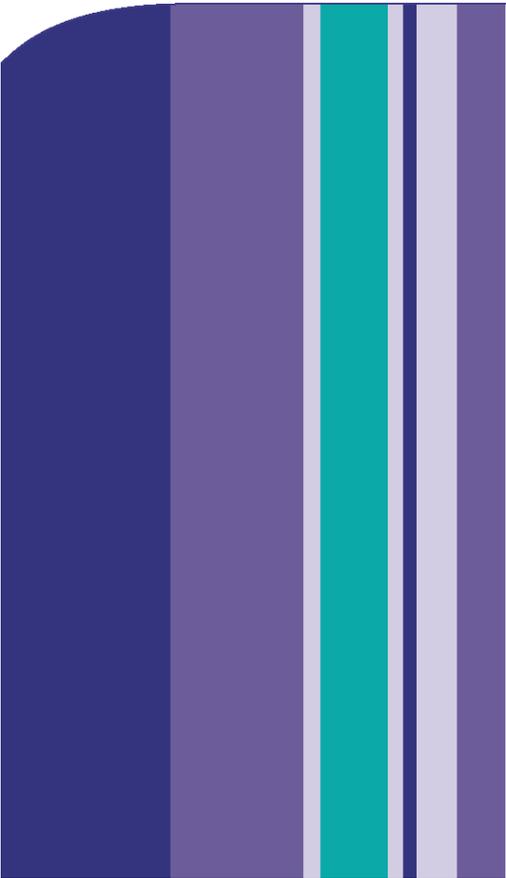


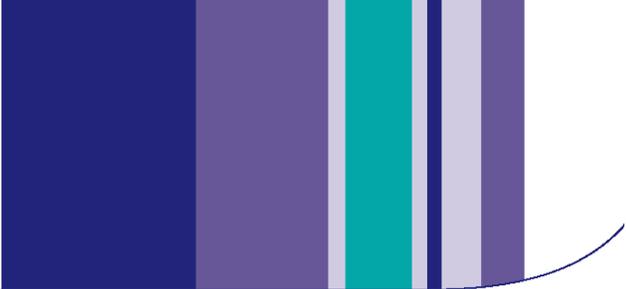
The mental health workforce in Wales

Skills and employability issues in the mental health workforce
in Wales



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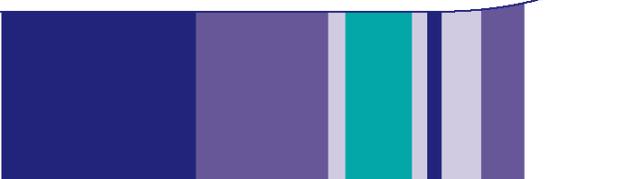
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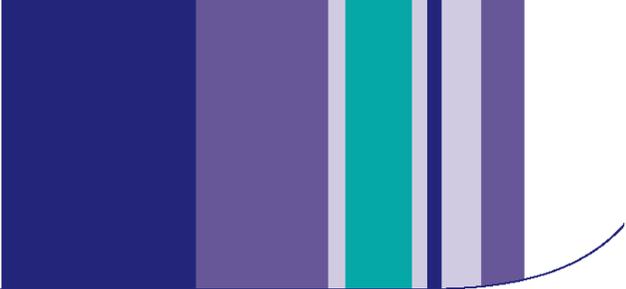
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1. Executive Summary

Commissioned at the beginning of 2011 by Skills for Health¹, this project sought to understand in greater detail the current and anticipated skills needs within the Welsh mental health sector, and to identify a range of possible opportunities for employment and skills development in the sector. The findings of this research report are intended to inform debate in this area and do not constitute either Welsh Government or Skills for Health policy.

The scope of the research included those services dealing with both serious 'psychoses,' issues such as schizophrenia and bipolar disorder, 'neuroses', and other conditions not normally referred to as mental illness, such as depression and anxiety disorders.

A combination of desk-based research and secondary data analysis was used, alongside an online survey, in-depth interviews and a focus group of stakeholders and experts. This consultation exercise formed a key part of the study to ensure that people from different areas of the sector were represented within the research.

The mental health workforce is estimated to comprise of approximately 22,000 individuals:

- Over 10,000 NHS/Social Service employees.
- 10,000 third sector workers (including 4,000 paid employees and 6,000 volunteers).
- 2,000 workers in the independent sector.

Almost half of mental health employers surveyed (46%) reported skills gaps amongst their existing workforce. Welsh language skills and ICT skills were identified as requiring attention within the next 12 months. A smaller proportion (16%) reported having vacancies that were difficult to fill due to the lack of skills available in the labour market.

Encouragingly employers viewed training and education available to the mental health workforce as largely appropriate. Despite a relatively high level of skills gaps being reported, a large proportion of employers do not believe there are qualifications lacking amongst their organisation's current workforce.

Staff retention is not considered a widespread problem amongst respondents in Wales. This is positive as continuity of care is particularly important in mental health as trust is often established over time between service user and mental health worker.

¹ Skills for Health Commissioned TBR Research Ltd to undertake this project



Many respondents highlighted the challenges that tighter spending will have on the provision of mental health services. Third sector mental health service providers, many of which are currently funded in part by local authorities, were anxious to highlight that the services they provide are likely to come under significant stress.

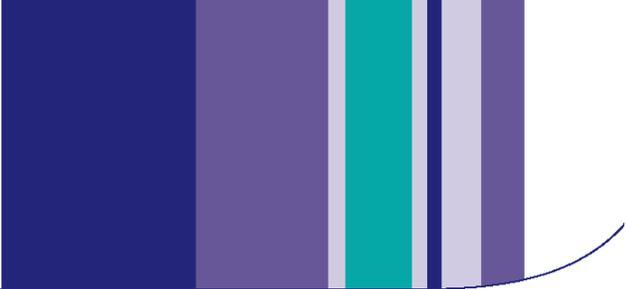
Participants in the workshop were keen to highlight opportunities to deliver high-quality services within a tighter financial regime. These include:

- A possible expansion of mental health care beyond traditional boundaries and across society. For instance, some degree of “de-medicalisation” in the overall approach might offer the prospect of attaining enduring improvements in mental health.
- Greater involvement of patients in service development may assist with the delivery of services. This may enhance the empowerment of the service user. It might also reduce the cost of provision.

Respondents were also keen to acknowledge that achieving higher quality care, within the constraints of reduced funding and in the longer term, may be contingent on there being associated changes in social attitudes to mental health.

Shifts in attitudes of the wider population towards mental health issues were also considered an area where, if progress were made, higher quality services might be possible. There were also suggestions that mental health well-being would be improved if services were organised more holistically and involved occupations beyond traditional professional and occupational boundaries, including non-specialist occupations such as teachers and social workers.

This work was an initial exploration primarily of the skills issues within the Welsh mental health sector. Given the context in which this work was being undertaken it was appropriate for some consideration to be given to options for the future of services and therefore likely future skills needs, both in health and related occupations. Its findings do not reflect the policies of the Welsh Government or Skills for Health. Indeed, further exploration of how services may be reshaped is obviously required. It is therefore hoped this report will be built upon by subsequent consultations by those working in the mental health sector in Wales, and also throughout the UK.



2. Introduction

2.1 About Skills for Health research and intelligence

Skills for Health, the sector skills council for the health sector across the UK, is charged with helping the sector develop a skilled, flexible and productive workforce to improve the quality of health and healthcare.

Skills for Health develop a range of regular assessments of the current and future skills needs of the health sector. These are developed using key national sources including, amongst others, the Labour Force Survey, Annual Business Inquiry, National Employer Skills Survey, Higher Education Statistics Agency as well as a whole range of industry intelligence and bespoke surveys, consultation activities and industry sources.

Skills for Health undertakes research into a range of themes which are designed to address gaps in our knowledge of the sector, encourage employers to raise the level of skills in the sector and adopt new ways of delivering healthcare. Themes recently developed and under development include:

- understanding 'turnover and wastage' in the health sector.
- understanding productivity and performance.
- 'third sector' and the volunteer workforce.
- The challenges of urban and remote working.

Skills for Health also commissions independent agencies to conduct research on its behalf. On this occasion we commissioned Trends Business Research (TBR) to undertake this work.

TBR have extensive experience in producing high-quality and robust research for many Sector Skills Councils on a range of topics including skills and labour market intelligence.

2.2 About this research

This project sought to take a review of the main skills and employment issues affecting the mental health sector in Wales. This research project was initiated by employer representatives within Wales.

The outputs of this study will be highly useful to Skills for Health as well as a potential wider audience of stakeholders. In particular, this study will inform potential joint working with other sector skills councils relevant to the mental health sector (e.g. Skills for Justice and Skills for Care and Development).



2.3 Methodology

This research was carried out over a 3 month period from January to March 2011 by TBR² and associate Andrew Garman on behalf of Skills for Health. It utilised:

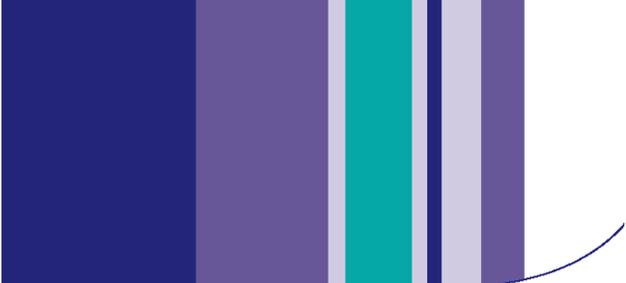
- Desk-based research to gain a detailed understanding of the key (international, UK-wide and Wales-specific) policies and drivers that are shaping the future of the mental health sector and workforce in Wales.
- An online survey of organisations engaged in the delivery of mental health services in Wales. The survey was primarily quantitative, gathering information on skills issues, use of training and investment in training. The survey was started by a total of 90 respondents, of which 68 provided useable responses.
- In-depth telephone interviews with 10 stakeholders in the mental health workforce in Wales. The interviews built a second layer of qualitative information on the data gathered through the online survey.
- A focus group in Wales. This provided a forum to discuss and debate the likely future of the workforce, and the findings of the online survey, in-depth interviews and desk-based research.
- Secondary analysis of a number of data sources from organisations such as WCVA, Stats Wales and from TBR's own business database called TCR.

2.4 Structure of the document

This document has four substantive sections.

- **The mental health workforce in Wales:** This section provides an overview of the size and shape of the mental health sector in Wales and its workforce. It considers the main skills and employment issues of the mental health workforce in Wales.
- **Skills demand in the mental health sector in Wales:** This section highlights skills shortages and skills needs within the workforce. It also considers future skills needs and particular characteristics of the workforce. This section incorporates findings from the online survey, in-depth telephone interviews and focus group event.

² TBR is the trading name of Trends Business Research Ltd, an economic and skills consultancy. www.tbr.co.uk

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- **Drivers of workforce development:** This section identifies and describes drivers of change in the mental health workforce in Wales. Awareness of these background influences is invaluable in order to understand employment and skills issues in the mental health sector in Wales. This section pays specific attention to policy related to mental health, considering the key international, UK-wide and Wales-specific policies and initiatives.
 - **Opportunities and barriers:** This section draws together the key messages emerging from the research and presents the key opportunities for, and barriers to, the future development of the sector, as well as spelling out the implications for the workforce.
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3. The mental health sector

- In 2009 approximately 10,000 people were employed in mental health services provided by the NHS/Social Services in Wales.
- The total number of people employed in the NHS mental health workforce increased by 6% between 2008 and 2009.
- Nurses make up almost 60% of the staff providing NHS mental health services.
- It is estimated that an additional 2,000 people are employed in the independent health sector providing mental health services in Wales.
- In 2007 the Welsh Assembly Government estimated that there were 4,000 mental health employees working in the third sector in Wales, in addition to 6,000 volunteers.

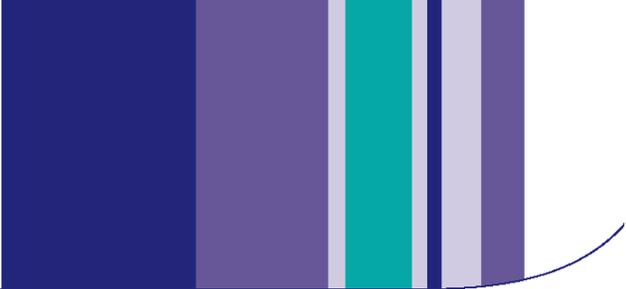
3.1 What is mental health?

This research captures information on independent, public and third sector organisations delivering mental health services in Wales. This covers both:

- Serious disorders: the 'psychoses', such as schizophrenia and bipolar disorder, which are usually referred to as 'mental illness', and
- Milder mental health issues: the 'neuroses', such as anxiety and depression, which are not usually referred to as 'mental illness'.

The bullet points above describe the 'core' of mental health provision, but it is important to highlight the wide scope of mental health issues and associated services. Between the extremes (for example, from a secure psychiatric unit housing individuals of danger to the public to mild depression and workplace stress, which might be treated through information, advice and guidance) there are also many different settings from which mental health services are delivered. These include occupational health, GP surgeries, specialist clinics, residential units, prisons, educational establishments and third sector providers (e.g. drop-in centres, community-based support, service-user-led support groups, advocacy groups and charities) as well as a wide range of independent providers from individual practising counsellors to large independent healthcare providers.

Given this complexity, the development of a finite definition for the structure and shape of the sector is complex. However, for the purpose of this research we have used the following categories to describe activity:

- 
- **Origin of service:** Whether the service is delivered by an organisation based in the public, independent or third sector.
 - **Service user:** Whether the service is provided to children (aged 0-16), young people (aged 16-18), adults (aged 18-65), older people (aged 65+) or a combination of these.
 - **Focus of service provided:** The issue/problem that the service addresses.

