees and asylum seekers are extensive and complex. They include getting access to good quality primary care – registration is often only temporary, and refugees tend to cluster on the lists of certain practices. It is also important to ensure an adequate service response to mental health problems. Some form of initial health assessment of new entrants would offer an opportunity to introduce health services, help individuals assess their own health and start a continuing process of contact with the NHS. Working with refugee communities in the planning, development and delivery of services is one of the most effective ways of ensuring appropriate services (London Health Observatory 2002, Aldous et al 1999).

A number of specific programmes have responded to problems of access experienced by the refugee and asylum seeker population in London. Some programmes are designed to address mental health needs in particular. Carey-Wood (1997) highlights a number of examples, including:

- The Somali Counselling Project, which carries out assessments of Somali refugees who require admission to hospital for psychological problems. The aim is to supervise treatment and aftercare, liase with statutory agencies on behalf of clients, and provide counselling for individual refugees.

- The Vietnamese Mental Health Project, which aims to improve mental health services for Vietnamese refugees by providing information on available services, and offering training, education and research. Project staff also manage a hostel providing accommodation for homeless Vietnamese people with mental health problems.

- The Breathing Space Project, an initiative between the Refugee Council and the Medical Foundation that aims to address the mental wellbeing needs of refugees and asylum seekers across the UK.

These specific programmes are important. However, mainstream services also need to respond to the needs of refugees and asylum seekers. Training NHS staff to understand these needs is crucial. The Department of Heath has produced an information and resource pack to help health workers meet the needs of this population, which includes a section on their mental health needs (Burnett and Fassil 2002).

Training and employing the refugee population

Ensuring that health services meet the health needs of refugees and asylum seekers alone is not enough. It is equally important that these individuals are able to sustain their own health in an environment that often discriminates against them or is ill-prepared to meet their needs.

There is good evidence that people in employment have better overall health, including mental health, than unemployed people. However, gaining employment can be difficult for refugees for a variety of reasons, including language, cultural, legal and discriminatory barriers.

A survey by the London Research Centre of 236 refugees and asylum seekers in London showed that only 38 per cent were in work, and that unemployment was high (at around 50 per cent), even for those who had been in the UK for five to eight years. Those who spoke good English stood a better chance of getting a job, but even so, 48 per cent of this group were unemployed (London Research Centre 1998).

Women refugees and asylum seekers face particular problems. Usually, they are classed as dependants of their husbands, and as such are barred from gaining work until refugee status or exceptional leave to remain has been granted. They tend to lack the same community and professional networks that males refugees have, through their greater numbers and for cultural reasons. For those able to work, the jobs are mostly low paid or unskilled, or do not make use of their existing skills and qualifications (Greater London Authority 2002b).

A number of agencies have developed specific support programmes for refugees and asylum seekers in London wanting to gain employment. For example, some schools offer classes to children and adults, to improve their English language skills. The Refugee Council Training and Employment Section offers vocational training courses for refugees and asylum seekers in the UK, which can lead to employment or higher education.

Employing refugees in the mental health workforce

The refugee community is one possible pool from which to recruit the health and social care workforce in London. This could help prevent the occurrence of mental health problems by securing employment for this vulnerable group, and could help overcome staff shortages in the NHS.

There are an estimated 1,000 to 2,000 doctors, and a similar number of nurses, among London's refugees and asylum seekers, as well as dentists and professions allied to medicine (Burnett and Fassil 2002). Yet refugees who are qualified health professionals often face severe problems entering health care practice in the UK:

- Those with advanced careers may find it difficult to return to training, which is sometimes necessary to allow registration with the relevant UK professional regulatory body, such as the General Medical Council (GMC).
- Their departure from their country of origin may have interrupted their training.
- They may not speak English well, which can cause difficulties in accessing information.
- Their documentation may have been lost or destroyed while travelling to the UK.
- Employment officers may not know how to help refugees get back into their chosen profession, and little support for childcare or the costs of retraining is available.

Where these problems are not addressed, the NHS is missing out. The qualifications and skill level among refugees is diverse. A study into the skills and qualifications of refugee women in London by the Mayor of London and the Greater London Authority (2002b)

identified many skilled refugees who were highly motivated to continue in their professional fields, but were prevented from doing so by various external barriers (including discrimination and status as dependants).

The study targeted women who had a background in teaching, nursing or medicine, or who had intended to enter these professions in their country of origin, but had interrupted their studies to come to the UK. Of the 231 refugee women interviewed, 53 were teachers, 51 were nurses and 75 doctors and other medical professionals. The remainder were actively seeking entry into these professions.

