

time to act

Choosing to Work in Mental Health:
The Recruitment of Health and Social Care Professionals

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*Report presented to:
The Mental Health Care Group
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December 2004*

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Executive Summary

EXECUTIVE SUMMARY

Background

Workforce issues remain the most significant challenge to the implementation of the changes and developments outlined in the National Service Framework for mental health and the NHS Plan. There are key concerns regarding the recruitment and retention of staff, and creating a workforce representative of the community served. Whilst there has been progress in creating new roles and types of mental health workers, there are difficulties in recruiting and retaining qualified professionals such as mental health nurses, psychiatrists, occupational therapists, social workers and clinical psychologists. In addition, there are problems in attracting sufficient numbers of people to train as mental health professionals, although the picture is mixed.

In order to address this there is a need to investigate the mechanisms for attracting and recruiting people onto mental health professional training programmes, the reasons for failing to recruit sufficient numbers of students, and to highlight examples of good practice. The main purpose of this project was to investigate these issues in England by focusing on recruitment to mental health nursing, clinical psychology, occupational therapy, social work and psychiatry courses in Higher Education Institutions.

Objectives

In order to make recommendations that will contribute towards improving recruitment onto mental health professional training programmes in England, the project aimed to:

1. Review existing published information about the recruitment of NHS and social care staff across a range of disciplines.
2. Identify the mechanisms for attracting and recruiting pre-registration and post-qualifying mental health staff. This includes an exploration of national variations and the identification of good practice.
3. Elicit a range of views from key informants on the problems of recruitment; the key elements of a cohesive and comprehensive strategy towards improving recruitment; the perceived organisational, structural and/or cultural barriers to recruitment; and examples of good practice that they were either involved with or were aware of.

Method

Data were gathered from the following sources:

A comprehensive literature search and review of relevant policy documents, research literature and opinion papers. A series of face-to-face and telephone interviews were

conducted with 35 key national stakeholders. The information gathered included:

- Routes of entry into mental health work
- Reasons for professionals either choosing or not choosing to specialise in mental health
- Perceived organisational, structural and/or cultural barriers to recruitment
- Examples of good practice in recruitment
- Suggestions for improving recruitment

The literature review and the interviews with key informants identified that there was a particular problem with recruitment onto pre-registration mental health nursing courses. To explore the issues in more detail a series of telephone and email interviews were conducted with informants from a sample of 38 Schools of Nursing in England. The information gathered included:

- Admission criteria
- Recruitment strategies
- Criteria for short-listing and rejection
- Interview procedures
- Examples of good practice
- Shortfall in commissioned places

Key Findings

Mental Health Nursing

There are problems of recruiting onto mental health nursing courses at both diploma and undergraduate level. These problems are worse in some parts of England than others. The Schools of Nursing in London and the South of England are generally recruiting to their commissioned numbers, and the majority of the courses are oversubscribed. The situation in the Midlands is also fairly positive with only one School experiencing difficulties recruiting to the mental health branch of their diploma and undergraduate courses despite large numbers of applicants. The picture in the North is less positive with seven out of the eight Schools surveyed experiencing a shortfall of mental health nurse students. It is not simply a question of attracting sufficient numbers of students however, as there are concerns regarding the calibre and suitability of some students that are currently being accepted onto courses. It is difficult to get accurate data on the numbers of applicants and accepted applicants due to the range of routes into training and the absence of any centralised database. Although large numbers of applicants are rejected at the short-listing stage, the majority are overseas students who do not fulfil the residency requirements of three years and are therefore not eligible for an NHS bursary. In most Schools, applicants are interviewed by mental health lecturers and few are rejected at this stage.

Social Work

There are problems recruiting mental health social workers and approved social workers in some localities. There is an ageing workforce and retention of staff also seems to be a key factor. At present, there is a lack of sound data on exact numbers of staff in employment. There are concerns that recruitment problems may worsen, (although the workload may increase) with the inception of the new Mental Health Act, and also as mental health social workers move from the local authority to work for NHS/integrated Trusts. A number of issues impact on recruitment, notably the limited opportunities to gain experience of this sort of work, either during school years or whilst on placement. Work overload, low morale and lack of opportunities for career progression amongst mental health social workers also affects recruitment.

Clinical Psychology

To date there has been a lack of accurate workforce data about the number of clinical psychologists who work in mental health. Although there has been additional financial investment to increase the number of training places for clinical psychology, there are currently no systems in place to ensure that the required numbers of clinical psychologists will eventually work in mental health to meet service developments and workforce demands. Clinical psychology courses are heavily over subscribed. Approximately 1000 applicants for clinical psychology training do not gain places each year and, although many in subsequent years successfully gain places, more work needs to be done to consider the career opportunities for this group. The profession and Higher Education Institutions are increasingly keen to work towards ensuring trainees are more representative of society, and that they are attracting more applications from men and people from ethnic minority groups to meet the diverse needs of services.

Psychiatry

The number of medical students entering psychiatry has always been relatively low, although there are marked variations between medical schools. Experience in the field seems to be the most critical factor in encouraging recruits to the profession. Charismatic teachers and high quality teaching are also important, as are certain personality traits. Reasons for not wanting to do psychiatry include a belief that it is unscientific and ineffective. There is evidence that devaluing and stigmatisation by peers may have a negative impact on recruitment. The Royal College of Psychiatry Working Party on Recruitment and Retention has suggested a number of strategies to address the problem of recruitment and retention in psychiatry, at a number of key points during a doctor's career. Recruitment may also

be positively affected by the overall increase in medical students, by the widening of access and graduate entry schemes in medical schools. The two year Foundation Programme, with options to study psychiatry electives in the second year may also be a positive development.

Occupational Therapy

Occupational therapy courses are generic and there are currently no professional regulatory requirements or national standards to ensure that mental health practice placements are included in training programmes. The emphasis placed on mental health issues rests with individual Higher Education Institutions and possibly on the particular interests of the teaching staff. Consequently many students feel inadequately prepared to work in the mental health field when they have qualified.

Whilst occupational therapy courses continue to attract sufficient numbers of students, there remains a shortage of qualified occupational therapists working in mental health. Those who do choose to work in the field value the variety and diversity of the work, the opportunity to use a range of therapeutic techniques, the chance to develop relationships with clients, and the friendly and supportive atmosphere. Staff are positively influenced by good quality practice experiences in mental health, personal experience of mental health problems, supportive relationships with their peers, and strong professional leadership.

Rotational posts are an integral part of the culture for newly qualified occupational therapists. It is during this period that many occupational therapists make their career choice to work in mental health. The reconfiguration of specialist mental health trusts has impacted on the opportunities for many newly qualified occupational therapists to experience mental health practice. The reconfigurations have however resulted in bigger clusters of occupational therapists in the mental health workforce and this is viewed as an important factor in their recruitment and retention.

Despite increased commissioned numbers and more robust workforce planning, there is no guarantee that mental health services will attract the numbers of occupational therapists required for service developments and workforce needs. This is largely due to the generic nature of the training, that there are no specific requirements for programme planners to include mental health placements in training courses, and that Workforce Development Confederations commission overall training numbers to courses and do not have ring fenced mental health student places to reflect specific workforce demands.

Executive Summary

Recommendations

Mental Health Nursing

- Public awareness of mental health problems and the services provided needs to be raised. It is important that the images portrayed are accurate and informative and attempt to reduce stigma. Mental health nurses need to make their role and functions more public.
- Opportunities for paid and voluntary work within mental health care need to be expanded as a way of dispelling myths and promoting interest in the field. More opportunities for work experience from schools and colleges need to be facilitated.
- Efforts need to be made to maximise interest in mental health amongst a wide audience. Recruitment campaigns need to differentiate mental health nursing from other branches of nursing. Mental health nursing needs to shed its 'institutional, middle-aged' image, and to be marketed as a 'non-institutional, autonomous, varied and dynamic occupation'.
- Workforce Development Confederations and mental health trusts should consider ways of increasing the numbers of staff that could be seconded to undertake their mental health nurse training. Many Higher Education Institutions and the Open University offer flexible training programmes that can accommodate students with family and caring responsibilities. Higher Education Institutions also need to review their AP(E)L arrangements. If these were robustly and universally applied this could reduce the length of training thus lowering costs and providing qualified nurses more quickly.
- Further research needs to be undertaken to gather accurate figures on recruitment to mental health nursing courses. Such research should include recommendations of how such figures could be collated centrally for the use of future workforce planning

Social Work

- A proactive stance needs to be taken to both recruitment and retention of mental health social workers and Approved Social Workers that brings together key stakeholders to develop national and local strategies.
- Experience seems to be the critical factor in encouraging people to take up a career in mental health. More opportunities for work experience, paid and voluntary work in mental health services both within the statutory and the voluntary sector need to be made available and promoted.