The service focus can cover a variety of needs and this drives the multifaceted nature of the sector. Different services may be required at different points throughout the care process. Categorisation offered by the Care Programme Approach³, the full outline of which can be found in appendix 8.9 of this report, highlights the complexity and breadth of the services offered in this field.

3.2 What does the sector look like in Wales?

The health sector as a whole employs 98,900 people in Wales⁴ and the mental health sector forms a key part of this workforce. However, providing definitive statistics on the size and shape of the mental health sector in Wales (or indeed in any UK nation) is challenging, due to the way in which workforce data is recorded.

The standard approach to measuring workforce size is to use data from the Labour Force Survey (LFS), or Annual Population Survey (APS). These surveys use Standard Occupational Classification (SOC) codes in order to present statistics on different occupational groups. Unfortunately, mental health occupations are not well represented by SOC code. The nature of the SOC system is such that occupations tend to be grouped together and therefore many cannot be specifically isolated in order to obtain statistics. For example:

- 'Mental Health Officers' are placed under a general 'Social Worker' occupation⁵.
- 'Psychiatrists' under 'Medical Practitioners'⁶.
- 'Counsellors' under 'Housing and Welfare Officers'⁷.
- 'Psychotherapists' under 'Therapists not elsewhere classified'⁸.

³ WAG (2010) Delivering the Care Programme Approach in Wales, Interim Policy Implementation Guidance

⁴ Skills for Health. (2011). Wales Skills and Labour Market Intelligence Assessment.

⁵ SOC code 2442

⁶ SOC code 2211

⁷ SOC code 3232



SOC codes do exist for 'Occupational Therapists'⁹ and 'Psychologists'¹⁰. However, there is a limit to the usefulness of this data. Firstly, these codes cover only one element of the mental health workforce. Secondly, as surveys, the LFS and APS are based on a sample of responses across the UK. Therefore data on employees in these specific codes in Wales is likely to be based on very small sample sizes. In order to understand how many are employed in the public, independent and third sector would further dilute the sample, making it likely for the data to be suppressed for disclosure protection.

Table 1: Available national statistics

SOC code: Occupation	2009
3222: Occupational Therapists	1,983
2212: Psychologists	421
All Employees in Wales	1,288,425

Source: APS 2009

Table 1 shows the data from the 2009 Annual Population Survey for these occupations. However, given the paucity of data available from national statistics, this report has drawn data from the following sources in order to profile the sector:

- Annual NHS Workforce Census, in order to profile publicly delivered mental health services. This data was drawn from Stats Wales.
- TBR Observatory, Trends Central Resource¹¹ to profile activity in the independent and third sectors.
- Wales Council for Voluntary Action (WCVA) 2010 report 'The Hidden workforce in health and social care in Wales - volunteer roles and skills' to provide further detail on activity in the third sector.

A limitation of these data sources is that they do not allow for a detailed examination of the qualification levels of the workforce, or specific identification of roles and occupations. Supporting evidence was generated through the survey conducted as part of this research project. However, this remains a gap.

⁸ SOC code 3229

⁹ SOC code 3222

¹⁰ SOC code 2212

¹¹ <http://www.tbr.co.uk/index.php?id=4>

3.2.1 Publicly delivered mental health services

Statistics are available from the Annual NHS Workforce Census¹² that enable a count of staff (and full-time equivalents, FTEs) by the 'area of work', many of which can be directly linked to providing mental health services. There are also a number that are perhaps indirectly linked; for example, learning difficulties and multi-therapies.

Table 2 provides a summary of the data available for 2008 and 2009, and shows that in 2009 approximately 9,800 people (8,700 FTEs) were employed in mental health services provided by the public sector. Overall 6% more people were employed in public sector mental health services in 2009 compared to 2008; this equated to 4% more FTEs¹³.

Table 2: The public sector mental health workforce in Wales

Area of work	2008		2009		% change 08-09	
	Employees	Full-Time Equivalents	Employees	Full-Time Equivalents	Employees	Full-Time Equivalents
Other psychiatry	3,619	3,335	3,757	3,426	4%	3%
Occupational therapy	1,362	1,186	1,433	1,214	5%	2%
Community psychiatry	1,086	1,012	1,261	1,168	16%	15%
Psychiatry	629	555	585	511	-7%	-8%
Other learning disabilities	505	480	528	500	5%	4%
Speech & language therapy	528	420	568	439	8%	5%
Clinical psychology	496	417	538	436	8%	4%
General psychiatry	338	321	334	314	-1%	-2%
Community learning disabilities	338	307	321	295	-5%	-4%
Learning difficulties	146	134	228	205	56%	53%
Child & adolescent psychiatry	78	70	73	64	-6%	-8%
Old age psychiatry	58	53	57	51	-2%	-4%
Psychiatry of learning disability	28	26	30	29	7%	10%
Forensic psychiatry	25	22	29	26	16%	18%
Multi-therapies	13	10	20	17	54%	61%
Art/music/drama/therapy	23	14	24	15	4%	8%
Psychotherapy	9	7	17	12	89%	67%
Total	9,281	8,368	9,803	8,720	6%	4%

Source: WAG, NHS Staff Resource Data 2008 & 2009

¹² <http://www.statswales.wales.gov.uk>

¹³ In looking at percentage change it is important to consider the absolute change also. For example, an 89% increase in psychotherapy staff seems extremely large, but the absolute numbers are small. In this case a rise from 9 workers to 17.

Those working in the sector are also classified by occupational groups. A detailed table showing the number of staff by occupational group and area of work is available in the appendix.

The NHS staff resource also provides data on staff in Social Service Departments. Table 3 presents data for those working either in residential or day/community mental health services. The percentage change in employment overall has been lower than that shown above. Additionally, although there has been a rise in the total number of people employed in residential facilities, the number of whole-time equivalents has dropped.

Table 3: The mental health workforce in Wales

Area of work	2008		2009		% change	
	Employees	Whole-Time Equivalent	Employees	Whole-Time Equivalent	Employees	Whole-Time Equivalent
Residential services for adults with mental health problems	66	50	70	49	6%	-2%
Day/Community Services for adults with mental health problems	277	225	278	230	0%	2%
Total	343	275	348	278	1%	1%

Source: WAG, NHS Staff Resource Data 2008 & 2009 Independent mental health services

In order to develop a view on the scale of independent mental health services in Wales the following table considers an extract from Trends Central Resource (TCR).¹⁴

TCR is a longitudinal business database from which individual organisations and practitioners can be identified. The key benefit of TCR to this project is that the identification of relevant records is not constrained by Standard Industrial Classification (SIC) codes which, similarly to SOC codes, do not adequately describe the sector. Organisations and practitioners can be identified using specific search terms matched to a description of the business activity. For example, searching for all records with the word 'counselling' and then sorting through to select those relevant to the mental health sector.

¹⁴ <http://www.tbr.co.uk/index.php?id=4>

Using this approach we are able to develop a view of the activity in the independent sector. However, it should be noted that this is not a census. Rather, it should be considered a minimum estimate.

The search of TCR has identified 133 organisations/practitioners, with a tendency for provision to be focused on one-to-one support, e.g. psychotherapy or counselling.

Table 4: The independent sector workforce in Wales

Type of activity	Organisations /Practitioners	Employment
Counseling	40	268
Substance misuse support	39	587
Psychologists/Psychotherapists	26	47
Occupational health	19	41
Residential mental health care	6	936 ¹⁵
Hospitals	3	153
Total	133	2,032

Source: TBR Observatory, TCR

TCR also identified 37 records for organisations operating in the health and social care sector where the name of the company was an individual's name. Working on the assumption that these individuals are likely to be engaged in the delivery of one-to-one support, it is likely that these people deliver services at some point in the care process. In total these 37 organisations employed approximately 80 people.

Finally, TCR also identified 57 'supporting' organisations (employing nearly 500 people) ranging across the independent and third sector. These organisations tend to deliver strategic support for the development of the sector.

¹⁵ This figure is skewed by the employment count of Mental Health Care Ltd, which in a group of care homes employs approximately 600 people. At the time of writing a query to validate the total number of homes had been lodged but remained unanswered.

3.2.2 Third sector mental health services

The third sector also operates across the range of services provided. Research undertaken by the WCVA estimated that there were approximately 44,300 volunteers in third sector health and social care organisations in Wales.

The report was not able to provide a weighted estimate of the number of these volunteers involved specifically in the delivery of mental health services. However, it does provide details on the specific number of volunteers in these roles noted by respondents, which could be considered as a minimum estimate.

Table 5: The volunteer workforce in Wales, core services

Role	Total number of volunteers reported
Medical: Service roles which have a direct impact on the service user's treatment	1,584
Medical equipment: The loan or provision of medical equipment related to a 'reablement' programme, enabling early discharge or maintaining independence	1,543
Therapeutic care: Other services related to specific conditions.	1,369
Total	4,496

Source: WCVA 2010 The hidden workforce in health and social care in Wales

The volunteer workforce also plays a crucial role in delivering services that are not focussed on medical or therapeutic treatments, with organisations and volunteers working across the range of 'services' described in section 4 above. Again, whilst not able to provide a weighted estimate of the size of this element of the workforce, the WCVA report does provide the specific number of volunteers in these roles noted by respondents, which could be considered as a minimum estimate.

Table 6: The volunteer workforce in Wales, supporting services

Role	Total number of volunteers reported
Advice: Advice services can be given in person or over the telephone, internet websites or web forums.	570
Care in the home: These are services provided in a direct way to enable people to live in their own home	2,657
Pastoral/Religious: Chaplaincy services and visitor schemes	281
Sports: Providing activities which encourage physical activity as therapy or health promotion	167
Transport services: Enabling attendance at medical appointments (primary and secondary care), enabling discharge from hospital.	1,152
Total	4,827

Source: WCVA 2010 The hidden workforce in health and social care in Wales

It is also worth noting that the third sector employs a significant number of mental health employees. A 2007 report produced for the Welsh Assembly Government¹⁶ estimated that there were 4,000 mental health employees working in the third sector in Wales, in addition to 6,000 volunteers. This figure of 6,000 volunteers is lower than the combined total of the volunteer workforce in core and supporting services illustrated in Table 5 and Table 6 above as that data is for the whole health and social care sector and as such is likely to overestimate the number of volunteers in the mental health sector.

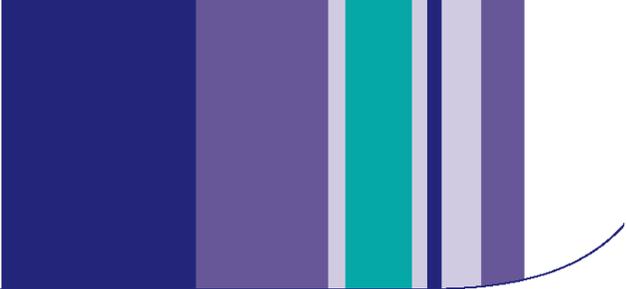
¹⁶ WCVA (2006): Health, Social Care and Well-being services provided by voluntary organisations in Wales: A report for the Welsh Assembly Government

4. Skills demand in the mental health sector in Wales

- The majority of mental health employers (60%) reported that they have not experienced difficulty in recruiting to any particular mental health occupations.
- 46% of Welsh mental health employers in the mental health sector reported skills gaps.
- Skills gaps in Welsh language skills and ICT skills are most widely anticipated to affect mental health organisations over the next 12 months.
- Mental health sector employers feel that more skills gaps exist amongst those workers who are less experienced, evidencing the fact that it is experience, rather than training that makes people 'work ready'.
- The majority of mental health employers (79%) do not believe staff retention is a major issue.
- Training and education available to the mental health workforce is seen as largely appropriate and to be meeting the needs of the sector.
- A large proportion of mental health employers stated that no qualifications were lacking amongst their organisation's current workforce.
- Volunteers are regarded as important in the sector, providing organisations with flexibility and capabilities in different specialisms, which could not always be provided by a single employed individual.
- Many third sector providers are anxious about the possible impact of government budget cuts which are expected to increase funding challenges for the workforce.

4.3 Skills and workforce issues

For the purposes of this report an online survey was completed by 68 respondents whose organisations provide services to people with mental health issues in Wales. Organisations which responded were evenly split across the independent, public and third sectors (see Table 12, page 59). The survey respondents were a mix of organisations which provide mental health services to all age groups including the elderly, adults, young people, and children or a combination of these groups (see Table 13, page 59).



The findings of the survey were contextualised through conducting in-depth interviews with key stakeholders in the mental health sector in Wales (please see section 8.8 for the full list of individuals and organisations interviewed).

4.3.1 Skills shortages

A skills 'shortage' is said to exist where there is a lack of adequately skilled individuals in the labour market to fill an advertised post.

The majority of mental health employers who responded to the online survey (60%) reported that they had not experienced difficulty in recruiting to any particular mental health occupations.¹⁷ However, 16% of mental health employers said that they had experienced skills shortages; this compares to only 6% of employers in the entire health sector¹⁸. Mental health employers who had experienced recruiting difficulties cite psychologists and mental health nurses as the hardest positions to recruit for.

Key stakeholders within the mental health sector also identify a shortage of psychologists and psychiatrists in Wales. This gap is likely to mean that service users cannot always get the treatment that they need. This is especially true in North West and Mid Wales, where rurality can create challenges, such as the greater distances that both mental health workers and service users need to travel, resulting in higher costs and fewer appointments.

Employers in the sector may be able to ameliorate any difficulty in recruiting psychiatrists by advertising vacancies abroad, as psychiatrists are on the Migration Advisory Committee's Shortage Occupation List; this is one of very few occupations in the mental health sector where employers are able to recruit workers from outside of the EU.

Another skills shortage identified across Wales was a lack of mental health workers with the skills to work with service users with anorexia.