The authors' recommendations included:

- improving information and signposts to refugees to facilitate re-entry into their chosen profession
- for a named person at the Workforce Development Confederations to co-ordinate initiatives aimed at bringing refugee nurses into the workforce
- for health authority staff to learn more about the working, culture, training and skills that refugee doctors and nurses bring with them.

The NHS will not be able to benefit from the skills of the refugee population until a number of issues are dealt with. These include:

- the need for language support and systems for providing health information to refugees
- confusion among health professionals over the rights of refugees and asylum seekers to health care
- improving the knowledge base about refugees
- financial assistance to enable asylum seekers and refugees to undertake education (London Health Observatory 2002).

A number of initiatives recruit refugee and asylum seeker health professionals into the NHS. For example, in Wales, the charity Displaced People in Action has initiated a scheme in which the NHS employs refugee doctors (Newvision 2002). Similarly, hospitals in Yorkshire are recruiting refugees with medical backgrounds to work as doctors and dentists in Leeds. This scheme has clear efficiency gains: it costs an average £3,500 to re-train a refugee doctor as opposed to around £200,000 to train a new medical student (Berlin et al 1997).

The General Medical Council has also attempted to ease the re-admission of refugee doctors into the profession by waiving the £145 fee for refugee doctors to sit Part One of the professional Linguistics Assessment Board test. This may be extended to asylum seekers who wait more than six months for decisions on their asylum claims (GMC website, details on p 56).

The Refugee Council and the British Medical Association are undertaking a joint project to create a database of refugees currently in the UK and in the process of re-qualification. In the scheme, refugee doctors on the database are notified about schemes designed to help them re-qualify (Refugee Council website, details on p 56). The database currently holds details of 281 refugee doctors in inner and outer London. Most of the medical specialisms are represented, with GPs comprising the greatest number (42) and general medicine (33) and obstetrics (29) following closely behind. Only ten have a psychiatric qualification. A similar database is planned for refugee nurses and allied health professionals.

Summary

Refugees have many urgent needs when they reach their destinations, including food, shelter and safety. It is only in the longer term that health problems (especially mental health problems, such as post-traumatic stress disorder) may become apparent. Many of these problems are compounded by racism, poverty and social exclusion. Access to appropriate services and care are major issues.

Any health strategy for London has to tackle the health needs and barriers facing the refugee population. This in turn requires a workforce that is culturally competent and appropriately skilled.

Employing refugees is one way of providing economic stability and improved health. In relation to the health workforce, many refugees have relevant qualifications and skills that could prove useful to a health service beset by staff shortages and a desperate need to recruit new workers. Many projects are being developed to match skills to jobs and create pathways into employment. Targeting refugee populations means not only boosting the labour market supply, but also enhancing the competence of the mental health workforce to provide culturally appropriate care.

As with involving service users in the workforce, employing refugees could have workforce implications of its own in terms of training and mentoring by qualified, established staff.

Discussion

This paper has set out to provide a profile of the mental health workforce in London. Data limitations, together with definitional problems, make this a difficult task, but a clearer picture is emerging than was possible six years ago, at the time of the 1997 King's Fund Inquiry. At that time, the following deficiencies were highlighted:

- patchy distribution of mental health professionals in primary care and a lack of specialist skills among GPs and practice nurses to diagnose and manage mental illness
- high levels of organisational and job instability, problems with inter-agency working and a lack of management capability.
- a crisis in recruitment and retention of mental health professionals of all disciplines in London and evidence that staff 'burnout' was high.

Progress in these three areas has been variable, as discussed in the following sections.

Patchy distribution

Another report prepared by the King's Fund as part of the 2002/03 Mental Health Inquiry (Rosen, Jenkins 2003) provides an insight into developments in the primary care sector. It showed some progress in terms of the distribution of mental health professionals in primary care. It found that access to counselling and psychological therapies had increased and anticipated that the new primary care mental health workers would fulfil an important role in improving clinical care.

However, the study identified limited educational activity designed to improve the clinical knowledge and skills of primary care clinicians in relation to mental health, and asserted that developing the knowledge and skills of primary care clinicians remains a key challenge. Other data show that despite a lack of adequate training, a large number of practice nurses report seeing, and being involved with, patients with mental health problems.

Organisational and job instability

Since 1997, the NHS and social care services have been re-structured at every level – some levels more than once. Although many of the changes and increased resources are welcomed, it is also difficult to determine what this has meant for job security and stability and overall morale and motivation – particularly with the mental health services.

