Briefing Paper 4: Creating a workforce for the future

Claire McCartan¹, Tomas Adell², Julie Cameron³, Gavin Davidson¹, Lee Knifton³, Shari McDaid³ & Ciaran Mulholland¹

¹Queen’s University Belfast, ²Mental Health & Capacity Unit, DoH, ³Mental Health Foundation

This briefing paper summarises key findings from three rapid evidence reviews (Transforming mental health services; International policy guidance and response to COVID recovery; International learnings on mental health plans, policies and implementation) commissioned by the Mental Health Foundation to help support the development of Northern Ireland’s ten year mental health strategy. It highlights some of the national and international evidence, offers examples of best practice and innovation and may be of interest to those responsible for developing the new strategy.

How should the workforce be structured?
The international evidence suggests some key considerations:
• A workforce informed by human rights, social justice, social determinants, a life course approach, public health, physical health
• Transforming emergency response and care
• Multidisciplinary care
• Integrated physical health care
• Collaborative care
• Effective/seamless transitions
• Community-based care and networks
• Ongoing workforce planning and development – estimating the number of relevant professionals and support workers needed e.g. Approved Social Workers

Where are the gaps? How do we fill them?
Training & Education
Mental health training
• In Scotland, mental health training is not only the remit of those providing support within educational settings, but delivered to non-mental health staff across health and social care services

Skills gap in digital healthcare
• COVID has accelerated online support but research has highlighted that there are skills gaps that need to be addressed. Assessing workforce need for training will be an important part of developing digital provision.
• Commentators have also recognised that digital healthcare is not always the most appropriate model and sensitivity of service users’ needs is recommended, particularly for at risk or excluded groups.

New modes of training delivery
• Opportunities to tackle training shortages during Covid have been adopted with some examples of excellent remote training and virtual training platforms to develop competencies.
Inter-Professional Education

• In Australia, for example, improving interagency collaboration has been facilitated by creating opportunities for co-training both at pre-qualifying, post-qualifying and continuing professional development has been demonstrated to help build networks, increase professional understanding and promote collaboration.

• Evidence that systemic approaches to working with families where parents experience mental health or substance use problems can be effective. Explicit models of co-working with other specialisms within psychosocial care models have helped to improve care and outcomes.

Human Rights

• The World Health Organisation recommends providing training for health and social care staff on recovery rights to help reduce human rights violations within mental health settings.

• Evidence also suggests that framing care around the principles of fair treatment and quality care is important. Clear commitments to providing care with freedom from coercive interventions, that respects the right for legal capacity, promotion of autonomy, choice and inclusion improves protection for the workforce and outcomes for service users.

• Opportunities to empower the workforce's advocacy role, promoting social justice and human rights can help embed this approach to improving care and reducing inequalities.

• Practical tools include the WHO’s Quality Rights Toolkit (WHO, 2012) which provides a training framework for assessing and improving quality and human rights standards in mental health.

Understanding the Social Determinants of Health

• Services that provide training to underpin how poverty and deprivation are inextricably linked to health and wellbeing can help increase understanding and empathy and help to tackle some of the social determinants of health.

• Application of syndemics (going beyond the medical/biological models of disease and acknowledging the social, environmental and economic factors when two or more diseases cluster in a population) to mental and physical health is a new approach to tackling illness and there are some interesting practice models to consider (Singer, Bulled, Ostrach, & Mendenhall, 2017).

• The importance of social contact, reducing loneliness, reducing stigma and exclusion has been highlighted in a number of international studies including the co-occurrence intersectionality of stigma and discrimination (Jackson-Best & Edwards, 2018). This is particularly important in the context of COVID where some communities experience stigma and discrimination.

Physical Health & Wellbeing

• The interlinked relationship between physical and mental health has been examined in international research (Stubbs et al., 2018). Findings have recommended that this link is made explicit and is made the responsibility of all practitioners. Campaigns such as ‘make every contact count’, taking opportunities to collect and monitor data on the physical health of service users can help to promote this aim.
• The growing interest in the psychosocial benefits of accessing green and blue spaces may promote options to deliver interventions in different contexts that can promote opportunities to access the outdoors and the benefits it may convey.

**Data Management**
- There is overwhelming evidence that the collection, interrogation and sharing of data is crucial. Prioritising the design and utilization and the effective management of data often requires significant investment and training.
- Streamlining administrative heavy caseloads and the ability to collect quality data can benefit professional and support roles.

**Supporting our Workforce**
- Research also acknowledges the difficult and complex nature of mental healthcare and the importance of providing help and opportunities for self-care, therapy and organisational support.

**Trauma-Informed Practice**
- There is much to be learned from the trauma-aware, trauma-informed approach adopted by the Scottish government (see for example [https://www.gov.scot/publications/adverse-childhood-experiences-aces/pages/trauma-informed-workforce/](https://www.gov.scot/publications/adverse-childhood-experiences-aces/pages/trauma-informed-workforce/)).