The mental health sector reports the most common impacts of skills shortages to be an increased workload for others and longer waiting times for service users. Other effects of skills shortages include difficulties in introducing new working practices and a compromising of the safety of service users or staff. The main reason given for difficulty in recruiting to certain occupations was the lack of applicants, followed by candidates having a lack of specialist skills or a lack of Welsh language skills.

¹⁷ 24% of mental health employers who responded to the survey had not tried recruiting recently.

¹⁸ NESS, (2005) quoted in Skills for Health, (2009), Sector Skills Assessment p55.



4.3.2 Skills gaps

A skills 'gap' is said to exist where individuals within the existing workforce have a miss-match between their skills and those needed to perform their role and meet organisational objectives.

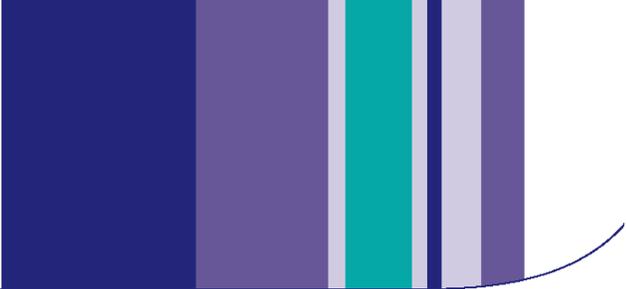
Skills gaps are a more significant issue for the mental health sector in Wales than skills shortages. Over half of respondents (54%) stated that they perceived there to be no skills gaps in the workforce of their organisation, leaving 46% of employers which do have skills gaps in their organisation. This compares to only 24% of employers in the entire health sector in Wales¹⁹. Therefore, it would seem that skills gaps are more prevalent in the mental health workforce in Wales than the workforce of the rest of the health sector.

The most commonly cited skills gaps indicated were Welsh language skills, followed by ICT skills and substance misuse guidance skills. The majority of respondents who said they had skills gaps (64%) indicated that Welsh language skills are lacking amongst their workforce, whilst over a quarter of respondents stated that ICT skills are lacking. Mental health sector stakeholders feel that more skills gaps exist amongst those workers who are less experienced, evidencing the fact that it is experience, rather than training that makes people 'work ready'. Therefore there is a gap in terms of 'work practise' when training.

Other specific skills gaps identified include management skills, counselling skills, effective listening and empathy skills and understanding individual service user's backgrounds, highlighting the importance of 'soft skills' to the sector. Some of these 'soft skills' (such as empathy) are considerably more difficult to teach or train, although there are some counselling courses which are able to help develop (rather than instil) the 'empathy skills' of those working in the sector. It is important that people with the right attitudes and soft skills undertake training, rather than trying to train these attributes into individuals after recruitment. Enabling service users to have an important role in recruitment and selection for training may help to address this issue.

Skills gaps in treating dementia and substance misuse were also mentioned and it was explained that these are being dealt with more frequently by mental health service providers. Many feel that workers within mental health now require an understanding of a much wider range of mental health issues than they did in the past. The sector crosses a lot of areas (for example medical treatment, psychological interventions and accommodation and housing support) and it is now more important to be aware of these. However, it was understood that not everyone working in the sector has sufficient knowledge to provide quality services across a range of sub-sectors of the mental health sector.

¹⁹ NESS, (2005) quoted in Skills for Health, (2009), Sector Skills Assessment p58.



The mental health occupations in which skills gaps are commonly found are social care support workers and nurses. One issue within nursing occupations is the occasional expectancy for nurses to provide occupational therapy, despite not having the specialist skills of occupational therapists. Such issues are common within the health sector and might be aided by the application of competence-based approaches to workforce planning.

The most common reason given for skills gaps within an organisation is a limited budget for training, followed by limited time for training. Other commonly cited reasons for skills gaps were difficulties in keeping up with changes in the sector and the limited availability of training. The impact of these skills gaps are difficulties in introducing new working practices and delays to developing new products or services.

It is interesting to note the different impact of skills shortages and skills gaps in the sector. The impacts of skills shortages are related to service delivery (i.e. recruiting to provide extra capacity) whereas skills gaps hinder service improvements. Thus, employers in the sector appear to recruit to increase capacity and then further train staff to improve performance.

4.3.3 Retention issues

The majority of respondents to the online survey (79%) thought that retention of mental health staff is not a problem at all. This was also echoed in the in-depth telephone interviews. However, a number of general trends relating to the movement of employees between organisations were mentioned.

Generally it is the young and motivated that move between organisations, especially as they are likely to be more mobile (e.g. because younger people are less likely to have families to uproot if they are to move jobs). As experience is very important to employers, organisations try to retain their most experienced workers, and these tend to be older.

Some specific occupations experience more issues relating to retention than others. In particular, it is perceived that social workers are more inclined to move away or out of the sector, whilst psychologists sometimes move to England after training in Wales in search of better opportunities and pay. It should be noted that it is not surprising that social workers have a great propensity to use their skills in other sectors, whereas other workers in the mental health sector (e.g. nurses) are far less likely to change sector as their skills are specific to the health sector.

The consequences of a lack of staff retention in the mental health sector would include less continuity for service users and therefore difficulties in delivering high-quality mental health provision.



It is important to understand the reasons behind low staff retention in order to address the issues causing staff to move between jobs. Retention of workers in any sector is often driven by job satisfaction, wages and training progression. The loss of employees in the sector is often to better paid positions and sometimes management roles. However, training strategies can help to retain workers.

4.3.4 Qualification levels

A large proportion of mental health employers stated that no qualifications were lacking amongst their organisation's current workforce. However, some employers would like more of their workforce to have undergone vocational training and/or more postgraduate level training (9%).

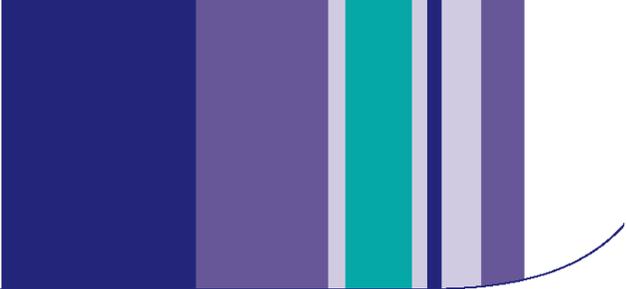
Qualifications currently held by employees in the sector are generally considered to be useful. Standards such as the Drugs and Alcohol National Occupational Standards (DANOS) are important for those both receiving and delivering training. QCF/NVQ level 3 is highly regarded as both an entry route to the sector and a suitable qualification for many social care support workers. However, some training and education is perceived as too general and professionals would like to see qualifications contain modules on specialist areas of the mental health sector. In particular, the NVQ level 4 was highlighted as one area where things could be improved in order to meet the needs of the mental health sector. It was felt by some that it focuses too much on service user care and not enough on managing a service user's mental health illness and the non-medical aspects of service user care.

The qualifications cited most frequently by respondents as lacking amongst new recruits are postgraduate level training followed by graduate level training.

When asked the minimum education level expected to be held by new recruits, the largest proportions of respondents cited

- Post-graduate level training (23%).
- None (15%).
- NVQs (15%).
- Other vocational training (15%).

The majority of respondents stated that the minimum educational level expected by new recruits varied by occupation with some occupations such as medical consultants requiring specific qualifications or accreditations.



4.3.5 Training issues

Training and education available to the mental health workforce is seen as largely appropriate and to be meeting the needs of the sector. Gaps in training include niche or specialised training that is specific to the mental health sector. This includes training in dealing with dementia, disability, 'difficult' service users and mental health specific social care.

In-house training is popular with mental health sector employers. Interestingly, practitioners would be interested in receiving training invitations from external providers. It was found that external provision is not always advertised as well as it could be. It is felt that more people would attend external provider's courses if they were publicised more effectively.

It is perceived that the training provided by employers is reactive and not proactive in many organisations. This is because employers find it difficult to anticipate the future skills needs of the individuals working in their organisation. Employers need to better understand future skills needs if training is to be more proactive and better able to meet the skills needs of the workforce of the future.

In general, respondents felt that 'wholesale' changes to training and education were unnecessary, but there should be a change in focus towards modules with a focus on specific aspects of mental health. For example there is a desire for mental health workers who work with elderly people to be able to undertake specific training related to dementia care.

4.3.6 Role of volunteers

Volunteers are very important in the sector. Volunteers provide organisations with a lot of flexibility and different specialisms, which may not always be provided by a small team of employees. They also bring a breadth of experience and are usually highly motivated.

There are a variety of motivations for a person becoming a mental health volunteer. For example, service users might decide to volunteer in organisations, whilst others may volunteer to take advantage of development opportunities. Roles that volunteers are commonly employed in include counsellors/psychotherapists and social care support workers. Other volunteers carry out administrative tasks. Volunteers can often be service users or ex-service users or people who have experience of mental health issues, perhaps through a family member. They often help with the less severe cases of mental illness and also provide support by giving charities a voice in influencing policy, as well as helping in fundraising and advocacy activities.

Commonly cited skills required by volunteers include service user communication/listening skills, confidentiality and disclosure skills and skills for dealing with service users and the public.



It is felt that some skills gaps exist amongst the volunteer workforce. For example, ICT has been a problem in some organisations but this was addressed by contracting in ICT trainers.

It was noted that volunteering is not always recognised as a viable career path for those entering the mental health sector. Volunteering can be described as a type of 'reablement' or a way of gaining social, employment and vocational skills and experience to enable re-entry into the workforce. In the case of mental health, volunteering is also a way of providing peer support, mentors and a safe environment which is accepting and which is part of modeling a society which is not prejudicial or exclusive.

However, the experience gained by volunteering can provide individuals with some of the necessary experience required to work in certain paid roles in the sector if they wish.

4.3.7 Role of international workers in the sector in Wales

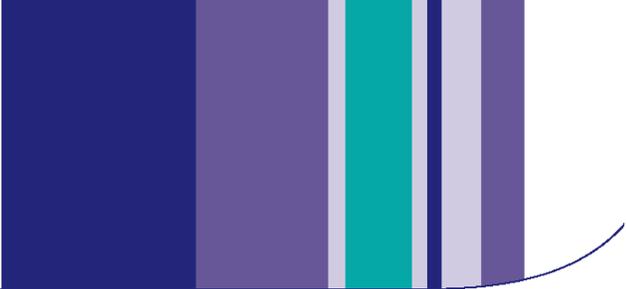
It has been reported that a large number of international mental health nursing employees work in the UK²⁰. It is essential that all mental health workers within the workforce in Wales, regardless of the country in which they qualified, have comparable skills and knowledge to deal with service users effectively. Structured personal development can ensure that workers have the skills to work in Wales effectively and are trained to the same level as native employees.

Very few mental health employers advertise job vacancies overseas. However, 15% of employers responding to the survey stated that their organisation does employ international mental health workers; the vast majority of international mental health employees in Wales are non-EU nationals. The international workers in the mental health sector in Wales are more prevalent in the NHS and also in more highly qualified positions. According to the online survey, the most common occupations for international workers to be employed in are medical consultants and nurses.

A report from the migration advisory committee (2009²¹) discusses how non-EU workers in certain occupations in the health sector may only be granted visas to work in the UK if their occupation is specified as a skills shortage under tier 2 of the points-based immigration system. This will increase the reliance on EU nationals in the health sector in the UK and will mean that organisations that have previously been dependent on recruiting non-EU international workers may struggle to staff their organisations adequately. As noted above, psychiatrists can be recruited under the migration advisory committee list, but very few other occupations in the mental health sector can recruit staff from outside of the EU.

²⁰ Centre for Mental Health workforce briefing (2003)
http://www.centreformentalhealth.org.uk/pdfs/briefing_20.pdf

²¹ <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/aboutus/workingwithus/mac/first-review-lists1/0409/mac-2nd-review-09?view=Binary>



4.3.8 Funding issues

Funding issues described by respondents are similar to those experienced in other sectors. Many felt that training and education can be too expensive and that sometimes, funding is not available to assist with these costs. Some practitioners indicated they would like to receive more funding for external training as often the majority of training provided is internal.

Some practitioners see that collaboration and the pooling of resources could help make training cheaper and more accessible, especially collaboration between the public and third sectors.

From a service delivery viewpoint, sometimes it is not the shortage of psychologists that makes accessing treatment difficult, but the lack of funds for organisations to provide sufficient services to meet demand. Government budget cuts are expected to increase funding challenges. For example, concern was raised as to whether many third sector mental health service providers that are currently funded by local authorities would be able to survive the funding cuts.

4.3.9 Future skills issues

The skills gaps most commonly anticipated to affect respondent's organisations over the next 12 months are Welsh language skills (43%) and ICT skills (29%). Substance misuse guidance is also cited frequently as a skills gap that will affect organisation over the next year (24%).

Following agreement by the National Assembly, the new Welsh Language Measure received Royal Approval on 9 February 2011 and is now a measure of the National Assembly (a Welsh law)²². It is not clear at present what impact this will have on mental health organisations and public bodies in Wales. However, it is likely to be an important issue for the future. The use of the Welsh language in mental health organisations causes fewer issues in urban South Wales than across Mid and North Wales.

One issue raised about the use of the Welsh language was that, whilst many mental health workers are comfortable in speaking conversational Welsh, some are unable to talk to the service user about their condition/treatment in Welsh (use of 'technical' language/medical terminology in Welsh). The use of Welsh is specifically relevant for service users who need to be able to revisit childhood memories and delve deep into their psyche. The Welsh language is also important in mental health advocacy.

Some mental health employers raised their concern that training may become less affordable as a result of reduced spending. There is concern that any reduction in Government budget allocation for mental health will affect training and wages negatively. It is anticipated that management skills

²² <http://www.assemblywales.org/bus-home/bus-legislation/bus-leg-measures/business-legislation-measures-wl.htm>



will become more important to provide the same services with reduced funding, whilst not compromising on the quality of service.