Recruitment and retention

The crisis in recruitment and retention of mental health professionals persists, and is in danger of worsening. The vacancy and turnover rates among key mental health staff are high, particularly in some professional groups, and show little sign of abating. The problem

is especially acute in London, where the health service is experiencing problems with recruiting, retaining and motivating workers across all sectors. This has a knock-on effect on the use of temporary staff, which has quality, safety and cost implications.

There have been a great many policy initiatives relating to mental health since the 1997 Inquiry, most of which originate from the National Service Framework for Mental Health. Increasingly, attention is being directed at addressing shortfalls in the workforce in the realisation that without a strong and stable workforce, mental health service reform cannot be achieved.

Government policy to address generic workforce problems is characterised by a drive to boost the numbers of key staff, improve working lives, develop career structures and opportunities, and implement radical pay reform. These measures are likely to have only a limited impact on mental health services, which have a number of unique challenges – such as stigma and unsafe environments – factors that act as deterrents in the retention and recruitment of staff.

Of greater significance are the initiatives highlighted on p 36 and the National Service Framework for Mental Health. These have led to the development of a bewildering array of working groups, taskforces, action teams and guidance documents. The overarching strategy on workforce for mental health, to be published by the Department of Health in Spring 2003, should bring much-needed clarity to what is an increasingly complex landscape involving many different agencies.

It is too early to judge the impact of the workforce programme of the National Institute for Mental Health (England). However, it offers the potential to bring coherence to the problems of recruitment and retention. It also – rightly – puts emphasis on designing local responses within the context of national frameworks and guidance.

At a national level, the greatest progress has been made in the areas of skill-mix and competencies, with the creation of STR workers and the framework of capabilities required of the workforce. Greater policy emphasis has been placed on issues of recruitment than on those of retention, although retention problems often tend to be more prevalent. Focused policies are needed to address a number of issues specific to mental health, such as:

- perceptions and stigma of the mental health sector
- stressful ward environments
- boundary issues
- shortfalls in training and career management.

The special needs of acute mental health

The four issues listed in the previous section can have a significant impact on the retention of mental health staff. This was brought home in the 'reality check' provided by a handful of acute mental health nurses. The retention of nursing staff is undermined by a great many factors that include a very stressful working environment, lack of control and autonomy, violence and intimidation, increasing substance misuse problems among patients, and having to deal with patients' social needs.

The Government has made its policy on violence towards health service staff clear. But the problems experienced by acute units require interventions that are more specific. The interviews started to expose a widespread problem of illegal drug taking and dealing (by dealers 'off the street') on the wards. In one of the interviews it was reported that guns had been brought on to a ward. There seems to be an acceptance that the rules that apply in other sectors and different walks of life do not apply in acute mental health. As a consequence, nurses working in these environments feel disillusioned and unsupported.

These problems are only compounded by a heavy reliance on temporary staff. Indeed, agency staff can exacerbate the workloads and stress levels of permanent staff and, again, the needs of acute mental health differ from other acute settings.

Expanding workforce capacity

Despite the problems associated with a dependency on temporary staff, the function of temporary staff in the workforce is being legitimised by initiatives such as NHS Professionals that seek to actively manage such staff. By recognising that temporary staff are a permanent characteristic of the workforce, the health service should be able to make better use of this resource. This could have real implications for mental health where reliance on temporary staff is high, but where the contributions they are able to make are often very limited.

The expectation on services to recruit and train service users as part of the mental health workforce, and evidence of the skills that refugee and asylum seekers can contribute to the health service, mark a growing recognition that the health service needs to identify new pools in which to recruit health workers. However, real barriers continue to prevent the health service from benefiting from the skills of individuals within these groups. Until these are confronted, the mental health sector will continue to miss out.

Conclusions and recommendations

Historically, the mental health service has been somewhat sidelined as a 'Cinderella service'. Today, problems of recruitment and retention threaten to overwhelm the sector and undermine the Government's plans for service reform.

The policy emphasis

Government policy increasingly recognises the problems faced by the mental health workforce. The emphasis on tackling these problems by facilitating local responses within national frameworks is welcome. Expanding the size and skill-mix of the workforce are key features.

More attention, however, is required on issues of retention. Poorly configured and managed services put staff under pressure, and the demands on mental health service staff can be particularly challenging and stressful. Training and education needs to prepare mental health professionals for these stresses and equip them with skills to cope with them.