- The shortage of placements for social work students in mental health services also needs addressing. Collaborative work between Higher Education Institutions, service managers and the Practice Learning Taskforce is important in developing a supply of high quality placements and adequate numbers of practice teachers to support them.
- Mental health needs to have a high profile within social work courses and to be promoted as an innovative and interesting area of work. Social work courses need to offer specific modules on mental health issues, as well as integrating it throughout the curriculum, with teaching input from inspiring practitioners and also from service users.
- Increased opportunities need to be provided for flexible and part time training. Social services agencies need to do more to encourage and support social care workers from mental health areas onto training programmes.
- The transition to the NHS needs to be carefully handled, with efforts to ensure that the social perspective is valued, and to prevent professional isolation of social workers. Efforts need to be made to promote and develop the role of mental health social work in social interventions and promoting social inclusion. Professional groups at national and local level, such as the Social Perspectives Network (SPN) and the Approved Social Work Interest Group (ASWIG) have an important role in providing mutual support and a sense of professional identity for mental health social workers.
- There is a need for more accurate data on recruitment and retention of mental health social workers and Approved Social Workers nationally to enable accurate workforce planning. There is also a need for research to establish the quantity and quality of mental health teaching in social work courses nation-wide, issues relating to obtaining placements, examples of good practice in attracting students into the mental health field, career destination studies and exploring barriers to working in this field.

Clinical Psychology

- There are differences in the way workforce data are recorded and utilised nationally. There needs to be a consistent approach and agreement amongst key stakeholders for determining future workforce planning needs.
- Clinical Psychologists should be included in discussions about workforce planning issues at both a national and a local level.

- There needs to be greater collaboration and partnership working between Workforce Development Confederations, primary care trusts and mental health organisations across the country to ensure priority areas for psychological services are recognised and then informs workforce planning.
- Further work is needed to explore the workforce, professional and financial implications of developing the Assistant/Associate psychologist role as a national initiative.
- Further work is required nationally to consider the available career opportunities and retention of the 1000 applicants who are unsuccessful each year in accessing clinical psychology training courses.

Psychiatry

- Recruitment and retention initiatives should focus on the whole career pathway. Students with an interest in psychiatry should be targeted, and their interest maintained and cultivated. There are various 'nodal points' which require particular attention to attract students and also to prevent wastage.
- The Royal College of Psychiatrists provides a vital focus for advancing knowledge in psychiatry, promoting positive attitudes and also acts as a centre for research and sharing ideas about teaching. It has recently expanded its team of staff working on recruitment and retention, which has developed promotional material, information packs and promotion of the speciality at careers fairs. This expertise should be capitalised on by Medical Schools, sixth form colleges and schools.
- The widening of access to medicine to attract more mature students with work experience and those with non-science backgrounds is welcomed as potentially increasing future numbers of psychiatric trainees.
- Opportunities for medical students to gain experience in mental health settings should be maximised via Special Study Modules, in the new Foundation programme and by integrating psychiatry with other aspects of the curriculum.
- Training experiences in psychiatry need to be of high quality and well supervised. Charismatic role models are important in inspiring interest in the subject. It is important too that a culture is fostered within Medical Schools where psychiatry is afforded high status and a positive image.
- Research is needed to look at different recruitment rates into psychiatry from different medical schools and the influencing factors.

Occupational Therapy

- The Health Profession's Council should consider making recommendations that all students should have the experience of working in at least one mental health placement during their training. Recommendations could also be made about the type and amount of mental health teaching that needs to be included in the course. This should reflect the key documents that have recently been published including the Capable Practitioner (SCMH 2001), the National Continuous Quality Improvement Tool for Mental Health Education (NCMH 2003), the Ten Essential Shared Capabilities (NIMHE 2004), and the Opportunities and Competencies for Community Mental Health Occupational Therapists (NCMH 2004).
- Workforce Development Confederations and Higher Education Institutions need to work together to find a way of ring fencing a dedicated number of mental health training places on occupational therapy courses to reflect mental health workforce demands.
- Workforce Development Confederations, Higher Education Institutions and mental health trusts need to consider ways of increasing the full and part-time funded secondment opportunities for staff interested in training as occupational therapists and then returning to work in the mental health service.
- There needs to be an increase in the number of rotational posts that go across health economies to ensure that newly qualified occupational therapists gain experiences in mental health.
- Mental health services, Workforce Development Confederations and Higher Education Institutions need to actively pursue the development of more joint appointments to promote the profile of mental health in training programmes.
- Mental health trusts should consider ways of ensuring that occupational therapists working within their service retain their professional identity.

Glossary

Glossary

AMHP

Approved Mental Health Practitioner

APEL

Accreditation of Prior Experiential Learning

APL

Accreditation of Prior Learning

ASW

Approved Social Worker

ASWIG

The Approved Social Worker Interest Group

AUTP

Association of University Teachers in Psychiatry

BASW

British Association of Social Work

BMA

British Medical Association

BPS

British Psychological Society

CCESTSW

Central Council for Education and Training of Social Workers

CCST

Certificate of Completion of Specialist Training

CFP

Common Foundation Programme

COT

College of Occupational Therapists

DoH

Department of Health

DipSW

Diploma in Social Work

GMC

General Medical Council

GP

General Practitioner

GSCC

General Social Care Council

HEFCE

Higher Education Funding Council in England

MHCGWT

Mental Health Care Group Workforce Team

MHSW

Mental Health Social Worker (without ASW qualification)

NCMH

Northern Centre for Mental Health

NHS

National Health Service

NIMHE

National Institute of Mental Health (England)

NMAS

Nursing and Midwifery Admissions Service

NMC

Nursing and Midwifery Council

NSF

National Service Framework

NVQ

National Vocational Qualifications

OT

Occupational Therapist

PLT

Practice Learning Taskforce

PRHO

Pre-registration House Officer

RCP

Royal College of Psychiatry

RGN

Registered General Nurse

RMN

Registered Mental Nurse

SCIE

Social Care Institute for Excellence

SCMH

Sainsbury Centre for Mental Health

SHO

Senior House Officer

SOE

Statement of Equivalence

SPN

The Social Perspective Network

SpR

Specialist Registrar

SSMs

Special Study Modules

STR

workers Support, Time and Recovery workers

SWAS

Social Work Admissions Service

TOPSSE

Training Organisation for Personal Social Services in England

UCAS

Universities and Colleges Admissions Service

UKCC

United Kingdom Central Council for Nursing, Midwifery and Health Visiting

WAT

Workforce Action Team

WDC

Workforce Development Confederation

WIT

Workforce Implementation Team

WNAB

Workforce Numbers Advisory Board

WFOT

World Federation of Occupational Therapy

WPA

World Psychiatric Association

INTRODUCTION

Workforce issues remain the most significant challenge to the implementation of the changes and developments outlined in the National Service Framework for mental health and the NHS Plan. There are key concerns regarding the recruitment and retention of staff, and creating a workforce representative of the community served. Whilst there has been progress in creating new roles for and types of mental health workers, there are difficulties in recruiting and retaining qualified professionals such as mental health nurses, psychiatrists, occupational therapists, social workers and clinical psychologists. In addition, there are problems in attracting sufficient numbers of people to train as mental health professionals, although the picture is mixed.

This report presents the findings of an investigation into the mechanisms for attracting and recruiting people onto mental health professional training programmes, the reasons for failing to recruit sufficient numbers of students, and the identification of innovative national and local recruitment strategies. It focuses on recruitment to mental health nursing, clinical psychology, occupational therapy, social work and psychiatry courses in Higher Education Institutions in England. Some work has already or is currently being undertaken in this area, notably in psychiatry and clinical psychology and where this is the case we have made every effort to highlight this.

The project was carried out against a backdrop of continuous and rapid change not only in the delivery of mental health services, but also around the work that is currently being undertaken to develop a workforce fit to deliver such services. A developing programme of work is currently being undertaken by a variety of key stakeholders including the Changing Workforce Programme, Trent Workforce Development Confederation and the Department of Health co-ordinated through the NIMHE National Workforce Programme on behalf of the Mental Health Care Group Workforce Team. Since starting the project a number of key documents have been published that will impact on the future education and training of mental health professionals. Notably, the Ten Essential Shared Capabilities (NIMHE 2004), and the National Continuous Quality Improvement Tool for Mental Health Education (NCMH 2003). Most recently, the National Mental Health Workforce Strategy was published in August 2004 (NIMHE/MHCGWT 2004). This document aims to provide some coherence to the complex and dynamic issues facing all staff involved in workforce planning, design and development. One of the sections focuses on recruitment and retention and it is anticipated that this project will contribute to the continuing programme of work in this area.