New skills will also be required to manage the pooling of resources and a more collaborative approach to working practices. It was noted that integrated service provision will become more prevalent (though already present) and will need to cover more areas. Collaboration between providers, local authorities, the independent sector and the NHS can result in the provision of a better service for service users. However, such collaboration does not always occur at present. New roles sometimes need to be created, or existing roles expanded to organise collaborative activities with other organisations.

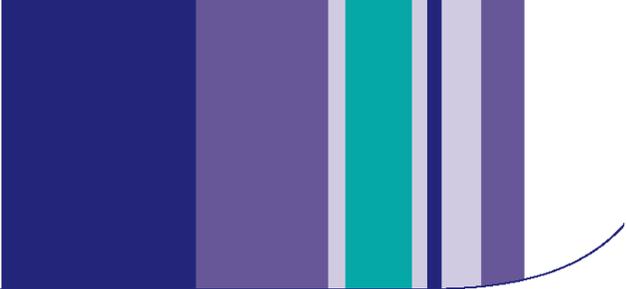
The future skills impact of demographic changes taking place across Wales was raised by a number of employers. For example, there are more elderly service users and more people with alcohol problems that require treatment. The future skills impact of this will be that employees in the sector need more skills to deal specifically with these types of service users.

Skills that are anticipated to become increasingly important include:

- Counselling.
- Management and leadership.
- Dealing with service users and the public.
- Service user communication and listening skills.
- Substance misuse guidance.

Raising awareness of mental health issues in Wales would enable more people who require treatment to ask for the help that they need and to know where to receive the treatment. It would also assist in removing the stigma associated with mental health issues and aid service users in their recovery process.

A trend in more qualified workers as a result of graduate unemployment (resulting in higher numbers of young people studying for additional qualifications instead of entering the workforce immediately) has been observed by some working within the sector. However, this may result in experienced, but lower qualified workers finding it more difficult to find employment in the mental health sector. It may also result in the sector employing these highly qualified yet inexperienced workers, which will have implications for managers within the sector as they seek to lead a less experienced workforce. It is important to note that individuals will not necessarily become competent workers simply by achieving an academic qualification and that there are other attributes that are needed, such as experience and skills which aren't taught as part of formal qualifications, e.g. empathy and other soft skills.



5. Drivers of workforce development

Policy

Mental health care is a devolved matter, for which WAG is responsible for delivery and policy. However, policy in Wales is still being influenced by Westminster (stemming from a number of policies including the 2007 Mental Health Act). The recent referendum vote for more powers for Wales means that the Welsh Government will be able to steer more distinctive mental health policies, should it wish to do so.

The Welsh Government has a number of mental health initiatives, as well as broader strategies which impact upon mental health services. The most recent mental health policy is the Mental Health Measure (2010) which identifies and addresses gaps in services and the structure of mental health services. Other broader Welsh Government policy such as the Welsh Language Measure, which applies duties on public bodies to provide services in Welsh, affects mental health service provision and the skills requirements of workers.

Skills Policy

A well-skilled mental health sector has benefits for the sector and the wider population. Addressing skills shortages and gaps is essential for the development of the health sector.

A number of skills issues are pertinent for the workforce including those that relate to the whole health workforce such as lack of leadership and management and gaps in problem solving and technical skills. Specific mental health skills issues include collaborative skills between organisations providing different mental health services, and Welsh language skills. These skills issues can inhibit the development of the sector and the effectiveness of service delivery.

Improved skills levels will aid the development of the sector, enabling it to respond effectively to challenges, enhance service effectiveness and provide a better quality of care to service users. In striving to achieve improved skills level in the sector, Skills for Health, other Sector Skills Councils and the Wales Employment and Skills Board (WESB) have an important role to play in integrating relevant policies and identifying the actions necessary to improve skills performance.

Funding

Public healthcare in the UK has been partly protected from spending reductions laid out in the 2010 Comprehensive Spending Review. WAG has also announced its intention to protect jobs in the health service in Wales.

Despite stability in Welsh Government spending for mental health services, the interconnectedness of mental health care provision leads to a number of potential issues including cuts to front line services, changes to the benefits system, reduced expenditure on training and decreases in third sector funding. These all have the potential to impact upon the mental health sector and the skills required to deliver services.

Economic Stress

The loss or lack of employment and reduced access to capital can have major impacts upon individuals and their requirements for mental health services. The recent economic downturn has had impacts upon individuals and businesses which have seen increased incidences of stress-related health problems.

To address mental health issues that occur from economic problems there will be a need for the workforce to have different skills and knowledge to respond to problems. Debt advice and financial knowledge, collaborative working practices and promotion of mental health issues could therefore become more important in the future.

Other key drivers include:

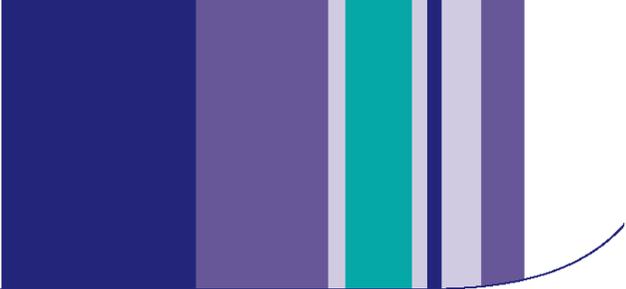
Social environment and demography: The social environment and demographic grouping of a person can significantly influence demand for mental health care.

Stigma: According to Mind Cymru²³, there remains a relatively high level of negative attitudes towards mental health in Wales, with no nationwide anti-discrimination campaign in place (unlike in England and Scotland). These negative attitudes expressed by people in Wales suggest that mental health service users are more likely to experience discrimination, e.g. by being turned down for employment. The effects of this discrimination could act as a barrier to recovery.

Skills: There are a number of skills issues in the mental health workforce that reflect the priorities of Skills for Health more broadly, e.g. desire for development of management and leadership skills in the sector, more ICT skills etc.

Service Development: Developments in service delivery will also have an impact on the workforce; significant service developments include investment in preventative measures, ensuring that 16-18 year old service users have access to mental health care, online ICT provision and ensuring that service users have a say in how their care is managed.

²³ Mind Cymru, *Mental Health: the Need for an Anti-discrimination Campaign in Wales*, Manifesto Briefing 2, 2011. The paper cites data from a recent YouGov poll on attitudes, however, the numbers surveyed in Wales are too small to allow comparisons between Wales and the rest of the UK.



5.4 Policy Context

The following section reviews the policy background in connection to mental health skills and employment. The section starts by reviewing the international policy context, before examining UK policy and exploring the mental health policy environment in Wales.

5.4.1 Global Context

Mental health has become an important policy topic within the European Union (EU) and there are several mental health priorities of the EU. The Green paper, Improving the mental health of the population: Towards a strategy on mental health for the European Union (2005)²⁴, outlines how mental health rates are very different across the EU, with some countries experiencing higher incidences than others. The strategy sees that one important step in reducing mental health problems is to create a framework for information exchange and co-operation. As such, the policy outlines how learning and exchanging experiences across borders can help services to address mental health issues more effectively.

In the global economy, the movement across borders of people for work is increasingly common and has become a necessity in highly skilled sectors such as healthcare. A high proportion of UK workers within healthcare were born overseas and this requires some adaptive and language skills (and consequently training and education)²⁵. Culture and language can be a potential barrier to overseas workers in the mental health sector, as there is a deep-seated need to understand the background of individuals and, in the case of native Welsh speakers, there is sometimes a need to be able to conduct therapy or counselling in Welsh.

Lack of support, policy and a lack of clarity in policy have contributed to incomplete coverage of provision across the globe. The World Health Organisation (WHO) sees that a key element in providing mental health care is having a mental health workforce that is skilled in providing “mental health promotion, prevention, treatment and rehabilitation”²⁶. It is imperative that mental health workers are served by education and training effectively and in order to do so, the WHO sees that training and education requires “coordination and the development of consistent policies between the mental health delivery sector and the training sector”. The WHO research points to the need for close collaboration between mental health policy and education and training, which enables workers to respond to policy change, healthcare and service demands.

²⁴ Improving the mental health of the population: Towards a strategy on mental health for the European Union (2005) EU:
http://ec.europa.eu/health/archive/ph_determinants/life_style/mental/green_paper/mental_gp_en.pdf

²⁵ Skills for Health, Migration Case Study (2006)

²⁶ World Health Organisation, Improving Health Systems and services for mental health (2009):
http://whqlibdoc.who.int/publications/2009/9789241598774_eng.pdf



5.4.2 United Kingdom Context

Mental health care is a devolved matter for which the Welsh Government (WG) is responsible for delivery and policy, although it remains influenced by Westminster.

Currently the structure and provision of UK mental health care stems from the Mental Health Act (amended 2007). These policies lay out how mental health problems can be addressed by healthcare services and what the structure of healthcare services should be. The Mental Health Act also demonstrates the close collaboration of mental health care and the criminal justice and social care systems through supervised community treatment. The act has important policy directives which shape the mental health workforce, the skills needed and employment roles. For example, within the 2007 amendment there is an emphasis on “broadening the group of practitioners”²⁷ that can be responsible for treatment of those with mental health problems.

The Mental Health System reform agenda²⁸ identifies the need to improve delivery and offer early intervention and prevention through its core objectives. To help improve the quality and productivity of the sector and enable the sector to change its emphasis. The four key elements are:

1. Transactional reforms: ensuring that money ‘follows’ the service users, rewarding the best and most efficient provision and giving the incentive to improve.
2. Demand side reform: More choice and a much stronger voice for service users.
3. Supply side reform: More diverse providers with more freedom to innovate and improve services.
4. System Management reform: A framework of system management regulation and decision making which guarantees safety and quality, fairness, equity and value for money.

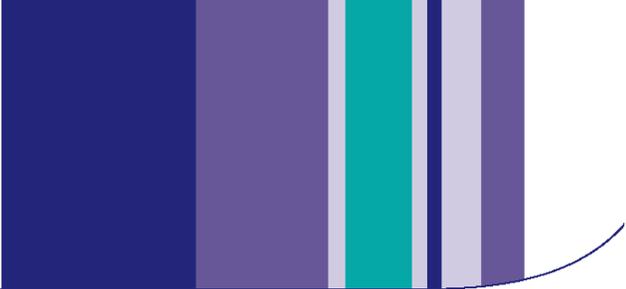
As a result of these four elements, there is a view that training and workforce development will have to change. The UK programme for government²⁹ sees a greater role for the independent and third sectors in the NHS and strengthening of service user responsibility. This will impact upon how workers train and who accesses training, which in turn has implications for skills policy³⁰.

²⁷<http://www.dh.gov.uk/en/Healthcare/Mentalhealth/InformationontheMentalHealthAct/index.htm>

²⁸ <http://www.dh.gov.uk/en/Healthcare/Mentalhealth/Systemreform/index.htm>

²⁹ http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/documents/digitalasset/dg_187876.pdf

³⁰ Skills for Sustainable Growth (2010) <http://www.bis.gov.uk/assets/biscore/further-education-skills/docs/s/10-1273-skills-for-sustainable-growth-strategy-summary>



The UK Government's latest mental health strategy for England, "No health without mental health", is likely to be of importance to Wales because of the strategies outlined to tackle challenges faced across all nations of the UK. For example, there is an issue across all nations with people with mental health problems also having poor physical health. The way in which England deals with this issue will be monitored in the other nations of the UK.

It is becoming increasingly apparent that mental health policy requires a collaborative approach from different Government departments; the NHS, local government, the third sector and the independent sector. The current policy focus from Westminster sees an emphasis on identifying the outcomes of treatment and care for service users, as well as paying more attention to the needs and actions of service users and GPs.

An area of particular UK influence is clinical work (especially the work of the National Institute for Health and Clinical excellence (NICE)), such as clinical trials, work patterns, guidelines and evidence-based medicine. The monitoring of health performance and developments across the UK is therefore important to how the mental health sector operates in Wales.

5.4.3 Wales Context

Wales has its own approach to mental health care and promotion of mental health services, which is outlined by the WG³¹. The policy environment is fluid and announcements in 2010 of new funding for dementia services³² and high-quality secure mental health services³³ shows that investment and policy can change rapidly.

The ongoing implementation of strategies and initiatives related to mental health service development demonstrates WAG's commitment to this area of the health sector. This is most recently evidenced by the Assembly's acquisition from Westminster of new powers to reshape mental health care and the production of the Mental Health Measure³⁴ (now law in Wales). This measure addresses gaps in previous legislation, seeks to identify mental health problems earlier and reorganises the structure of support services to ensure that service users have a choice of healthcare provision. It also seeks to make provision for care and treatment plans for all those in receipt of mental health services and extend mental health advocacy.

Mental health policy is a particular focus for the WG and devolved decisions can impact positively upon mental health services. As a result, there is

³¹ <http://www.wales.nhs.uk/publications/adult-health-e.pdf>

³² <http://wales.gov.uk/topics/health/nhswales/healthservice/mentalhealthservices/dementia/?lang=en>

³³ <http://wales.gov.uk/publications/accessinfo/dmewhomepage/healthdrs/2010/mhsactionplan/jsessionid=BCrIMtMK9kGRZ3nyqC1QDz0GsXzHdzghqXh0YLg4vbpbGrhJ6J!-971712554?lang=en>

³⁴ <http://www.assemblywales.org/bus-home/bus-legislation/bus-leg-measures/business-legislation-measures-mhs-2.htm>



support amongst MPs³⁵ to see more devolved decisions made by the WAG to help Wales deal with mental health issues.

The recent referendum vote for more powers for Wales means that the WG will be able to steer more distinctive mental health policies, should it wish to do so.