The acute mental health sector requires particular attention and policies tailored to its very specific needs. A range of measures is needed to improve the working environment, for acute mental health nurses in particular. Clearer policies about acceptable behaviour by patients and visitors on the ward, together with the authority to take action where these are violated, and greater cross-agency collaboration (particularly with the police), are the minimum that is required.

Recommendations

- An in-depth study of the acute mental health ward environment should be undertaken to examine the extent to which problems of violence exist and are caused or compounded by the consumption of illegal drugs and alcohol on the wards.

- Clear drug and alcohol policies are needed for acute mental health wards, along with adequate and planned back-up to enforce them.

Profiling the workforce

Definitional and data limitations make it difficult to quantify recruitment and retention problems with any certainty. Better data, collected routinely and according to national standards, is badly needed. Until then, it is difficult to judge whether the contemporary workforce in London is better equipped than that of 1997 to cope with the health and healthcare needs of individuals in London with mental health problems.

Recommendations

- Workforce Development Confederations should carry responsibility for compiling robust data specifically relating to the mental health workforce. The Department of Health should co-ordinate this activity and ensure that the data are able to support workforce planning and design.

- A minimum dataset to inform the routine and mandatory collection of workforce data across the specialties should be introduced as a matter of urgency.

A more responsive service

Without a more stable workforce, mental health services will struggle to meet the needs of different client groups. This working paper draws attention to the very particular needs of refugees and asylum seekers. This is a major issue for London, which has rising numbers of asylum seekers and yet shortages of staff to meet their health needs, including in relation to mental health.

One way of helping to address the social and health needs of the refugee and asylum seeker population is to increase employment opportunities. Employment within the health service could help tackle staff shortages and enhance the competence of the mental health workforce to provide culturally appropriate care. Similar issues apply relating to employing mental health service users.

The availability of mental health services to prisoners is also cause for concern and requires further analysis.

Recommendations

- Language support, better information for refugees and streamlined and co-ordinated approaches to identifying and assisting those refugees with professional qualifications into the health workforce, as well as training to enable NHS staff to understand and meet the needs of refugees, are needed.

- An in-depth study of the mental health services available to prisoners should be conducted, along with an evaluation of the impact of the PCTs taking over the management of health services in prisons. To facilitate this, reliable data on the profile of mental health staff employed in prisons is needed.

Appendix: Workforce response in prisons

In the past few years, the prison health service have become a much-debated topic and the focus of government attention. In 2002, the Government announced that from April 2003 the funding responsibility for prison health services in England would be transferred from the Home Office to the Department of Health. Subsequently, PCTs would become responsible for the commissioning and provision of health services to prisoners in their areas.

Among the various health-related problems that prisoners experience, mental health problems, drug dependency and communicable diseases are the main causes of ill health. Statistics show that 90 per cent of all prisoners have a diagnosable mental health problem and that the rate of suicide in prisons is higher than in the community (Home Office 2002). Treating these problems – particularly mental health problems – is crucial for the success of prisoners' rehabilitation and resettlement.

In order to provide an effective service to prisoners with mental health problems, a fully trained workforce is needed. However, not all doctors in charge of inpatients in prisons may have the appropriate training and skills (Reed and Lynn 2000). One survey showed that only 21 of the 190 doctors employed by the prison service were members of the Royal College of Psychiatrists or held a diploma in psychological medicine (Thomlinson 1998).

The same applies to nursing staff. In another survey, 32 per cent of prison health service staff were non-nursing trained carers, 44 per cent were general nurses, and only 24 per cent were mental health or dually trained nurses – for example, in mental health and drug misuse. Multi-disciplinary teams made up of prison staff and psychologists should also be available, depending on the needs of prisoners (Reed and Lynn 2000).

Another crucial point relating to prisons that needs further investigation is night staffing. It would appear that there are no standards for night staffing, and comprehensive access to nursing staff at night is patchy (Reed and Lynn 2000).

Summary

Staffing in prisons and the mental health services available to prisoners are two important issues that have been foremost in the concerns of many of the stakeholders interviewed in the compiling of this working paper. The area of mental health services in prisons is an important and complex topic, and it is beyond the remit of this paper to examine it in any depth. However, the following key issues deserve attention:

- the importance and need for an independent in-depth study into the issues around health services available to prisoners and adequate trained staffing (daytime and night)
- the fragmentation of services and information
- the need for reliable data on the profile (including number, expertise and skills) of mental health staff employed in prisons.

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Nurse Rotation Scheme	www.nurserotation.com
Refugee Council	www.refugeecouncil.org.uk
South London and Maudsley NHS Trust	www.slam.nhs.uk

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