The report is presented in three parts. The first part

provides a comprehensive background to the investigation. It highlights the challenges in recruiting and retaining mental health staff, the range of strategies that are currently being employed to address this issue, the roles and remit of the complex and evolving national workforce groups, and the changing nature of the mental health workforce including the development of new roles and types of workers. A rationale for the focus of the project is given together with an outline of the methodology used. The findings are presented in part two. Each profession is considered separately as the issues facing clinical psychology for example, are very different from those facing mental health nursing. A relatively standard format has been used to present the findings although some additional information was gathered on mental health nursing because of the particular and well publicised difficulties the profession is facing in terms of recruitment onto pre-registration courses. Some examples of innovative practice in recruitment have been identified but these are by no means exhaustive. Part three summarises the findings, draws some conclusions and makes a series of realistic and pragmatic recommendations.

PART ONE: Background NATIONAL CONTEXT

Policy Drivers

Mental health services are in the midst of an exciting and challenging process of change to implement the National Service Framework for Mental Health (NSF) (DoH 1999a) and the NHS Plan (DoH 2000a). There are changes across both primary and secondary adult mental health services, covering all agencies involved in the delivery of mental health care. The plans for adult mental health care include:

- Significant financial investment
- Expanded and improved services from primary care to high secure hospitals
- Investment in attracting new staff at all levels, from support staff to psychiatrists
- Broad planning and change programmes as part of the wholesale restructuring of NHS and social care infrastructures (SCMH 2003).

These changes however have significant workforce implications. The aspirations of the NSF cannot be delivered without a combination of increased numbers of staff and the rapid enhancement of skills and competencies (SCMH 2000). It has been estimated that some 10,000 new staff are needed to deliver the new and expanded mental health services across the country (SCMH 2003).

Background

What are the challenges?

Reports and papers have highlighted that workforce issues remain the most significant challenge to the implementation of the NSF and the NHS Plan (SCMH 2003, 2000, 1997; Kingdon 2002; WAT 2001, 2000; Payne 2000; DoH 1999a; Gourney & Birley 1998). The NSF for example, highlighted key concerns regarding the recruitment and retention of staff, and creating a workforce representative of the community served.

There are difficulties with recruiting NHS mental health staff such as psychiatrists (Appleby 2002), mental health nurses (Ward 2000), clinical psychologists and therapists (Craik et al 1999, Lynam & Walker 1999). Some social services departments have similar problems with the recruitment of adequate numbers of approved social workers. There is subsequently a shortage of staff in most of the major professional groups, and the problems are worse in inner city areas.

A recent report published by the NHS Confederation (NHS Confederation 2003) also suggests that the Government's draft Mental Health Bill could dramatically increase the workload of key mental health staff and possibly contribute to the workload crisis. The report shows that the draft Bill would lead to a 50% rise in the number of tribunal hearings and a doubling of the workload associated with the legislation for psychiatrists, social workers and administration staff. It estimates that this is likely to require an additional 1,000 extra staff just to manage existing caseloads. Psychiatrists have also expressed concerns that the reform of the Mental Health Act could adversely affect the recruitment and retention of junior grade psychiatrists (Pyott 2002).

So why is recruitment such a problem at the moment? A recent report by the Audit Commission (Audit Commission 2002) highlights that the UK labour market is currently highly competitive with employment at a historically low level. This means that all employers have to compete harder to attract and retain staff. Within this context, there are widespread reports of recruitment and retention problems across local public services not just mental health. There are concerns about shortfalls in the number of staff, with fewer younger people being attracted to work for the public sector in the first place and a potential demographic 'time bomb' with 27% of the public sector workforce now aged 50 years or over.

The scale of the challenge is reflected in targets set by the Government across key public services. The NHS Plan has set targets for the recruitment of 35,000 more nurses, midwives and health visitors, 15,000 more consultants and general practitioners (GPs) and 30,000 more therapists and scientists by 2008 (DoH 2000a). The Government has also set targets for teachers and the police (Audit Commission 2002). Mental health services therefore have to compete with the rest of the public services.

It is however an international rather than simply a national problem. Feifel et al (1999) report a fall in numbers of medical students choosing to do psychiatry in the USA. There are also concerns in the USA about numbers of occupational therapists choosing to practise in mental health (Hulse et al 2000), and the dwindling numbers of mental health nurses in the face of increased demand (Oerman & Sperling 1999). Recruitment difficulties are reported for mental health nurses in Australia too (Happell & Rushforth (2000), and Ireland has experienced a similar decline in numbers on pre-registration psychiatric nursing courses as in Britain (An Bord Altranais 1999). Interestingly, McElwee (1998) notes that courses in social care at degree and diploma level in Ireland (whose graduates often do work with similar clients to those of psychiatric nurses) are over-subscribed.

Labour market trends

As identified in the previous section, the shortage of mental health service staff reflects the tight national and international labour market. The mental health disciplines have suffered particularly because training has not been expanded sufficiently to meet demand and because the drop-out rates from some professional courses are high (WAT 2000).

Within the overall national picture, there are widespread geographical differences, reflecting local labour market conditions. All other things being equal, turnover is most likely to be high where there are a large number of alternative jobs available within the travel-to-work area, and to be low where a change of job involves a house move or a major alteration of travel routine. But differences from region to region also reflect local employment cultures which explain why staff, in some areas are ready to change jobs for relatively little additional reward, while elsewhere they are more inclined to stay put (Audit Commission 1997).

A range of factors that have a measurable influence on turnover have been identified by the Audit Commission (Audit Commission 1997).

These include:

- Non NHS pay levels for comparable jobs.
- Size of private healthcare sector within the district.
- The presence in an area of more than one NHS Trust within travelling distance of where employees live.
- Local employment levels.
- Cost and availability of housing.

What do people want from work?

The Audit Commission (Audit Commission 2002) identified that the biggest single reason that people identified for joining the public sector is the opportunity to 'make a difference'. People want to make a difference, in a job that satisfies them, and with a reward package that meets their needs.

An earlier report of staff turnover (Audit Commission 1997) identified some aspects of work that were associated with satisfaction.

These included:

- Achievement
- Recognition
- Content of work
- Responsibility
- Opportunities for advancement
- Personal growth

The reasons why people leave their jobs are many and various. Research consistently shows that most leave because they are dissatisfied with their current jobs rather than because they are attracted by others. The Audit Commission report in 1997 identified that some aspects of work associated with dissatisfaction included:

- Policy and administration
- Supervision
- Physical conditions
- Pay
- Inter-personal relationships
- Status
- Security

Changing patterns of work and demography pose many challenges for mental health services in particular.

The following examples were highlighted in the report Finding and Keeping (SCMH 2000).

- Many Trusts have a high proportion of employees in their fifties who may be tempted to retire early for a number of reasons.
- Many of these older employees have significant responsibilities for eldercare. Some of them might like to stay on in their jobs if they could reduce their working hours or change work roles, but may be dissuaded from doing so because the NHS pension scheme is based on the final three years' salary.
- There are increasing numbers of women in the workforce, and many of them still shoulder the responsibility for arranging and paying for childcare.
- Whether or not they have children, both women and men are increasingly concerned about work-life balance.

The report also identified a range of issues that contributed to poor morale and disenchantment among mental health staff.

These included:

- Heavy workload
- Long hours
- Inability to deliver best quality care
- High turnover
- Staff shortages
- Reliance on bank, overtime and agency staffing
- Budget problems
- Few resources for development
- No effective workforce planning
- Continuous pressure
- Worried about the risk of violence
- Concerned about who would take the blame if things went wrong
- Anxieties about loss of role clarity and professional autonomy
- Perception that their job was low status and poorly paid

Image and perception

The Audit Commission report (Audit Commission 2002) found that public sector staff think that their image in the eyes of the public would discourage potential recruits. This finding was followed up by a review of the media coverage of public sector stories to see if the evidence supported this perception. The review found that while media coverage is extensive, the picture of public sector work presented to the reading public is unremittingly bleak. All types of story across all the newspapers were reported negatively, but some were more critical than others.

More specifically, there is evidence to show that, despite advances in treatment of people with mental health problems and the move to community care, stigmatisation of people with mental health problems remains widespread (Byrne 2001, Crisp 1999, Crisp et al 2000). Being labelled as mentally ill carries both 'internal consequences' in the form of shame, secrecy and reduced self esteem, as well as 'external consequences', characterised by prejudice and discrimination. In 1998, the Royal College of Psychiatrists launched a five year campaign, 'Changing Minds', to address the issue of stigmatisation of the mentally ill. To guide the campaign, a survey was commissioned to explore current public opinion about people diagnosed with one of seven common mental disorders. The findings revealed that people with mental illness were frequently believed to be dangerous, unpredictable, difficult to talk to, having a poor prognosis, responding poorly to treatment, only having themselves to blame and that they should be able to 'pull themselves together'.