The WG has launched a number of mental health strategies and initiatives since 2001³⁶, setting out aims and objectives for the future. The ambition is to have modernised, strong, accessible mental health services³⁷ and social services³⁸ in Wales and ensure that the best care is provided for service users. In order to do so, there is emphasis on staff having the necessary support to offer effective mental health care provision. There is also a focus within WG policy upon linking service delivery, in particular between worklessness and mental health care. There have been initiatives between Job Centre Plus and Local Health Boards (LHBs³⁹) to help support those with economically associated mental health challenges.

The revised adult mental health national service framework (NSF) and action plan for Wales⁴⁰ identifies priorities for mental health services. The NSF contributes to healthcare standards and it aims to assist in implementing the vision set out in the 2001 Mental Health Strategy⁴¹. The key actions resulting from the NSF include assisting workers:

- In facilitating social inclusion, health promotion and tackling stigma.
- To become more empowered.
- To promote opportunities for normal patterns of daily life for mental health users.
- To be part of service provision that is equitable, accessible, effective, comprehensive and responsive.
- In delivering effective, comprehensive and responsive services.
- To assess service user care pathways.
- To become better skilled and supported effectively.

³⁵ <http://www.publicfinance.co.uk/news/2009/11/mps-back-mental-health-powers-for-wag/>

³⁶ <http://www.mentalhealthwales.net/mhw/strategy.php>

³⁷ http://www.wao.gov.uk/assets/englishdocuments/Adult_Mental_Health_Services_Baseline_Review.pdf

³⁸ <http://wales.gov.uk/topics/health/publications/socialcare/strategies/lives/?lang=en>

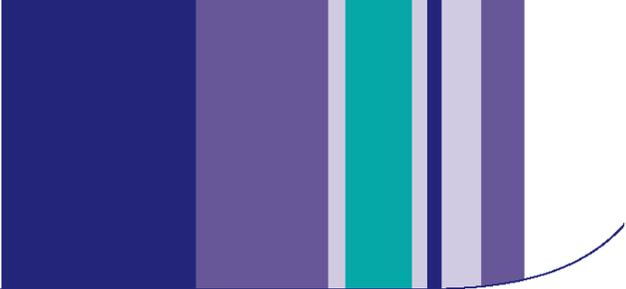
³⁹ Healthcare services are organised into 7 Local Health Boards (LHBs) across Wales. Each of these boards are responsible for mental health services in its area.

⁴⁰ NHS, 2005, The Revised Adult Mental Health National Service Framework and an Action Plan for Wales:

<http://www.wales.nhs.uk/sites3/Documents/438/Raising%20the%20Standard%20%28english%29.pdf>

⁴¹ Adult Mental Health Services for Wales, Strategy Document 200:

<http://www.wales.nhs.uk/publications/adult-health-e.pdf>



These actions have clear implications for the workers in the mental health sector. They demonstrate the broad range of skills that workers need to have in the sector and how policy can shape skills requirements in the sector⁴².

Wales has a bilingual policy which is encapsulated across health strategies. Welsh language is also important in mental health advocacy and the recent Welsh Language Measure reaffirms duties on bodies to provide services in Welsh. Welsh language provision contributes to offering mental health services that are accessible, encompassing and flexible, but can also require employers and workers to have Welsh Language skills, requiring training and/or more selective recruitment.

5.4.4 Skills Policy

The 'Skills That Work for Wales - A Skills and Employment Strategy and Action Plan' (2008)⁴³ notes that addressing skills and employment issues can support the economy and give people the skills to succeed. The mental health sector plays an important role in society and the economy by assisting people back into work and therefore reversing negative health effects like poor self esteem and depression⁴⁴.

The Wales Employment and Skills Board (WESB) is responsible for integrating relevant policies, such as skills and health and working with Sector Skills Councils (SSCs) to identify the actions necessary to improve performance. The WESB was created to drive forward the implementation of the Skills and Employment Strategy. The board can contribute to skills development for the mental health sector by strengthening the employer voice on skills in Wales and giving expert advice to Welsh Ministers.

The SSCs in Wales strengthen the employer voices in skills provision. The WG wants the SSCs to be the strategic interface between itself and employers, and to work collaboratively where there is an overlap in footprints. The mental health workforce overlaps with the interests of the social work and justice workforce and therefore the findings of this report will be of interest to the SSCs which cover these footprints.

⁴² NHS, 2005, The Revised Adult Mental Health National Service Framework and an Action Plan for Wales:

<http://www.wales.nhs.uk/sites3/Documents/438/Raising%20the%20Standard%20%28english%29.pdf>

⁴³ Skills That Work for Wales, A Skills and Employment Strategy and Action Plan, available at: <http://www.learningobservatory.com/uploads/publications/1723.pdf>

⁴⁴ Skills That Work for Wales A Skills and Employment Strategy and Action (2008): Plan <http://www.learningobservatory.com/uploads/publications/1723.pdf>



5.4.5 The Big Society

The Big Society is a policy agenda introduced by the coalition government (2010) to empower local communities to '*come together, solve the problems they face and build the Britain they want*⁴⁵, with an aim of rebalancing the economy and mending 'Broken Britain'. Local communities, families and the third sector are being encouraged to take responsibility for local development issues that span social, economic and environmental agendas. The third sector is essential to aid the implementation and operation of The Big Society in engaging people and pushing local agendas forward⁴⁶.

Given the importance of third sector delivery to the mental health sector, the renewed focus of the Big Society on voluntary activity could have major implications. However, impacts on the third sector in general, and with regard to mental health specifically, are currently unclear especially in the light of public sector spending cuts (see section 5.5.1). Therefore, exactly how the development of the Big Society will impact the mental health sector in Wales is also as yet unclear. Yet it is envisaged that the Big Society will give more responsibility and power to third sector groups in the mental health sector in Wales, and enable them to undertake their work more freely in a supportive political environment.

It is anticipated that the Big Society will drive a need for more volunteer managers. Volunteer management requires a particular set of skills and attributes, different to those required for managers of paid staff. Research conducted for Skills for Health in 2010⁴⁷ identified the three core skills of volunteer management as recruitment and induction, ongoing support and development, and volunteer withdrawal and departure. The research report concluded that the main issues facing volunteer managers was difficulty in recruiting volunteers and also identifying and providing suitable training for volunteers.

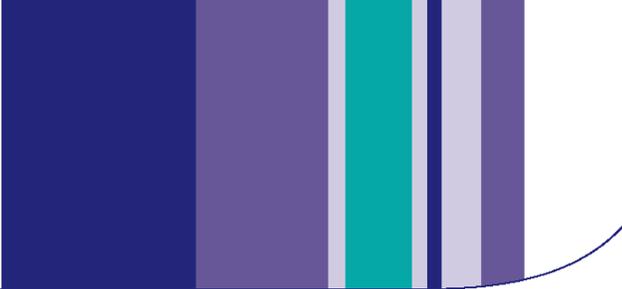
Volunteers are not under contract or contractually compelled to undertake activities, therefore this needs to be acknowledged in management styles⁴⁸. As such, it is likely that more formal training in how best to recruit, engage, motivate and manage volunteers will be in demand.

⁴⁵ Cabinet Office (2010) Building the Big society

⁴⁶ Nick Hurd Minister for Civil Society, (2010) Civil Society website http://www.civilsociety.co.uk/finance/news/content/6766/hurd_confirms_the_end_of_futurebuilders?print=1

⁴⁷ WCVA 2010 The Hidden workforce in health and social care in Wales

⁴⁸ Institute for Volunteering Research (2010) Valuing Volunteering Management Skills.



A policy response to the Big Society issued by the WCVA⁴⁹ suggests that the Big Society already exist in Wales, through the WG strategy and action plan for supporting the voluntary sector in Wales⁵⁰ and through strong third sector commitment to 'Big Society' values such as:

- Volunteering and active citizenship.
- Increasing citizen and community involvement in shaping local services.
- Community ownership of local services.
- Third sector delivery of public services where is it best placed to do so.
- Citizen directed services, based on co-design and co-delivery.

5.5 Key Drivers

5.5.1 Funding

Public healthcare in the UK has been partially shielded from spending reductions laid out in the 2010 Comprehensive Spending Review. The budget outlined by the WG revealed 'real term' cuts⁵¹ in health spending but ring-fenced mental health funding. Efficiency savings, however, will be sought across Government services. Currently mental health services attract just 12% of the budget for health and social services⁵² and just 6.5% of research expenditure; these figures could become even smaller in the future⁵³.

Despite this, funding for mental health is very important with the case for investing in the sector being to not only improve the health of the nation, but also to save money, given that the economic impact of poor mental health in Wales is considerable (estimated to be £7.2billion p.a.⁵⁴).

⁴⁹ WCVA. (2011) "Big Society" in Wales – good news, old news or no news?

⁵⁰ <http://wales.gov.uk/topics/housingandcommunity/voluntarysector/publications/thethirddimension/?lang=en>

⁵¹ <http://www.guardian.co.uk/politics/2010/nov/17/welsh-assembly-government-budget-cuts>

⁵² "9% of the National Health Service's and social service's spending in Northern Ireland, 11% in Scotland, 12% in England and an estimated 12% in Wales is allocated to mental health services. This is disproportionate to the human and economic costs of mental disorders." *Royal College of Psychiatrists website*, www.rcpsych.ac.uk/campaigns/fairdeal/whatisfairdeal/funding.aspx

⁵³ *Ibid.* This compares with 25% for cancer research.

⁵⁴ <http://www.walesonline.co.uk/news/wales-news/2010/03/17/poor-mental-health-costs-7-2bn-each-year-91466-26047623/>

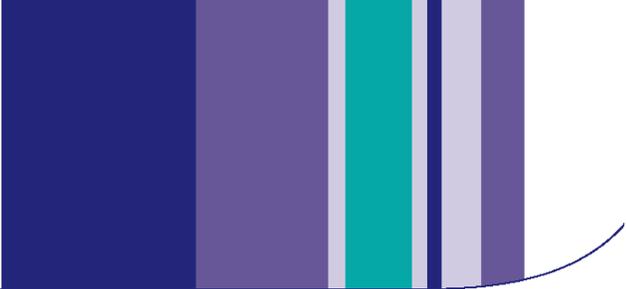


Reduced healthcare funding could have two impacts upon the mental health workforce and services:

1. A reduction in spending on services and initiatives (not yet fully implemented) borne out of the desire to reduce the UK's budget deficit.
2. An increase in mental health challenges as a result of socio-economic pressures resulting from the recession and spending reductions.

Despite stability in the WAG's spending for mental health services in Wales, the interconnectedness of mental health care provision leads to a number of potential issues which impact upon the mental health sector. These include:

- **Possible cuts to front-line services in social care and judiciary services.** These could impact upon how service users are referred or supported. Signposting or communication skills could therefore become more important for workers in the mental health care sector, who will need to have a good knowledge of the service network infrastructure.
 - **Changes to the UK Welfare system could have implications for those with mental health difficulties.** Removing benefit payments for those who miss welfare appointments could have adverse impacts upon those with mental health problems. In turn, this could increase the amount of service users and service users with multiple problems (e.g. depression & loss of benefits). The consequences of this for the workforce could include the need to understand the changing environment of the welfare system as well as skills to engage with users with multiple problems. Changes in specific parts of the benefit system, e.g. to disability living allowance, could significantly alter what service users and carers are able to afford to pay for services.
 - **There is the potential for reduced funding to lead to reduced provision of training and education by employers.** Training and education are important features of workforce development. Reduction in the amount of training or education reduces the ability of employers to address skills gaps and shortages. Consequences of not undertaking or receiving less training include not being able to respond to service user problems and increases in workforce problems like absenteeism and retention of workers.
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- **Cuts to other organisations, Non Departmental Public Bodies (NDPBs), Assembly Government Sponsored Bodies (AGSBs) and charities.** For example, MIND's budget has been reduced placing pressure upon certain services. These changes could affect how mental health service users are treated. This will require resource management skills within the sector to deal with increased, or more diverse, workloads. If local authority funding provided to third sector organisations is to be reduced, the existing third sector workforce could become stretched, as time and monetary resources have to be diluted to reach further. Leadership and management is, therefore, likely to become increasingly important in third sector organisations.

5.5.2 Economic Stress - Increasing social stress due to the economic factors, including unemployment.

Loss or lack of employment and reduced access to capital can have major impacts upon individuals and their requirements for mental health services.

Economic downturns have seen increases in mental health issues such as stress, anxiety and depression⁵⁵; this impacts upon individuals and businesses. The increased strain upon services⁵⁶ in this environment requires organisation and management skills to ensure that users are dealt with effectively. Better collaboration between healthcare providers and support and advice services can help service users to deal with healthcare problems more effectively.

As more people experience economic problems, there will be a need to understand and address wider and related mental health challenges. For example, Mind⁵⁷ found that mental health service users with economic problems find the transition into full-time work difficult and daunting. To deal with these issues, there can be a requirement for different skills and knowledge (such as debt advice) to respond to problems. The increased incidence of debt in the UK could require practitioners to have skills in coping and responding to unexpected unemployment, mounting levels of debt, and helping service users deal with creditors. This could require re-skilling, action and investment to best support 'new' and existing mental health service users. Furthermore, this also accentuates the need for communication between local health and advice services⁵⁸.

⁵⁵ Jenkins, Fitch, Hurlston and Walker, 2009, Recession, debt and mental health: challenges and solutions, *Mental Health in Family Medicine*;6:85–90.

⁵⁶ Mid, *Stress and mental health in the workplace*, 2005:

http://www.mind.org.uk/assets/0000/6976/Stress_and_MH_in_the_workplace.pdf

⁵⁷ Mind Cymru, *Manifesto briefing*, 2011

http://www.mind.org.uk/assets/0001/0652/Final_Mind_Cymru_employment_briefing__English_.pdf

⁵⁸ R Jenkins, C Fitch, M Hurlston et al (2009) *Recession, debt and mental health: challenges and solutions*



5.5.3 Social environment and demography

Social environment and demography refers to general societal aspects of life that can impact upon mental health care requirements, such as where people live, who they are and what their cultural backgrounds are. The social environment and demographic grouping of a person can significantly influence demand for mental health care.