**How professionals are deployed**

**Primary care**
- Integrated psychosomatic care – models such as Medical-Psychiatric Units have been shown to help the early detection of comorbidity and initiate multi-disciplinary treatment (Van Schijndel et al., 2017).
- Collaborative chronic care (CCC) – this approach provides psychological support in conjunction with treatment co-ordination where a care manager works in co-operation with the patient’s GP and psychiatrist and can be more affective in managing chronic disease in multiple conditions through better engagement, treatment adherence (Carlo, Barnett, & Unützer, 2020).
- This relies on good quality data collection and management to create an SMI registry within primary care, gathering physical health metrics (such as BMI, cholesterol, smoking), community mental health referrals but also tracking outcomes to improve screening. The registry is then used to conduct psychiatric caseload reviews at primary care/behavioural team meetings helping to create a best practice model for SMI within primary care.

**Emergency Care**
- In Southern California, an Emergency Department offers interdisciplinary care providing 24-hour psychiatric support in a specialist quiet, therapeutic setting (Krekler, 2020).
• Mobile intervention and treatment teams in New York (NYC Thrive) also provide intensive community-based treatment for up to 30 days.
• Community-based emergency care has also been extended across the New York city (NYC Thrive) providing services including telehealth in shelters, and walk-in provision.

Inpatient Treatment - General Hospital Settings
• There are a number of examples of proactive psychiatric consultation models e.g. involvement of psychiatric services with all patients with chronic conditions in general hospital settings.
• Behaviour Intervention Teams comprised of a psychiatrist, nurse and social worker joint-work cases, each performing their individual professional tasks, collaborating together and with other staff and as a result, significantly reducing length of stay for patients (Sledge et al., 2015).

Psychiatric Inpatient Treatment
• A co-produced narrative therapeutic approach has been used in the South London and Maudsley Trust Hospital. Service users are trained as Tree of Life workshop facilitators and using a strengths-based approach facilitates a culturally diverse collaborative recovery. The programme is one example of innovative evidence from Lower- and Middle-Income Countries (LMICs) where resources are limited and can be mobilized quickly.

Integrated Care
• Examples of integrated care models such psychosocial oncology in cancer care services in the 1980s have not been replicated within other specialisms, the most obvious being cardiac care and its high comorbidity with mental health conditions.
• Mental health problems are typically comorbid in many long-term health conditions and careful management of both physical and mental health needs is beneficial for service users.
• Better screening and case identification may improve through integrated care models and data collection.

Community-based mental health care
• In recent years, we have seen an emphasis on moving away from inpatient care and the reliance on shared accommodation with live-in staff. The preferred ‘housing first’ model where support is separate from where people live. Pilots in Canada have demonstrated significant reduction in homelessness rates and greater treatment engagement.
• The European Community Mental Health Services Provider (EU COMS) Network has developed 6 principles for community-based mental health care based on collaboration with patients and carers (Keet et al., 2019):
  1) Human rights
  2) Public health
  3) Recovery
  4) Effective evidence-based interventions (such as CBT, MI and psychodynamic therapy) tailored for service users’ values, preferences and choice
  5) Builds a community network of care within a broader network of self-help, family, friends, informal resources and generic community services
6) Peer expertise – additional expertise contributes alongside scientific evidence and practical knowledge and skills

- Providing employment support
- Socially focused interventions including parenting and school-based programmes
- Outreach services with offender populations

**Community networks of care**

- This model aims to bridge the gap between professionals and non-professionals with care provided through integrated care models with a community mental health team acting as a central node.
- The different disciplines within the community mental health team take a shared responsibility for the interventions

**Public health function/universal mental health**

- Encouraging co-operation with other professionals – GPs, other key contact points – teachers, community, carers
- Promotion of self-help initiatives and activities

**Scope for new roles e.g. advanced practitioners, peer support**

- Service user/carer voice
- Effective co-production - participation in development, implementation and evaluation of services
- Peer support – demonstrates that recovery is possible and within the right framework of support, supervision, training, financial recognition that sets out clear individual and organisational roles and responsibilities has the potential to add an additional area of expertise within a multi-disciplinary team – there are good resources and international learning to draw on to develop an effective peer support worker network as one part of mental health service delivery (Christie, Smith, Bradstreet, & McCormack, 2015; Keet et al., 2019).
- Advance clinical practitioners can come from a range of professional backgrounds including nursing, pharmacy, paramedics and occupational therapy allowing them to take on expanded roles and scope of practice caring for service users. Health Education England is currently developing national training standards for advance practice education and accrediting training programmes for advance level practice. The NHS Long-Term Plan has placed advanced clinical practice as central to help transform service delivery by providing enhanced capacity, capability, productivity and efficiency within multi-professional teams.
- Some studies have highlighted the importance of practitioners appropriately sharing their own experience as service users – harnessing professional lived experience may also help to reduce stigma.
References