Background

The most negative attitudes were held towards people with schizophrenia, alcoholism and drug dependence. It was suggested that the public needs education about the different disorders, and that any anti-stigma campaign needs to start in schools. In addition, particular attention needs to be paid to promoting more positive attitudes towards people with mental health problems in the media, with a particular emphasis on challenging the perceived assumption that mental illness means violence. Health care workers are likely to share some of these perceptions held more widely in society, so stigma also needs to be addressed as part of professional training (Crisp et al 2000).

The Workforce Action Team Report (WAT 2001) also suggested that the stigma associated with mental illness may be linked to problems of recruitment and retention of the mental health workforce, and that this issue needed further exploration. In 2003, the Department of Health commissioned the mental health charity, Mentality, to research the impact that stigma might have on recruitment and retention of staff in mental health services. Contrary to expectation, it was revealed that participants felt generally that the stigma related to working in services was negligible compared to the stigma experienced by users of services, and that it did not really impact on problems of recruitment and retention. Working in mental health was felt to be a positive career choice, even a 'vocation'. Professionals found their work rewarding and it provided them with opportunities to be creative, flexible and empowering. Common drivers for taking up this type of work included personal experiences such as exposure to mental health services and positive placement experiences. More important than stigma in relation to retention, were basic terms and conditions, such as having to cope with constant changes affecting their work and working environment, increased administration and thus reduced time for client contact, lack of career opportunities, stress and professional isolation. The latter was particularly important for occupational therapists and social workers in mental health.

NATIONAL INITIATIVES

Workforce groups: roles and remit

The Workforce Action Team (WAT)

The Department of Health established the WAT to look at the workforce, education and training issues of the mental health workforce as one of the five underpinning programmes in support of the NSF for mental health. The remit of the WAT was 'to enable mental health services to ensure that their workforce is sufficient and skilled, well led and supported to deliver high quality mental health care, including secure mental health care'. The WAT brought together a range of expertise (professionals, service users and carers, independent and voluntary sectors) to develop a coherent programme of work. Ten key areas of work were identified, one being recruitment and retention. The WAT produced an interim report in 2000 (WAT 2000) and a final report in 2001 (WAT 2001). The recommendations from the final report are now being taken forward by the Mental Health Care Group Workforce Team and have been fed into the National Institute for Mental Health's (England) national workforce programme.

The Mental Health Care Group Workforce Team (MHCGWT)

Following a general review of workforce planning across the NHS, a number of Care Group Workforce Teams have been established including the MHCGWT. The MHCGWT started work in the spring of 2002. Its overall aim is to help build capacity in the mental health workforce as part of a modern mental health service across health, social care and the independent and voluntary sectors. The MHCGWT has assumed responsibility for all the ongoing work emanating from the WAT and other pieces of activity, often being taken forward by small, highly focused sub-group working. The current sub groups include:

- Recruitment and retention
- Education and training
- New ways of working
- Workforce development and numbers

The National Institute for Mental Health (England) (NIMHE) and the National Workforce Programme

NIMHE is part of the Modernisation Agency and its role as the implementation arm of the Department of Health, is to ensure that policy is turned into effective action, working closely with local NHS and social care systems and the non-statutory sector. The National Workforce programme sits in NIMHE as one of its key programmes. As an advisory body, the MHCGWT looks to the NIMHE National Workforce Programme to help deliver and implement the workforce strategy, working in conjunction with all the relevant stakeholders.

NIMHE has formed a small Workforce Implementation Team (WIT) to oversee the National Workforce programme and the team is accountable to the MHCGWT for its work, actively participating in, or in some cases leading some of the sub groups of the MHCGWT. The programme has four main themes: workforce design and development, education and training, recruitment and retention and new ways of working. One of the WIT's key projects is to increase national recruitment to achieve a workforce representative of its community.

Workforce Numbers Advisory Board (WNAB)

The WNAB advises the national Workforce Development Board on the overall numbers of undergraduates and postgraduate education and training places to be commissioned in each staff group. It also advises on targets for workforce distribution and the number and location of training places to support this aim.

Policy reports

Table 1 summarises the key general reports that have been published to date on recruitment and retention in the NHS and the public sector. It does not include the reports that have focused on individual professional groups as these have been included in the findings section of this report.

Background: Table 1: Reports on recruitment and retention

Report	Scope
Audit Commission (2002) Recruitment and Retention	Focuses on size and nature of recruitment and retention problems across the public sector; why people join, remain or leave; and successful initiatives (not specific to mental health)
Audit Commission (1997) Finders, Keepers	Focuses on reducing high turnover rates in the NHS (not specific to mental health)
DoH (2003b) Mental Health Services: Workforce Design and Development	Sets out the principles and methodology by which local mental health and social care economies can estimate the demand for staff across the statutory sector.
DoH (2002a) A Health Service of all the Talents: Developing the NHS Workforce	Sets out proposed changes in education, training and employment of staff to deliver the flexible, multi-skilled workforce that the NHS of the future will need (not specific to mental health)
DoH (2000) Meeting the Challenge: for Allied Health Professionals	Examines the government's commitment to expanding the roles that allied health A Strategy professionals play in health and social care within the modernised NHS. It also considers ways of expanding recruitment and retention.
NHS Executive (2000) Recruiting & Retaining Nurses, Midwives & Health Visitors in the NHS	The report sets out the results so far of the Government's strategy to increase the number of nurses working in the NHS and to improve pay and conditions (not specific to mental health)
SCMH (2003) A Mental Health Workforce for the Future	Has a section on recruitment and retention
SCMH (2000) Finding & Keeping: Review of Recruitment & Retention in the Mental Health Workforce	Describes and analyses the difficulties in recruiting and retraining mental health staff and identifies practical & sustainable ways of addressing those difficulties.
WAT (2001) Mental Health National Service Educationthe NSF and the NHS Plan, one section and Training Underpinning Programme: Final Report	Presents a national picture of the staff needed to deliver Framework Workforce Planning, focuses on recruitment and retention
WAT (2000) Mental Health National Service Framework Workforce planning, Education and Training Underpinning Programme: Interim Report	Sets out the current issues facing services in the areas of workforce planning, education and training, and recruitment and retention.

Recruitment strategies

Recruitment strategies in the public sector

The recent Audit Commission report (Audit Commission 2002) highlighted that a wide range of recruitment and retention initiatives are in place across the public sector, with action being led by Government, professions, national organisations and local employers. Major strategies include:

- Recruiting key workers from overseas
- Encouraging workers who have left to return
- Re-engineering traditional skill mix requirements, enhancing existing roles and creating new ones
- Widening the pool by recruiting from non traditional groups and running 'grow-your-own' initiatives
- Improving the working lives of staff and reducing unnecessary administrative work.

Recruitment strategies in mental health

The following is a compilation of recruitment strategies and recommendations made in a series of reports (NHS Executive 2000, SCMH 2000, WAT 2000, DoH 1999a) and newsletters and minutes produced by NIMHE and the MHCGWT. These include recommendations to encourage staff to return to work, to remain in work, and to attract new recruits to train as mental health professionals or to work in other roles. The key recommendations include:

- Attracting staff from black and ethnic minority backgrounds
- The potential recruitment of refugees and asylum seekers
- Attracting individuals from all parts of the local community so that the workforce reflects the diversity of the local population
- Encouraging professionally non-affiliated people currently working in the mental health services to train as mental health professionals
- Attracting more mature students with appropriate life skills
- Targeting older people, women returning to the workforce after a career break, young people making training choices, and people who are considering retraining in mid career
- Making flexible working options and family friendly policies a reality.
- Flexibility in pension arrangements
- Improving the supply of affordable housing, helping staff to live where they work
- Creating new roles
- Employing service users and carers

- Raising the profile of careers in mental health services
- Developing a learning organisation and culture
- Promoting new ways of working across professions and between qualified and unqualified staff. Emphasis on flexible working and innovation.