Geographic location/living situation

Certain domestic situations such as single-parent families, those living in low-quality housing, or individuals living in effective isolation, are also likely to procure higher levels of lifestyle-related illnesses, which are often manifested as mental health problems.

Age/lifestyle/living situation

The numbers of elderly people and individuals with unhealthy lifestyles (evidenced through higher levels of obesity and alcohol consumption⁵⁹) are increasing in Wales. Elderly people and socio-demographic groupings with unhealthy lifestyles are more likely to experience more mental health issues⁶⁰. For example, elderly people are likely to suffer from more mental health issues due to often experiencing more socially and physically isolated living conditions and deterioration of physical health. As life expectancy increases and elderly people live longer there will be increased pressure on dementia services and a need for more mental health workers to specialise in this field.

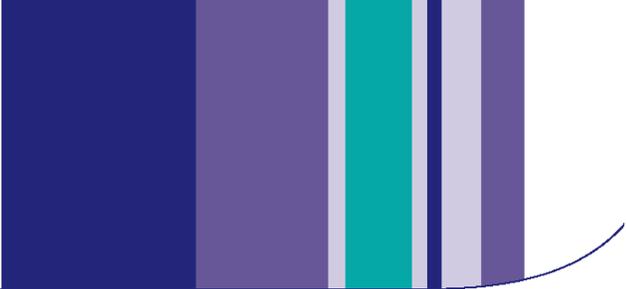
Gender/sexuality

A report by Mind⁶¹ states that men who are from black and minority ethnic (BME) groups or from gay communities are most likely to have high levels of mental health problems. The report advocated offering more male-friendly services and finding new ways to engage BME men. Traditionally males do not seek medical services as frequently or willingly as females and this has to be acknowledged in mental health service provision. This has been noted as particularly problematic in times of economic stress, such as the recent recession, where men tended to be more likely to be out of work.

⁵⁹ Welsh Audit Office; Adult mental health services in Wales: A baseline review of service provision, available at:
http://www.wao.gov.uk/assets/englishdocuments/Adult_Mental_Health_Services_Baseline_Review.pdf

⁶⁰ Guardian 2006

⁶¹ Mind, Men and mental health get it off your chest, 2009:
http://www.mind.org.uk/assets/0000/0185/men_and_mental_health_report_summary.pdf



Access to mental health services should not be restricted by social background, demography or geographic location⁶². However, healthcare provision varies significantly between different sub-regions of Wales⁶³. Therefore, different methods of service provision in delivering mental health care are likely to be required in different parts of Wales. One example is the need to take account of greater distance between mental health service users in rural areas. This is addressed to some extent by the Rural Health Plan⁶⁴ which aims to ensure that the future health needs (including mental health needs) of rural communities in Wales are met.

To provide good healthcare services to all ages it must be acknowledged that the skills and service delivery requirements are quite varied for different age, sex and social groups⁶⁵. Specific skills and the provision of suitable training are required for working with less confident service users and those with more moderate mental health problems who are less likely to voice problems.

An understanding of Welsh-specific culture and language is also important for good engagement and effective service delivery to the different types of people in Welsh society. As some mental health workers originate from abroad⁶⁶ there is a requirement for adaptive skills to be developed⁶⁷; this is also true to some extent for workers who migrate from elsewhere in the UK. Due to the cultural and language differences in Wales, international workers are likely to require even further cultural education and language training to work effectively in Wales.

5.5.4 Stigma

The stigma of mental illness is a burden on those affected by mental illness and their families, but it also prevents people from seeking help in the first instance, potentially causing mental health issues to escalate in their seriousness. It follows, therefore, that future demand will depend, in part at least, on the extent to which sufferers are deterred from seeking help by their perceptions of the discrimination and stigma that might follow.

⁶² Adult Mental Health Services raising the standard The Revised Adult Mental Health National Service Framework and an Action Plan for Wales, 2005

⁶³ Welsh Audit Office; Adult mental health services in Wales: A baseline review of service provision, available at:
http://www.wao.gov.uk/assets/englishdocuments/Adult_Mental_Health_Services_Baseline_Review.pdf

⁶⁴ Welsh Assembly Government (2009): Rural Health Plan: Improving integrated service delivery across Wales.

⁶⁵ Barnardos Child and Adolescent Mental Health National Assembly Elections 2007

⁶⁶ Skills for health Identifying the movement of the workforce around the health sector, working paper.

⁶⁷ Skills for Health, Migration Case Study 2006



According to Mind Cymru⁶⁸, there remains a higher level of negative attitudes in Wales with no nationwide anti-discrimination campaign in place (as there is in England and Scotland). These negative attitudes expressed by people in Wales suggest that mental health service users are more likely to experience discrimination e.g. by being turned down for employment. The effects of this discrimination could act as a barrier to recovery.

The extent to which mental health provision is demanded could be dramatically affected by those that have leadership roles in society: politicians, educators, newspaper editors, campaigners who have the potential to reduce stigma around seeking help for mental health issues.

The impact of any improvement in societal attitudes to mental health is hard to predict. On the one hand, as noted above, more people may be encouraged to come forward and seek help. This would increase demand for talking therapies. On the other hand, reducing stigma would decrease the stress felt by those affected which would in itself be of therapeutic benefit. For those that have to live with mental health difficulties, living a normal life would become easier and the dependence upon support services would be correspondingly reduced.

The extent to which stigma is removed from mental health also depends upon social determination, i.e. the extent to which Welsh society regard the poor mental health of its citizens as unacceptable. However, having an understanding of poor mental health and doing something about it are two different things, especially in times of austerity and competing calls for funds. This driver reflects a state of dissatisfaction with mental health provision, both in Wales and more generally in the UK. Some headline issues are:

- The incidence of male suicides in Wales is the highest of any region in the UK⁶⁹.
- Wales is home to seven of the top 10 areas for prescription of antidepressants in England and Wales⁷⁰.
- Waiting lists for counselling are increasing – a decade ago, the waiting list in one geographical area was 18 months. Recently, this has grown to two years⁷¹.

The impact of this driver on the workforce clearly depends on the type of investment that the Welsh government wishes to make. It is possible that other areas of the health sector, e.g. the elderly or the more seriously ill, will receive additional investment instead.

⁶⁸ Mind Cymru, *Mental Health: the Need for an Anti-discrimination Campaign in Wales*, Manifesto Briefing 2, 2011. The paper cites data from a recent YouGov poll on attitudes, however the numbers surveyed in Wales are too small to allow comparisons between Wales and the rest of the UK.

⁶⁹ Briefing on Suicide in Wales, National Public Health (2008). www2.nhps.wales.nhs.uk

⁷⁰ http://www.mind.org.uk/news/4464_wales_needs_to_talk

⁷¹ Ibid.

5.5.5 Skills

Skills priorities for the UK health sector as a whole have an impact on future changes for the mental health sector. As a highly skilled sector, addressing skills shortages and gaps is essential for development of the health sector.

Research conducted for Skills for Health⁷² highlights a number of important skills priorities for the health sector as a whole, which are also relevant for the mental health workforce:

- Skills development for intermediate roles.
- Continual Professional Development (CPD) for all roles.
- More effective use of ICT within the health sector.
- Developing the capacity and capability of the third sector workforce⁷³.
- Specific skills gaps in problem solving skills, other technical and practical skills and customer handling.
- Developing management and leadership.

It is important to address these skills issues and understand how they affect the workforce, to resolve problems with service provision. For example, a lack of leadership and management can create problems with motivation or direction.

In addition to those identified in sections 4.3.1 and 4.3.2, other skills shortages and gaps specific to the mental health workforce have been identified in wider research. These include:

- Skills shortages occurring for mental health nurses⁷⁴ affecting coverage of mental health provision.
- Lack of promotion of mental health issues⁷⁵.
- The need to collaborate with criminal justice systems⁷⁶ to reduce re-offending requires diagnosis skills and the ability to think about wider sentencing options.

Skills issues, such as those outlined above, can cause challenges such as poor service coverage, lack of promotion and development, and difficulty in collaborating with other service-related areas.

⁷² Skills for Health (2011): Sector Skills Assessment

⁷³ Both paid and voluntary workers

⁷⁴ AGCAS (2010) Occupational profiles: Mental Health Nurses

⁷⁵ http://www.centreformentalhealth.org.uk/publications/promoting_mental_health_Wales.aspx?ID=614

⁷⁶ http://www.centreformentalhealth.org.uk/publications/blurring_the_boundaries.aspx?ID=608

Retention of mental health workers is important for both employers and service users. A report by a number of children's charities (led by Barnardos) in 2007⁷⁷ highlighted particular concerns about mental health provision for young people in Wales (also identified in England⁷⁸), which included "difficulties in attracting people to work in Child and Adolescent Mental Health Services (CAMHS) and a shortage of generic child psychiatrists and primary mental health workers"⁷⁹. An implication is that not being able to retain psychiatrists can affect the service experience for users who do not see regular psychiatrists and there is an economic cost to employers of high staff turnover.

This issue of worker retention has also been recognised by the NHS, which has determined that demographic shifts such as an ageing workforce and a lack of younger women applying for work in the NHS are leading to vacancies and shortages in the health sector's workforce⁸⁰.

5.5.6 Service Developments:

Preventative Measures:

The extent to which investing in preventative mental health measures is a driver of the sector and workforce in the future depends upon how the WG wishes to catch mental health issues early on.

For different reasons, many people do not seek help for mental difficulties at an early stage. Given the debilitating effect of depression, anxiety and other issues, this can lead to a negative spiral where, perhaps over many years, issues become multiplied and lead to greatly compromised lifestyles and/or more serious conditions. For this reason, early intervention and preventative measures are receiving more attention as a cost-effective way of improving the well-being of the nation.

Across the border in England a recently published (and generally well received) UK government strategy paper, "No Health Without Mental Health"⁸¹, sets a new tone in mental health strategy. The overall aim of the strategy is holistic; "*to promote positive mental health and well-being amongst the whole population.*" There is the clear intent that the NHS will no longer focus its attention on treatment alone, but will move towards early intervention and prevention. Children and young people are a particular area of focus with an expansion of talking therapies for this group proposed.

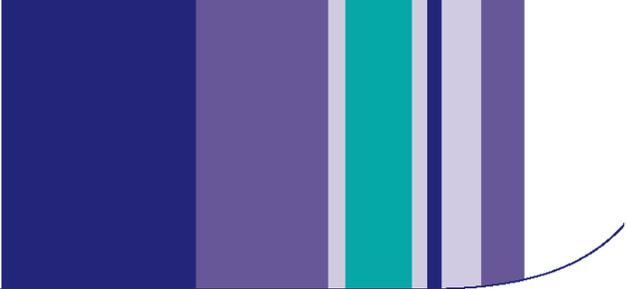
⁷⁷ Barnardos, Child and Adolescent Mental Health Briefing Paper, available at: http://www.barnardos.org.uk/wales_bp_english_2_mental_health.pdf

⁷⁸ <http://www.bbc.co.uk/news/health-12338540>

⁷⁹ Barnardos, Child and Adolescent Mental Health Briefing Paper, available at: http://www.barnardos.org.uk/wales_bp_english_2_mental_health.pdf

⁸⁰ NHS National Workforce Project – Vacancies and Shortages

⁸¹ http://www.dh.gov.uk/en/Aboutus/Features/DH_123998



A key driver for this new strategy is a desire to put mental health on a par with physical health. It recognises the interplay between mental health and society and encourages cross-departmental working. There is also a strong cost-benefit argument underpinning the early intervention strategy⁸².

The impact on the workforce, should this approach be adopted in Welsh policy, would be a move towards the talking therapies and a move away from purely 'medical models'. This would require the training of many more therapists than currently exist in Wales. There would also be a higher demand for therapists and support workers qualified to work with children and young people.

Traditionally Wales has not followed the English investment in talking therapies such as 'Improving Access to Psychological Therapies' (IAPT), perhaps explaining the higher use of anti-depressants, and there may be continued resistance to going down this route. However, there is a growing evidence base behind cognitive behavioural therapies, which has been part of a successful drive in England to increase access to psychological therapies for service users. It is worth noting that the IAPT programme in England came with significant funding and if Wales were to adopt a model which placed more emphasis on IAPT then it would also have to consider the financial implications.

A key challenge for those advocating preventative and early intervention measures in a cost-constrained world is that it may mean diverting attention and resources from the more serious and visibly ill individuals to those who may not be showing serious symptoms and who are keeping their pain to themselves.

Gap in provision for 16-18 year olds:

Another service development that will impact the sector in the future is the increasing recognition that there is a gap in services for 16-18 year olds. It is being recognised that often, those aged 16-18 are not well supported, being too old for Child and Adolescent Mental Health Services (CAMHS) and too young for adult services. This is particularly unfortunate as this age is a time of great change and great potential for psychological difficulties. It is also a time when vulnerable young people can become parents prematurely, with a risk of propagating issues on to the next generation.

The role of charities, such as Young Minds, will be crucial in ensuring that young people of 16-18 can access mental health services today, otherwise demand for mental health services from the adults of tomorrow will be greater and require more resources. It is also important that the mental health workforce engaged with 16-18 year olds have received training to heighten awareness of mental health issues experienced by individuals within this age bracket.

⁸² Mental health promotion and mental illness prevention: the economic case. Knapp, D., McDiad, D. and Parsonage, M. (eds). London: Department of Health.



Service user voice:

In many respects, due to its nature, mental health provision is co-created with the patients themselves. Mental health workers will need to ensure that service users have a real say in how their care is provided and how the sector operates. This is beneficial to the patient as well as the sector overall.

Effective patient participation would help to reduce stigma around mental health. They would be less likely to feel pressured into undergoing treatments or care that they wished to avoid.

Service users value stability and continuity. Ensuring that staff retention within the mental health sector remains strong in Wales will provide benefits to the quality of service delivery. Organisations which understand this dynamic will seek to minimise their turnover of staff. Service users, given some additional responsibility for their care, will be better able to manage care and reduce the strain on mental health professionals by not leaving mental health professionals to take difficult decisions in isolation.

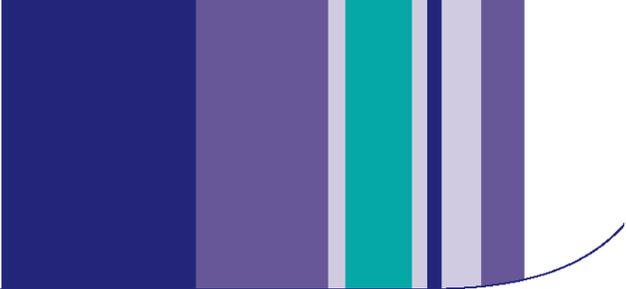
Some might see this approach as risky. Providing such a voice to service users might seem like a radical alteration to patterns of working amongst the mental health workforce in Wales.

Online ICT:

In recent years there has been a trend for provision of some mental health services such as counselling to be provided, or at least supported by, online tools. If this trend continues then there will be some significant implications for the workforce. This is particularly around the challenges of providing an appropriate level of empathy whilst counselling online.

The application of ICT to mental health service provision does have limitations. It is likely that it will be part of a mix that can be used, as appropriate, depending on the needs of the patient. The use of telephone counselling has increased and experience suggests it works well. However, it is not particularly widespread.

Such technological developments in technology could be harnessed most effectively in rural areas of Wales where service users and/or mental health workers have long travelling times, making regular visits to all service users impractical.



6. Barriers and Opportunities

This section presents the opportunities for developing the mental health sector workforce and what may be the barriers to such development. It is based primarily on views of participants in our focus group, but also includes output from elsewhere in the study.

Our study did not allow for us to take a much broader view of the issue in Wales and consult with as wide a range of interests as we would have liked. However, we felt it would be valuable to present an analysis of the potential barriers and opportunities to be presented. Further development of these perspectives is likely to be required.

As is common with such analyses, some themes identified could be viewed from both an *opportunity* perspective and a *barrier* perspective. To avoid duplication such themes are stated as one or the other.

6.6 Opportunities

6.1.1 Expansion of mental health care across the sectors and across society

Mental health policies in Wales have recognised the environmental or societal contributions to the causes and maintenance of poor mental health. It is possible to see the start of a greater balance between the medical community and the role of wider society.

An extension of this trend has implications for the definition of a “mental health workforce” because a very wide range of providers and stakeholders would need to play their part. This could include social services, the police, the judiciary, the education system, employers, the arts, the faith community and others.

Individuals from those organisations would need to develop an understanding of “mental health first aid” as they come into contact with current, or potentially future, service users. The medical part of the mental health workforce could be more focused on severe cases and possibly have a protection role at its heart. This trend has three components:

1. **A greater co-operation between services with joined-up care for individual service users:** This implies that mental health training would be required for services such as the police, social services, welfare providers and teachers. This may lead to the emergence of hybrid roles such as the psychiatric nurse - social worker.
 2. **The education of society to reduce stigma and discrimination and empower people to be helpful rather than damaging:** This could include public anti-discrimination and education campaigns. Stigmatisation adds to the burden of service user care. Diminishing
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stigma is therefore a cost-effective opportunity to reduce that burden and release resources to improve care in other ways. There is also an opportunity to introduce education about mental health into schools. This could also be a way of encouraging young people who need help to come forward for counselling or other support, rather than allowing their issues to escalate.

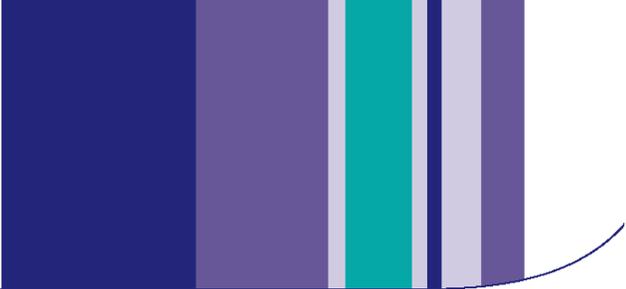
3. **An increased emphasis on preventative and early intervention measures:** It is increasingly believed that early or preventative interventions are more cost effective⁸³, often avoiding the debilitating effects of chronic mental health and preventing the vicious cycle that emerges when conditions like depression and anxiety take over. Measures such as counselling, advice, education, social action and self care will take us further away from the medical model of mental illness and closer to tackling the underlying causes with a wider range of expertise.

6.1.2 A more service-user oriented approach

Restoration to good mental health involves, amongst other things, the re-acquisition of personal power. Workshop participants highlight a number of features of provision that may have the effect of disempowering them. These included:

- A potential 'leakage' of the coercive mentality that exists in the care of the more seriously ill into sectors where coercion is not necessary.
- Low input of service users in designing their individual care.
- A requirement to travel long distances to receive a service.
- Poor continuity of care with changes of carer; in this field relationships based on trust are paramount.

⁸³ Mental health promotion and mental illness prevention: the economic case. Knapp, D., McDaid, D. and Parsonage, M. (eds). London: Department of Health.



Should these factors be present they may slow recovery, or even aggravate the psychological issue. There are, however, opportunities to improve care at zero or low extra cost. Such improvements might involve:

- Involving service users more in the design of service provision.
- Involving individual service users more in the design of their own care.
- A culture shift away from regarding mental illness as a disease to listening to and empowering the service user.
- Sharing best practice in providing flexible, service user-centred care.
- More interactions in Welsh with those whose first language is Welsh.

Overall, these opportunities are consistent with the identified priority of Skills for Health, which aims to increase self-managed care.

6.1.3 More consistent and effective service provision

The workshop participants believed that there was considerable heterogeneity in the quantity and quality of service provision in Wales. Establishing the causes for this remained beyond the scope of the project. A number of opportunities were suggested for improving services at little or modest cost:

- Sharing training more widely; for example, MIND's "ASSIST" training in suicide prevention could be promoted or even made compulsory for all those whose roles impact on mental health.
- Better dissemination of best practice in service provision, considering practice also from outside of Wales.
- The Learning Disability service in Wales may also provide some useful service provision models.

There is also an opportunity to even out the provision of counselling/psychotherapy where waiting times can be very long, in some places up to two years⁸⁴. Training and deploying CBT therapists, the NICE-recommended therapy which is growing fast in England, is expensive both in training and deployment. Noting that a) there are a number of under-utilised, diploma-qualified counsellors in Wales and b) that trials show that non-CBT therapies, such as person-centred and psychodynamic therapies, are as effective as CBT^{85,86}, there is an opportunity to better utilise this resource at a lower cost.

⁸⁴ Mind: Wales Needs to Talk:

http://www.mind.org.uk/mind_cymru/news/4464_wales_needs_to_talk

⁸⁵ Stiles, W. B., Barkham, M., Mellor-Clark, J and Connell J. (2008). Effectiveness of cognitive-behavioural, person-centred and psychodynamic therapies in UK primary-care routine practice: replication in a larger sample. *Psychological Medicine*, 38, 677-688.



Schemes whereby the service user is empowered to select a (perhaps more local) counsellor that suits their needs and style, and have the counsellor reimbursed could be considered, especially for non-urban areas. Such schemes could be delivered at lower cost than the IAPT-type schemes which have a heavy monitoring and administrative load.

Overall the provision of counselling and psychotherapy has been shown to be cost-effective compared to drug therapy and is generally preferred by service users. In addition it can, particularly early in life, help ensure that problems do not escalate with the concomitant personal and societal impact.

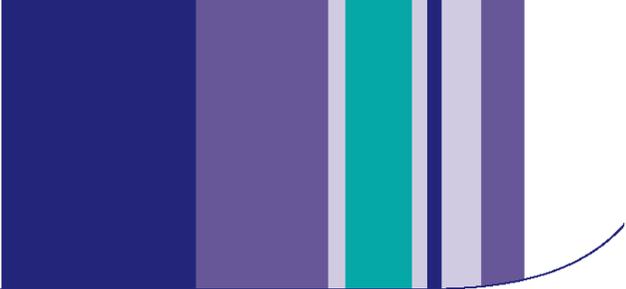
A more even and effective service delivery could be helped by better management and IT skills, consistent with the identified priorities of Skills for Health. Both would be helpful in bringing service provision up to a more consistent standard, sharing best practice and securing efficient delivery.

6.1.4 Implications for the Workforce

The opportunities identified by the workshop have a number of implications for the workforce overall:

- Staff in other non-medical sectors such as police, teachers, social workers and welfare providers will need to be trained to varying extents, depending on the role, in meeting the needs of those with mental health needs and/or changing attitudes to mental health.
- Staff will be required to work more across boundaries and may even be re-organised to provide better continuity of care.
- It will become harder to define the mental health workforce as these changes emerge.
- There will be a culture shift towards more service-user centred ways of working.
- A need to improve Welsh language skills in some areas.
- An increased focus on training and sharing best practice.
- Emergence of new roles which cut across existing disciplines.

⁸⁶ Ward, E., King, M., Lloyd, M., Bower, P., Sibbald, B., Farrelly, S., Gabbay, M., Tarrier, N. and Addington-Hall, J. (2000). Randomised controlled trial of non-directive counselling, cognitive-behavioural therapy, and usual general practitioner care for service users with depression. I: Clinical effectiveness. *British Medical Journal*, 321, 1383-1388.



6.7 Barriers

6.2.1 Political and managerial factors

There is a reported gap between the intentions of policy makers and what actually happens in practice on the ground. Respondents believe that many of the policy initiatives have not made very much of an impact by the time they have filtered down to the 'coal face' of service-user care. Analysing this difficulty is beyond the scope of this project, but respondents identified a range of factors which could be considered as barriers now and/or in the future:

- High level of delegation of operation design to individual health boards, resulting in variation in service provision.
- Tendency not to involve service users in service development and to seek their feedback.
- Partnership working being at strategic rather than purely operational level.
- Gaps in service provision due to tight selection criteria.
- Difficulties getting local authorities and local health boards to work together more effectively.
- Short-termism fostered by the need for immediate results and restricted budgets.

6.2.2 Professional Bodies

Professional bodies related to the mental health sector have worked together well in recent years under such initiatives as New Ways of Working for Everyone in mental health (NWW). Their actions have helped to ensure that a wide array of mental health services have been provided in Wales and the rest of the UK.

Workshop participants remain unclear how professional bodies might react if there was a need for new roles to be introduced to the sector. It is possible that the professional bodies may wish to retain much of the status quo. This might reduce the growth of new roles and further development of working practices.



6.2.3 Societal Barriers

Reducing stigma and discrimination is a slow process. Barriers include:

- The tendency for tabloid newspapers to sensationalise mental illness.
- Socio-economic stress leading to a less understanding, more blame-oriented attitude.
- Absence of mental health education in schools and other educational institutions.

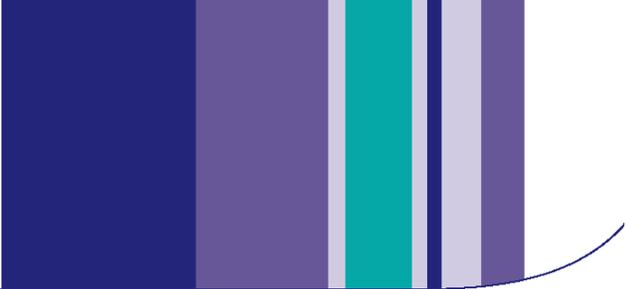
6.2.4 Development of a Third Sector strategy

While the role of the third sector in mental health is widely appreciated and valued, workshop participants were anxious that there does not seem to be a broad strategy. This might lead to some continuation and perhaps an exacerbation of the tendency for charities to duplicate effort in some areas (geographical and functional) but also potentially leave unfilled gaps in other areas.

Currently it is unclear how the Big Society will impact on the ground. Change without a strategy brings with it the threat of confusion and distraction in a sector which prefers to focus on being close to the service user and meeting their needs well.

6.2.5 Implications for the Workforce

Should these barriers to change be unaddressed the shape of the workforce would be largely unchanged. Increased demands on service provision (see section 5) may lead to greater stresses on the workforce. The continued impact of stigma and discrimination will make life more difficult for providers and service users alike.



7. Conclusion

Overall the Mental health workforce in Wales appears to be stable. Some skills shortages are believed to be occurring within some occupations (psychologists and mental health nurses). However, none are deemed, at this stage, to be critical. Existing training and education is largely appropriate and meets the needs of the sector.

A bigger issue for the Welsh mental health sector appears to be around Skills Gaps, particularly in Welsh Language Skills and Information Technology. These have been identified as requiring attention in the next 12 months by a large proportion of employers.

This report has outlined how the future of skills and employment in mental health are being shaped by a wide range of drivers including changes to funding and a range of economic pressures.

These drivers have brought to the fore the importance of management skills to deliver services with restricted budgets and helping people who require treatment to deal with financial problems. The drivers also highlight how the rise in life expectancy is leading to a requirement for people to have the breadth of skills to deal with both physical and mental health issues.

There are a variety of ways in which skills and employment issues need to be addressed. One solution is the ongoing refinement of the training occupations and professionals to meet the needs of the future. Skills and employment issues need to be dealt with effectively and there are several methods (innovative work practices, leadership, policy changes, funding) that can be used to address skills issues and the drivers behind them.