General National Initiatives

Employment of service users

South West London and St. George's Mental Health Trust has developed a 'User Employment Project' where previous use of mental health services is included in the selection criteria for posts. Since 1995, 40 people have been recruited into supported employment in the Trust and 57 volunteers have been taken on. The programme recognises the benefits of recruiting people who have experienced the service first hand, and has been used as a model for similar initiatives in other parts of the country. Based on a model from Colorado, the project comprises three components: a supported employment programme to help service users in gaining and sustaining employment as care assistants, outreach/project workers etc., a volunteer programme and an employment charter designed to reduce discrimination. The trust advertises its policy of actively seeking to employ people who are from groups which are traditionally under-represented, such as people from ethnic minority groups and former service users (Davidson et al 1999, Perkins et al 1997).

National Pilot Study

The Centre for Ethnicity and Health at the University of Central Lancashire has been commissioned by the MHCGWT to undertake a national pilot study examining the range of issues which impact on recruitment and retention in the mental health workforce.

Details of this project can be obtained from:

Professor Kamlesh Patel or Robert McDonald

Centre for Ethnicity and Health

University of Central Lancashire

Preston PR1 2HE

Email: kkpatel@uclan.ac.uk or
rvmcdonald@uclan.ac.uk

Positive messages in recruitment campaigns

The recruitment and retention sub-group of the MHCGWT published a range of positive themes and messages in 2002 regarding working in mental health that should be included in recruitment campaigns. These include:

- Need to avoid negative stereotypes of both patients and professionals
- Many people who encounter psychiatric services are intelligent, interesting and creative

Background

- Point out that many of our greatest artists, poets, novelists, philosophers, musicians and even scientists have been people who have struggled with mental health problems
- Focus on people with mental health problems as struggling with 'existential' issues such as the nature of reality, suicide and the meaningfulness of life itself. Professionals have to be able to 'get alongside' people in these struggles and engender a spirit of hope
- Accept that psychiatric services have been experienced as oppressive. As well as expanding community services there is a need for qualitative change in the sort of care delivered. We need professionals who are interested in the challenge.
- Accept that people with mental health problems suffer discrimination and extreme forms of social exclusion. Professionals in the field have a role in the fight against discrimination.
- We are looking for people who like listening, who are themselves imaginative and creative
- We should specifically target people who have had their own struggles with mental health problems
- Need to target people from minority ethnic communities. The mental health workforce should broadly reflect the communities it serves.

The National NHS Recruitment Campaign

First launched in 1999, the National NHS Recruitment Campaign has the following aims: raise the profile of careers in the NHS, encourage new entrants into training, encourage applicants to vacancies, attract back returnees, promote recruitment from a wider base, and provide national brand in NHS careers. The early campaigns focused on careers in nursing and persuading former staff to return to the NHS. Subsequent campaigns have broadened this focus to cover all careers in the NHS.

National NHS Job Shop Day

A National NHS Job Shop Day is held in the autumn to maintain the momentum of the NHS Recruitment Campaign. This is an opportunity for Workforce Development Confederations (WDCs) and local NHS Trusts to showcase the NHS and target new recruits and returnees back into the NHS. Job shops can range from a stand at a local shopping centre or hospital to a specifically chartered recruitment bus. Many job centres are also involved in the event.

NHS Careers

Launched in 1999, this is an interactive service offering careers information for nurses, health visitors, midwives, doctors, allied health professional and healthcare scientists. NHS Careers operates both a national call centre and a web site providing information and advice on careers in the NHS to young and mature people and their advisers, as well as current NHS staff and former NHS staff who may wish to return. NHS Careers provides careers literature and also supports and facilitates national and local careers activities. The service has proven to be very successful and receives over 10,000 emails and telephone enquiries per month. The contact details are:

Website: www.nhs.uk/careers

Helpline: **0845 60 60 655**

Email: advice@nhs Careers.nhs.uk

New NHS Careers Mental Health Advert

As part of the 2003 National NHS Recruitment Campaign, a new NHS careers advert was produced promoting careers in mental health, including nursing. Featuring a young man, David, who suffered from a panic disorder, the advert explains how David was supported through a treatment programme by a clinical psychologist, community mental health nurse and an occupational therapist. The advert explains the rewarding nature of a career in mental health and how these key members of staff were able to help David recover.

The National Campaign at a Local Level

The campaign provides a national brand for the NHS that can be adapted at a local level to increase the impact of local recruitment activities. The successes the NHS achieves in growing its workforce are directly related to local initiatives that are developed at confederation, health community and trust level, linking in local messages with the national campaign.

WDCs work closely with the NHS trusts to organise local events and campaigns aimed at raising the profile of the roles within the NHS and at recruiting and retaining staff. These events and campaigns vary from trust to trust depending on the individual needs of the local area and organisation. Some target school children and arrange visits to children of various ages, whilst others identify the large pool of former staff in the area and target efforts at encouraging them to return to the NHS.

Positively Diverse Programme

The Positively Diverse Programme is a national initiative which has about 40 member organisations, mainly NHS Trusts, which encourages local action in the development of strategies to address issues of equality and diversity. A report of the first phase of the project has been published with examples of good practice (www.doh.gov.uk). There is also a workbook and toolkit to help support other organisations who wish to take part in the programme.

Bradford Health Authority has initiated a number of innovative projects enabling health and education to work together to boost recruitment and retention amongst minority ethnic communities. The Manningham Jobshop in Bradford is a very successful project developed under Positively Diverse, which works to attract people from black and ethnic minority communities into a range of health care jobs. The Healthcare Apprentice Scheme also developed in Bradford, helps black and ethnic minority people to enter pre-registration nursing courses. The scheme involves working with schools, local communities and Higher Education Institutions (DoH 2000d).

Access to Health and Social Care

Trent WDC has employed a Project Manager for Access to Health and Social Care. The aim is to provide an interface between training in Further Education, which leads to professional training in health and social care. There are 12 Access to nursing/health professions courses available in the Trent region. An agreement has been reached that the Trent region Access programme in the future will be broad based and generic, comprising of specific elements which relate to a variety of professions - interprofessional, rather than specific to nursing for example. Some of the Access programmes comprise of units which provide an awareness of mental health issues and these have been valuable in terms of students moving on to work in the field.

For further details contact Val Wood, Project Manager, val.wood@trentconfed.nhs.uk

Mental Health Recruitment and Retention Database

A database of initiatives that have been implemented locally to deal with recruitment and retention issues has been developed. It aims to provide a method of sharing what is happening in local areas to increase workforce numbers in terms of what has succeeded and also what has not been successful. The database can be found at: www.clwdc.nhs.uk

Other Resources

A guide to effective practice in recruitment and retention can be found in the NHS Recruitment Handbook

'Information, Resources and Good Practice for HR Teams and Everyone Involved in the Recruitment of NHS Staff'. This can be found on the Department of Health website www.doh.gov.uk

The Department of Health website also includes information on the following recruitment and retention initiatives:

- Return to Practice
- NHS Professionals
- NHS GP Golden Hello Scheme
- International recruitment
- NHS Zero tolerance
- Valuing diversity
- Retention: IWL Standard
- Childcare strategy
- Flexible Retirement
- Improving Working Lives for Doctors
- Flexible Careers Scheme for Doctors
- Flexible Careers Scheme for Doctors
- NHS GP delayed Retirement Scheme
- Doctors' forum
- Family Friendly policies

New Roles and Types of Workers

Despite increasing the numbers of training places for professional staff, with international recruitment, and with retaining staff more effectively by making working life more attractive, there will still not be enough staff to deliver the new modernised mental health services. The introduction of new roles is one way of addressing this problem. The key new roles that have been recently introduced are described below.

The Assistant Practitioner

This new role has been developed as a generic level 4 worker (as determined in the Agenda for Change framework). This means that the role requires skills, knowledge and competencies from a number of different disciplines. The actual skills and competencies are determined by the service in which they work. The education programme that has been selected to support the initiative is a Foundation Degree. This course combines work-based learning, skills, knowledge and competencies within the delivery of the programme. This initiative is currently being piloted in Manchester. It takes workers two years full-time or three years part-time to complete. It has a wide entry gate in terms of educational requirements with no specific qualifications for mature students. The current challenge is for the WDCs to get agreement with education providers on the accreditation of prior (experiential) learning (AP(E)L) arrangements for those assistant practitioners who may wish to go on to access a professional training course (Greater Manchester WDC 2003).

Background

(Associate) Mental Health Practitioner

Local mental health service providers in collaboration with the University of Southampton have set up an innovative 'earn and learn' approach to employing and educating future mental health workers. The (Associate) Mental Health Practitioner programme aims to provide graduates with health or social care related first degrees with the chance to develop a career in mental health and social care. Based on the skills, attitudes and knowledge highlighted in the Capable Practitioner (SCMH 2001), the aim is to train future mental health staff fit to practice in modern acute mental health and social care settings. Trainees will be fully employed by the service providers and attend the academic element of the programme (Postgraduate Diploma in mental health studies) at the University of Southampton on a part-time basis over two years, whilst simultaneously undertaking supervised work experience throughout. Trainees start on an annual salary in the region of £14,200 in the first year, rising incrementally to over £17,000 on successful completion of the programme. All academic course fees will be paid for the trainees. Following successful completion of the programme and a period of consolidation in practice (two-three years), trainees will have the option of completing a Masters programme. The first intake of 28 trainees started in September 2003, with subsequent intakes commencing annually until 2005 (Kingdon 2002).