Workshop participants highlighted a number of opportunities that the sector has to make significant long-term changes to the mental health sector, including:

- Increased involvement of non-medical service providers to provide a more effective, socially-oriented approach.
- To orient provision more closely to the needs of service users.
- Sharing best practice more effectively, public education campaigns to reduce the stigma of mental health issues.

These opportunities have implications for the skills and employment in the sector. Workshop participants identified a number of barriers to pursuing these opportunities. Funding cuts and misunderstandings about what really makes these organisations operate effectively were high on the agenda.



Shifts in attitudes of the wider population towards mental health issues were also considered an area where, if progress were made, higher quality services might be possible. Workshop participants also suggested that mental health and well-being would be improved if services were organised more holistically and involved occupations beyond traditional professional and occupational boundaries, including non-specialist occupations such as teachers and social workers.

This work was an initial exploration primarily of the skills issues within the Welsh mental health sector. Given the context in which this work was being undertaken, it was appropriate for some consideration to be given for options for the future of services and therefore likely future skills needs, both in health and related occupations. Its findings do not reflect the policies of the Welsh Government or Skills for Health.

Further exploration of how services may be reshaped is required. Future research and development will build upon this initial research by exploring, with a wider range of stakeholders, issues surrounding mental health.

8. Appendices

8.8 Acknowledgements

Skills for Health would like to thank everybody who supported this research and made its completion possible. Gratitude is expressed to those people who gave up their time to take part in interviews or to attend focus groups in order to provide the invaluable information that underpins the comments in this report, and to those organisations that took time to read this report and provided invaluable advice.

Specifically, TBR would like to thank the following people for their contribution to this research:

Table 7: Virtual Reference Group for the project

Name	Organisation
Sheila Lyons	Care Council for Wales
Wayne Raper	Teen Challenge
Sarah Lamberton	WCVA
Andrew Harvey	Skills for Health
Marc Lyall	Skills for Health
Ian Wheeler	Skills for Health
Lorraine Yeomans	Skills for Health

Table 8: Focus Group participants

Name	Organisation
Penny Gripper	Service user representative
Paul Dunning	ABM Health board
Philip Jones	Insight CBT
Sarah Lamberton	WCVA
Andrew Garman	Q Futures
Marc Lyall	Skills for Health
John Stephenson	Skills for Health
Lorraine Yeomans	Skills for Health

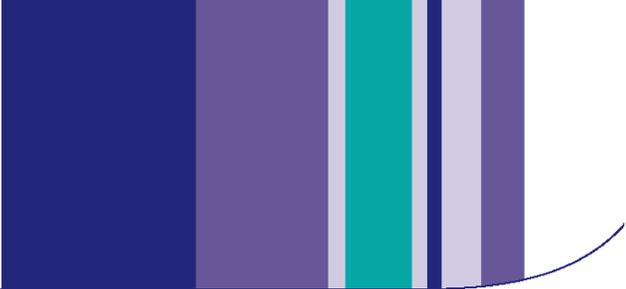
Table 9: Telephone interview participants

Name	Organisation
Kay Evans	WAG
Eileen Murphy	Eileen Murphy Consultants & Associates
Wayne Raper	Teen Challenge
Sarah Lamberton	WCVA
Sheila Lyons	Care Council for Wales
Nadia Hook	United Response
Gary Sheaf	CREATE Swansea mental health services
Irene Hogan	Hafal
Lyndsay Foyster	Mind
Lynne Thomas	Involving People

Table 10: Others who contributed to this work

Name	Organisation
Wyn Thomas	Betsi Health Board
Lyn Tawmley	Age Cymru
Liz John	NHS
Charmine Sminkle	Care Council Wales
Kathryn McCullagh	British Psychological Society
Rachel Bowen	Mind Cymru
Jill Jones	West Wales Action for Mental Health

We would also like to thank Duncan Cobbett, Fiona Dodd, Anna Edwards, Jonathan Guest, Lisa Shearer at TBR for the management of primary research and the production of the Skills and employability issues in the mental health workforce in Wales report.



8.9 Range of mental health services

- **Medical treatment.** Medication forms a significant part of treatment for many service users. In addition to the prescription of treatments and ongoing review and monitoring it is important for users to:
 - Receive appropriate information, advice and guidance on any proposed treatment.
 - Be able to access information on the latest medical treatments and discuss these in the context of their needs.
 - Understand and manage the side effects of treatments.

- **Other treatments, including psychological interventions.** Alongside medical treatments it is important that a range of psychological therapies and specialist services are available. These are many and highly varied. The following list⁸⁷ is by no means exhaustive, and does not attempt to list services available in Wales. Rather, it provides an insight into the range of interventions available. Therapies might include:
 - Counselling
 - Cognitive behaviour therapy (CBT)
 - Psychoanalytic therapies
 - Systemic therapy
 - Eclectic therapies
 - Integrative therapy
 - Personal construct therapy
 - Art and/or drama therapy
 - Transactional analysis
 - Group analysis
 - Applied relaxation therapy
 - Autogenic training
 - Cognitive analytic therapy (CAT)
 - Dialectical behaviour therapy (DBT)
 - Eye movement desensitisation & reprocessing (EMDR)
 - Hypnotherapy
 - Interpersonal therapy (IPT)
 - Problem-solving therapy
 - Psychoanalytically informed day hospital treatment
 - Psychodynamic-interpersonal therapy
 - Rational emotive therapy
 - Schema-focused cognitive therapy
 - Social skills training
 - Stress inoculation therapy
 - Supportive psychotherapy

⁸⁷ Department of Health (2001) Treatment Choice in Psychological Therapies and Counselling



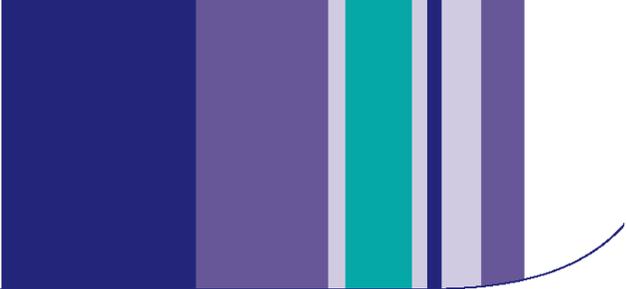
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- **Personal care and physical well-being.** People who have had contact with mental health services have an average 8.8 years shorter life expectancy than those who have not⁸⁸. As such, supporting physical well-being is extremely important. This includes:
 - All aspects of general health, including medical, dentistry and optometry.
 - Support with diet and lifestyle.
 - Support related to substance misuse, including smoking.

 - **Accommodation and housing support.** Support with accommodation may vary according to the extent of the service user's needs. For example, services range across:
 - Support in managing own home/property.
 - Living in own home with support.
 - Living in shared accommodation with support.
 - Homelessness and supported housing.
 - Specialist 24-hour accommodation.
 - Stays in hospital and discharge support.
 - Maintenance and security of user's homes in their absence.

 - **Work and occupation.** Support to re-enter the workforce or maintain employment whilst dealing with a mental health problem is very important. Equally so are services and guidance for employers where a member or staff may be struggling with a mental health issue, or providing a caring role for a family member or friend. Services might include:
 - Occupational therapy.
 - Specialist supported employment services.
 - Volunteering and/or community work.
 - Vocational guidance and recruitment support.

 - **Training and education.** Similarly to support in obtaining or maintaining employment, service users may need support to continue in full-time (or part-time) education, or to re-enter the education system. As such, services might cover:
 - Support or assistance in the formal education system.
 - Access to and support to use distance learning packages.
 - Vocational or work-related training support.
 - Interest-based adult/community education.
 - Guidance on self-study.

⁸⁸ http://www.mentalhealthwales.net/mhw/whole_physical.php

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- **Finance and money.** Maintaining a means of support and control over personal finance is important. This involves both salary/wage considerations but also benefits, tax credits and other support available through the welfare system.
 - Guidance on and support to access appropriate benefits and financial support.
 - Assistance in managing personal finances and budgeting.
 - Support and protection for those potentially vulnerable to financial abuse.
 - Support for long-term financial planning where appropriate.

 - **Social, cultural and spiritual.** Promoting a normal pattern of daily life is important, both for service users and carers. As such, support in the following areas is key:
 - Participating in social activities (particularly if in hospital or supported accommodation).
 - Maintaining or building relationships, both with family and existing friends but also new community relationships.
 - Engaging with a religion of the service user's choice.
 - Participating in existing hobbies or developing interests both individually and in a group.

 - **Parenting or caring relationships.** It is important to ensure that appropriate support is available for the family of the service user throughout the care process. This includes both the direct recipient of care and treatment and those responsible for or involved in the care process. Services include:
 - [For parents] support to maintain links with children.
 - [For children] support to maintain links with parents or carers.
 - Consideration for others who may be cared for by the service user.
- 
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8.10 Tables

Table 11: Mental health sector employees by occupation

Occupational Group	Area of work	2008		2009		% change 08-09	
		Employees	Full-Time Equivalents	Employees	Full-Time Equivalents	Employees	Full-Time Equivalents
Health Care Assistants	Learning difficulties	80	74	182	166	128%	124%
	Psychiatry	564	513	518	477	-8%	-7%
	Speech & language therapy	0	0	0	0	n/a	n/a
	Occupational therapy	4	3	4	3	0%	-2%
Health Care Assistants Total		648	590	704	646	9%	9%
Hospital Medical and Dental staff	Child & adolescent psychiatry	78	70	73	64	-6%	-8%
	Forensic psychiatry	25	22	29	26	16%	18%
	General psychiatry	338	321	334	314	-1%	-2%
	Old age psychiatry	58	53	57	51	-2%	-4%
	Psychiatry of learning disability	28	26	30	29	7%	10%
	Psychotherapy	1	1	1	1	0%	0%
Hospital Medical and Dental staff Total		528	492	524	485	-1%	-2%
Nursing, midwifery and HV staff	Community learning disabilities	338	307	321	295	-5%	-4%
	Community psychiatry	1,086	1,012	1,261	1,168	16%	15%
	Other learning disabilities	505	480	528	500	5%	4%
	Other psychiatry	3,619	3,335	3,757	3,426	4%	3%
Nursing, midwifery and HV staff Total		5,548	5,134	5,867	5,388	6%	5%
Scientific, therapeutic and technical staff	Art/music/drama/therapy	23	14	24	15	4%	8%
	Clinical psychology	496	417	538	436	8%	4%
	Multi-therapies	13	10	20	17	54%	61%
	Psychotherapy	8	6	16	11	100%	79%
	Speech & language therapy	528	420	568	439	8%	5%
	Occupational therapy	1,355	1,181	1,426	1,209	5%	2%
Scientific, therapeutic and technical staff Total		2,423	2,048	2,592	2,127	7%	4%
Support Workers	Learning difficulties	66	60	46	39	-30%	-35%
	Psychiatry	65	42	67	34	3%	-19%
	Speech & language therapy	0	0	0	0	n/a	n/a
	Occupational therapy	3	2	3	2	0%	-1%
Support Workers Total		134	103	116	74	-13%	-28%
Public sector workforce Total		9,281	8,368	9,803	8,720	6%	4%

Source: WAG, NHS Staff Resource Data 2008 & 2009 (TBR Ref: W1/S0)

Table 12: Number and proportion of respondents that are based in the public, private and voluntary sectors

	Survey Count	Percent
Voluntary	28	41.2%
Public	23	33.8%
Private	21	30.9%
Total Responses:	68	100%

Source: TBR 2011 (TBR Ref: W4/S1a)

Table 13: Number and proportion of respondents that provide care for the following age groups

Value	Survey Count	Percent
Adults (18-65)	64	94.1%
The elderly (65+)	41	60.3%
Young people (16-18)	28	41.2%
Children (0-16)	17	25.0%
Total Responses:	68	

Source: TBR 2011 (TBR Ref: W4/S1a)

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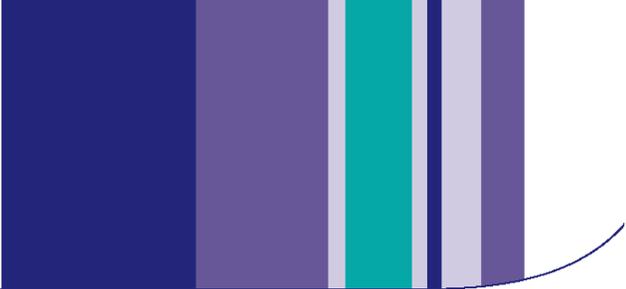
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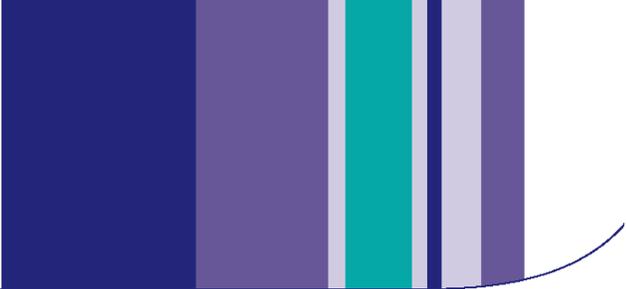
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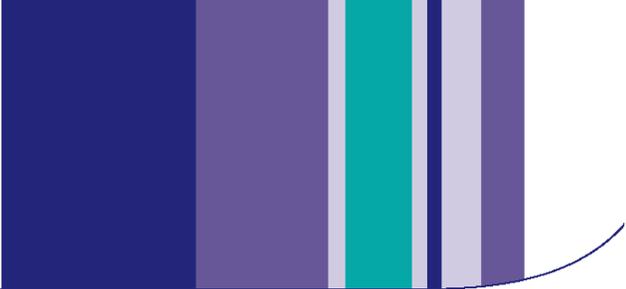
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