Support, Time and Recovery (STR) Workers

STR workers are so-called because they provide Support, give Time to the service user and thus promote their Recovery. Service users often complain that mental health staff do not spend enough time with them. This is particularly the case on acute wards where staff are often too pressurized to spend time with service users or work with them therapeutically. STR workers' dedicated role will be to support service users by spending time with them, listening and talking to them, and helping them with practical tasks. They may work in a variety of settings within the community or hospital. They work as part of a team, receive regular supervision, and spend negotiated time with individual service users. The aim is to create 3,000 STR workers in England by 2006.

The role has distinct boundaries. STR workers do not, for example, provide clinical or medical treatment, administer medication, section or administer compulsory medication under the Mental Health Act, provide therapy, or act as care co-ordinators under the Care Programme Approach. STR workers may come from a variety of backgrounds and many of them may be users or carers themselves. They may also hold a variety of qualifications, but all will undergo a nationally agreed induction and training programme with the aim of achieving NVQ level 3.

For further information see:

The Mental Health Policy Implementation Guide: Support, Time and Recovery (STR) Workers (DoH 2003c). This document is available on:

www.doh.gov.uk and www.nimhe.org.uk

Graduate Primary Care Mental Health Workers

The NHS Plan set a target for 1000 graduate workers in post by December 2004 to build capacity in primary care. They are to be funded by resources allocated to Primary Care Trusts while Trent WDC is co-ordinating the setting up of training arrangements nationally. The starting point for the graduate primary care mental health worker was clearly to tap into the large number of psychology graduates produced annually. Graduates in the other health and socially related fields and people with equivalent qualifications will also be eligible to apply for these posts and to undertake a postgraduate mental health certificate to prepare them for this role.

For further information see: Fast-forwarding Primary Care Mental Health: Graduate Primary Care Mental Health Workers. Best Practice Guidance (DoH 2003d).

This document is available on:

www.doh.gov.uk and www.nimhe.org.uk

Associate Psychologist

The development of the Associate Psychologists role (Intermediate Grade of Psychologist) attempts to address accessibility to Psychological Services as there are currently lengthy waits to see a Chartered Clinical Psychologist. An example of this is in Penrith and Eden, where an Associate Psychologist has been working alongside Clinical Psychologists in the Adult Mental Health and Child and Family Teams. In both service, the Associate has been able to work with clients, under supervision, using specific, time-limited behavioural or cognitive behavioural approaches. This has resulted in a reduction in waiting times for first appointments but has also allowed the qualified clinical psychology staff to devote more time to the assessment and treatment of more severe, complex cases.

New Ways of Working in Psychiatry

NIMHE and the Royal College of Psychiatrists together with a range of professional staff and user organisations involved in mental health care have joined together to form a National Steering Group with two sub-groups. These groups are supported by the Changing Workforce Programme and are looking at new ways of working for consultant psychiatrists and working across professional boundaries. The work is set against a backdrop of concern at the level of vacancies for psychiatrists and other key mental health staff, the demand for new approaches to mental health care, the challenges of new policies such as the proposed new Mental Health Act and the European Working Time Directive.

Counselling

Primary Care Trusts are increasingly employing counsellors to deal with clients with mild to moderate mental health problems in primary care settings, often under the auspices of a psychology department. Sibbald et al (1996) have produced a paper evaluating the role of counsellors in GP practices. A recent paper by King et al (2000) presents a randomised controlled trial of their effectiveness in working with people with depression and anxiety. More information can be found on www.cpct.co.uk

The Focus of this Project

If the demands of the NSF for mental health are to be met, there remains a need to increase the number of training places for professions such as psychiatry, mental health nursing, occupational therapy, clinical psychology and social work. The current recruitment and retention problems cannot be tackled simply by increasing the numbers available for recruitment (SCMH 2000) or by the introduction of new roles and workers. Despite the rapidly changing mental health workforce, there remains strong support for the retention of the above professional specialities. Pulling Together (SCMH 1997) for example, found little evidence or support for radical configurations of current professional boundaries. The report strongly argued that there is a great value in diversity and each of the current mental health professions has strengths and skills to offer the services of the future. It is right that the diversity of service users' needs is matched by a diversity of professional backgrounds and skills.

There are however significant problems in attracting sufficient numbers of people to train as mental health professionals, although the picture is mixed. Whilst this poses little or no problem for occupational therapy and clinical psychology where there is heavy competition for places, mental health nursing reports substantial problems in filling commissioned training places. Psychiatry and social work report similar difficulties with recruitment.

In order to address these problems there is a need to investigate the mechanisms for attracting and recruiting people onto mental health professional training programmes, the reasons for failing to recruit sufficient numbers of students, and to highlight examples of good practice. The purpose of this study is to investigate these issues in England by focusing on recruitment to mental health nursing, clinical psychology, occupational therapy, social work and psychiatry courses in Higher Education Institutions.

METHODOLOGY

Aim and Objectives

The overall aim of this study is to make recommendations that will contribute towards improving recruitment onto mental health professional training programmes in England.

There were four specific objectives:

1. To review existing published information about the recruitment of NHS and social care staff across a range of disciplines.
2. To identify the mechanisms for attracting and recruiting pre-registration and post-qualifying mental health staff. This will include an exploration of national variations and the identification of good practice.
3. To elicit a range of views from key informants on the problems of recruitment; the key elements of a cohesive and comprehensive strategy towards improving recruitment; the perceived organisational, structural and/or cultural barriers to recruitment; and examples of good practice that they were either involved with or were aware of.
4. To translate these findings into pertinent and realistic recommendations for the future recruitment of mental health students and staff.

Methods

Our approach used a range of methods to access the diverse types of evidence and knowledge required to understand the current difficulties in recruiting to mental health professional training programmes.

Data were gathered from the following sources:

Literature search and review

Comprehensive literature searches were conducted to identify relevant policy documents, research literature and opinion papers. The searches were limited to the English language, from 1990-2004, and hand-weeded for salience. This was complemented by a hand search of pertinent journals. Additional information was obtained from a range of web sites and the minutes of meetings, notably those of the Mental Health Care Group Workforce Team and its Recruitment and Retention sub-group.

Methodology

Interviews with key informants

The study began with a series of face-to-face or telephone interviews with key national stakeholders. This included representatives from nursing, occupational therapy, social work, psychology and psychiatry who have been or are currently involved in recruitment work and projects; representatives from the professional bodies such as the Royal College of Psychiatrists and the British Psychological Society; and representatives from organisations concerned with mental health recruitment such as NIMHE, the WDCs and the MHCGWT. Appendix A lists the 35 informants interviewed. The information gathered included:

- Routes of entry into mental health work in their profession
- Reasons for professionals either choosing or not choosing to specialise in mental health
- Perceived organisational, structural and/or cultural barriers to recruitment
- Examples of good practice in recruitment
- Suggestions for improving recruitment

See Appendix B for a copy of the interview schedule, and Appendix C for the good practice data collection sheet

Focused interviews with Schools of Nursing

The literature search and the interviews with key informants identified that there was a particular problem with recruitment onto pre-registration mental health nursing courses. The precise nature of the problem was unclear although a number of issues emerged, namely:

- Schools of Nursing often have admission criteria above the minimum required by the profession
- Application forms may be screened by teaching staff who are not mental health trained leading to suitable applicants being rejected
- There are no common criteria for rejecting candidates, often within individual institutions and also across institutions
- There is no consistent way of giving rejected candidates feedback on what they would need to do to be successful in the future

Much of the above information however was anecdotal. To explore the issues in more detail a series of telephone and email interviews were conducted with informants (recruitment officers, mental health teachers, admission tutors) from a sample of Schools of Nursing in England. The information gathered included:

- Admission criteria
- Recruitment strategies
- Criteria for short listing and rejection
- Interview procedures

- Examples of good practice
- Shortfall in commissioned places

See appendix D for a copy of the interview schedule.

38 Schools of Nursing were approached to participate in the study out of a possible 50. Initial inquiries were made by phone to Admissions Departments, and following the request for information, a copy of the question schedule was e-mailed to the appropriate person. For most schools, two or more informants were needed, usually a senior member of staff from the Admissions Department and also heads of mental health, lecturers for particular courses or the Admissions tutor. Whilst the Admissions Departments tended to have the figures and short-listing information, lecturers knew about the interviewing procedure. In some cases questionnaires were e-mailed back, and in others staff were willing to talk over the phone as well, giving an opportunity to explore the issues in more depth. Whilst some schools expressed an interest in the study, and were pleased to find they were not the only ones to be struggling with recruitment to mental health, or wanted to share examples of good practice, others were reluctant to take part, as the questions were perceived as arduous. Considerable effort had to be undertaken to chase up responses from some schools, and despite this, statistical data was not received from just over half the schools.

Facts and Figures

In order to strengthen the information gathered from the literature review and interviews, it was necessary to gather further data on the shortfalls in recruitment to each of the mental health professions. Data were gathered from a variety of sources including the WDCs, the WNAB, the Nursing and Midwifery Admissions Service (NMAS), and the Royal College of Psychiatry.

PART TWO: Findings

MENTAL HEALTH NURSING

Education and training

Mental health nurses are the largest professional group within the mental health workforce. Mental health nurse training may be studied at diploma, undergraduate and in some instances at postgraduate level. Access to programmes is through either the Nursing and Midwifery Admissions Service (NMAS) for diploma programmes or the University Central Admissions Service (UCAS) for undergraduate programmes. Students may be taken by some Schools as direct applicants, e.g. from ACCESS courses or late applicants after the NMAS deadline in June. Students normally choose to specialise in mental health nursing when applying for training programmes.

The Nursing and Midwifery Council (NMC) has recently agreed that it will discontinue setting specific educational standards for entry onto courses (www.nmas.ac.uk). Instead it will set general entry requirements that are relevant to professional needs. This change requires the rules for nursing and midwifery education to be altered. The existing educational requirements will apply until the new rules are approved by government. These are:

- 5 GCSE/GCE O levels, grade C or above; or
- 5 CSEs grade 1; or
- 5 SCEs grade 1 (Scotland); or
- 5 SCE ordinary, grades A-C (Scotland); or
- GNVQ Intermediate level plus one GCSE/GCE O level, grades A-C; or
- GNVQ Advanced level or NVQ level 3; or
- SVQ level 3; GSVQ level 3 (Scotland); or
- SVQ level 2 (Scotland) if the programme began after September 2000; or
- A Kite marked Access to Higher Education course; or
- EDEXEL Foundation (BTEC) National or Higher National Diploma; or
- Passes in the Northern Ireland Grammar School Senior Certificate of Education; or
- A qualification awarded by the NNEB dating from 1985.

At present acceptable qualifications vary considerably between individual Higher Education Institutions and this is largely determined by the academic level of the training programme and availability of places. In terms of duration of programmes, statutory requirements are laid down by the NMC who stipulate that all programmes are structured with a twelve month Common Foundation Programme where elements of learning take place with nurses from other branches of nursing, and a two year branch specific component (DoH 1999b). In addition, programmes must

be flexible and where there is evidence of prior learning it is possible to complete programmes in two years. Part time programmes are also available in some parts of the country. All nurse education and training programmes must reflect equal balance between theory and practice (UKCC 1999). Practice placements for mental health branch students are normally mental health focussed throughout the three year training period and these may take place in both statutory and non statutory organisations. Student nurses are normally exposed to multi professional and multi agency working practices and currently they must be mentored and assessed by a qualified mental health nurse (UKCC 1999). Training programmes are largely skills based and learning outcomes are clearly stipulated by the NMC to reflect fitness for practice, professional award and employment. Programme learning outcomes are not specific to mental health nursing.

Students who undertake an NHS funded degree course receive a means tested bursary. Students are paid, but the grant allowance received depends on personal income or that of their partner/parents. Students who undertake an NHS funded diploma course receive a non means tested bursary that currently stands at £5,432 per annum (£6,382 in London).

Depending on circumstances, students may receive extra allowances, for example if they have children (www.rcn.org.uk/resources/becomenurse/php).

Facts and figures

A number of key reports have highlighted the current shortage of mental health nurses (SCMH 2003, 1997; WAT 2001, 2000). 2.1% of nursing posts in psychiatry are considered hard to fill, and 85% of NHS trusts report difficulties in recruiting and retaining nursing staff generally (SCMH 2000). Of the UK nursing staff increases in 2001/2002, 42% came from international recruitment, including over 3,000 nurses from South Africa (from where NHS organisations have now been instructed not to recruit). Only 4.7% of the international recruitment was for mental health (SCMH 2003, NMC 2003). Half of the UK registered nursing workforce is now over 40 years old and there is a long-term trend of an ageing workforce (SCMH 2003, NMC 2004).

In 2003, there were 94,626 registered mental health nurses in the UK (NMC 2004). Many of these however do not work in mental health settings or within the NHS. One third of practitioners hold more than one registerable or recordable qualification and it is not possible to identify with any degree of certainty which ones they are using in their current practice.

In England, there are currently 44,728 (headcount) / 39,383 (whole time equivalents) qualified mental health nurses working in the NHS. Approximately 34% of these are male and 66% are female).

Findings

Mental health nurses constitute 12.3% (headcount) / 13.5% (whole time equivalent) of the qualified nurse workforce.

There was a 14.4% increase in qualified mental health nurses from 1997 to 2002 (Brimblecombe 2004).

Despite this increase, the vacancy rates (three-month vacancies) remain relatively constant. For example, in 2004, the vacancy rates for community mental health nurses were 1.9% (2.7% in 2003, 2.0% in 2002), and for other mental health nurses were 4.7% (4.7% in 2003, 4.4% in 2002). There are also wide variations between Strategic Health Authorities that do not appear to follow a particular pattern (DoH 2004c, 2003e, 2002b). For example, the highest vacancy rates for mental health nurses (not community) were 16.8% in Bedfordshire and Hertfordshire, 13.4% in North West London, 14.5% in South East London, 10.5% in Greater Manchester and 10.2% in Hampshire and the Isle of Wight. The lowest vacancy rates were Northumberland, Tyne and Wear 0.6%, Cheshire and Merseyside 1.0%, Trent 0.6%, and Coventry, Hereford and Worcester 0.6%.

There are long standing problems in recruiting students into mental health nursing and the attrition rate from courses is reported to be high (WAT 2000). Our figures however show that the attrition rates are not bad in the majority of schools surveyed but this is possibly an underestimation of the true picture nationally (see appendix E). Four million pounds was invested in 2000/2001 on new training commissions for mental health nurses. It was anticipated that this would generate an additional 300 mental health nurse training places (WAT 2000, p6). See box below for details of the number of training commissions for mental health nurses in England in 1999 and 2002/2003.

Mental Health Nursing Training Places (Brimblecombe 2004)

	1999	2002/2003
MH degree	222	389
MH diploma	2704	3456
Total	2926	3845

Recruitment to diploma courses

The following data is taken from the fourth Nursing and Midwifery Admissions Service (NMAS) Statistical Report submitted to the Department of Health (NMAS 2004). This report provides information and data on applications to pre-registration nursing and midwifery training diploma programmes for the year 2003. Diploma level courses are currently offered at 50 Higher Education Institutions in England. From July 2002 to June 2003 110,000 application packs for nursing were sent out, and 32,585 completed application forms were returned

(all branches of nursing). NMAS passed on 29,979 application forms to the Higher Education Institutions. Of these applications, 15810 were successful, 13324 were unsuccessful, and 553 candidates withdrew.

The total number of applicants to train as mental health nurses in 2002/2003 was 12,979 (4,659 male; 8,320 female). 36% were men and 60% were aged 26 years and above. 31.8% of applicants were British and 33% were Black African. See box below for details of applicants by age and gender.

Applicants

Male

25 & under	1,420
26 & over	3,239

Female

25 & under	3,709
26 & over	4,611

Total

25 & under	5,129
26 & over	7,850

2,540 applicants were accepted to undertake a mental health nurse training programme (692 male; 1,848 female) in 2003/2003. See box below for details of accepted candidates by age and gender.

Accepted applicants

Male

25 & under	208
26 & over	484

Female

25 & under	778
26 & over	1,070

Total

25 & under	986
26 & over	1,554

65.1% of accepted applicants were British and 16.6% were Black African. A higher percentage of accepted applicants for mental health had degrees or higher degrees compared with other branches of nursing (11% of mental health students are graduates compared with 6% of the total group). The boxes below illustrate the changes in the numbers of candidates applying for, and being successful in securing a place to train as a mental health nurse from 2000 to 2003.

Applications

2000		2001		2002		2003	
Male	Female	Male	Female	Male	Female	Male	Female
7963	9350	10808	11574	6728	9476	4654	8320
Total	17286	Total	22382	Total	16204	Total	12979

Accepted

2000		2001		2002		2003	
Male	Female	Male	Female	Male	Female	Male	Female
777	1538	779	1678	717	1708	692	1848
Total	2310	Total	2457	Total	2425	Total	2540

13% of applicants to mental health nurse diploma courses were accepted in 2000, this increased to 19.6%

in 2003. The box below shows how this figure compares with the other nursing branches in 2003.

	No of applicants	No of accepted applicants	% accepted
Mental Health	12979	2540	19.6%
Midwifery	5847	609	10%
Adult	36843	10347	28%
Learning disability	2301	568	25%
Child	11841	1535	13%

These figures suggest a shortfall of 916 students accepted to start mental health nursing diploma courses in 2003. It is important to note that although access to programmes is officially through NMAS, some Schools are taking direct applicants, mainly from Further Education colleges from the ACCESS or Certificate in Mental Health courses. Some Schools also take direct applicants after NMAS has closed for applications in June. These figures from NMAS are therefore likely to be an under-estimation of the total number of applicants and accepted places.

Recruitment to degree courses

In 2002/03 there were 389 places for students to undertake an undergraduate degree in mental health nursing. Nursing is categorised in Subject Group B, Subjects Allied to Medicine, for the purpose of UCAS statistics. The statistics give the total number of applicants and accepted applicants for all the subjects coming under this umbrella. It is therefore not possible to determine the number of applicants and accepted applicants for the undergraduate mental health nursing courses.

Findings

Issues identified in the literature

Recruitment to Mental Health Nursing

85% of Trusts report difficulties in recruiting nurses, particularly in mental health (SCMH 2003).

The workforce is getting older, with one third of current Registered Mental Nurses (RMN) in practice coming up for retirement in the next five years, at the same time as courses have been attracting insufficient students. There are particular concerns about the staffing of in-patient units, which have lost out with the development of community based services (Nursing Times 2000).

Helmsely-Brown & Foskett (1999) attribute the problems of recruitment, which have beset nursing in recent years to demographic changes, changes in work patterns and new opportunities for education and training for young people. As the field of work has opened up for women, fewer are now choosing to enter nursing (Firby 1990). Foskett & Helmsley-Brown (1997) revealed that almost a quarter of young girls hoped for careers in the arts and media compared to only 11% who were interested in healthcare careers. In addition, young women these days are more likely to opt for medicine rather than nursing. Reasons for not choosing nursing included it being seen as a female occupation (boys), low status, 'dirty', manual work shift-work with limited career opportunities, and nurses were seen as subordinate to doctors. Students tend to hold traditional images of nursing in hospitals, and are unaware of the different specialities or of recent changes in the education and training of nurses.

Staff shortages were predicted at the inception of Project 2000 training for nurses in 1986, which brought supernumerary status and the move to a more academic course at diploma level (Reid 1996). Whilst in 1984, there were 75,000 student and pupil nurses in training (most of these contributing significantly to patient care in their 'apprentice' role), by 1994, the number of trainees had halved, and most of these were no longer counted within the workforce numbers (Buchan 1997). With Project 2000, training of enrolled nurses also ceased, as did opportunities for post registration training of general nurses in psychiatry, which had traditionally accounted for a considerable number of qualified staff in mental health (Ferguson 1992). White (1999) argues that there is a need to improve flexibility of student transfer between branches once they have completed the Common Foundation Programme and gained some experience in the different aspects of nursing. Since opportunities for students to change speciality once qualified are limited, it is important that they follow their preferred speciality from the start. This may also serve to reduce attrition rates.

Retention of nursing staff has also been a cause for concern. Student wastage from mental health nursing courses is high

(Coakley 1997).

In a study of 31 RMN students completing their course in 1984, Nolan (1993) found that about half of them did not intend to remain long term in the field. Murrells & Robinson (1998) carried out a longitudinal study of RMNs who qualified in 1993-4, and found that although the sample showed a positive orientation towards working in psychiatry, 7% planned not to be involved in mental health 6 months post-qualification, and 17% anticipated feeling like this 5 years later. High stress and low pay have been identified as disincentives to entering or continuing in nursing, as has the growth of non-NHS work (Buchan 1997).

A number of factors appear to be influential in the choice of mental health nursing as a career, including demographic factors, personality, interests and values, experience of mental health nursing and quality of teaching.

Murrells & Robinson (1998), from Kings College, in their longitudinal study of RMNs found that, of a sample of 405, 32% were male, and 36% were over the age of 30. Their educational backgrounds were quite diverse, with 28% of them having taken the UKCC entry test and 97% had worked prior to starting their RMN course. Barriball & White (1996) suggest that general nurses have often harboured a longstanding desire to pursue a career in nursing, whereas those working in mental health tend to have made their decision later in life. Experience in the field of mental health either prior to the course or as part of nursing also seems to be critical in influencing people to choose this career. The Careers Team at Kings College, London found that 47% of their sample had experience of working with people with mental health problems, either in a paid or voluntary capacity, prior to making their career choice, whilst 22% of them had personal experience of a mental health difficulty or knew someone who had. 67% expressed an interest in human behaviour (Murrells & Robinson 1998).

Moir & Abraham (1996) interviewed undergraduates pursuing psychiatric nursing about their career choices. Mental health nursing was seen to be more challenging, involving complex skills, scope for creativity, and offers time to talk to patients as opposed to general nursing which they saw as technical, structured and task orientated. Staff in mental health were seen to be afforded more respect and autonomy. Students faced difficulty making the choice, which often had to be justified to family and friends. Psychiatric nursing was seen as lower status, and they felt they had to forego the career opportunities available to general nurses.

Pye & White (1996), in a similar study, also found that more male and mature students as well as those with a previous employment history chose the mental health branch. Placement experience during the Common Foundation Programme (CFP) was crucial, either reinforcing their original decision to do general nursing

or influencing students to change their minds and specialise in mental health. Different learning styles and interests were apparent between the two groups, with the mental health students preferring more discursive and experiential learning whilst general students tended to prefer the biomedical sciences. Again career opportunities were felt by both groups to be better in adult nursing.

Ferguson & Hope (1999) conducted a longitudinal study of degree students who had chosen the mental health branch at the end of the CFP. Experience prior to or during the course was again the major factor in choice of the mental health branch. The work was felt to be more interesting and challenging than general nursing. Students also preferred the more relaxed ward atmosphere in psychiatry, and being allowed more independence. Mental health students were more interested psychology and communication skills, and more of them had Arts A levels than the general nurses. Again, making the choice was difficult, due to giving up long held ambitions, unease about career options afterwards, and some negative responses from friends and family.

Personality factors, attitudes and interests also seem to be different in those students choosing mental health as opposed to general nursing. Mental health students tended to be more radical, liberal and inwardly directed as opposed to practically orientated compared to a similar group of general students (Clarke 1996). He questions whether psychologically minded RMN students would be 'capable or willing' to undergo the broad based CFP of Project 2000 courses. Evidence from Ferguson & Hope (1999) above supports these concerns, since their RMN students felt frustrated by what they felt was irrelevant material to mental health within the core curriculum. Some of these problems have been taken account of in the new Making a Difference curriculum for nurses training, which involves a shorter generic element (DoH 1999b).

Childs (1987) on the basis of observation of 66 interviews for student nurses, suggests that interviewers actually look for different qualities and aptitudes for the different branches. In potential RMNs, they tend to look for someone who could cope with an unstructured, fluid and demanding work environment, use their initiative and work as part of a team. Many of the applicants for mental health were older, had relevant work experience and had experienced some sort of family disruption themselves. For the RGN course, interviewers were looking for people who could cope with stress, responsibility, discipline, who were in good health and had a realistic picture of the work. Childs suggests that these different aptitudes reflect the different nature of the work, and suggests that these need to be made more explicit to applicants.

A small Australian study revealed that a new problem based learning approach to teaching about mental health could have an impact on reducing the fear and stigma associated with this type of work. It also produced a marked increase in students' interest in mental health nursing as a career (Happell 1997, Happell & Rushworth 2000).

There is evidence from the research, of a number of factors which may put people off becoming mental health nurses, relating particularly to stigma and negative connotations associated with work with the mentally ill. Gabbard & Gabbard (1997) comment on the powerful influence of television and newspapers in shaping attitudes to mental health. In recent years, with the move to community care, the media has fuelled alarm about the care of people with mental health problems, with wide coverage when the system is believed to have failed and successes being rarely reported (McBobbie & Thornton 1995). Stacklum (1981) discusses the high levels of anxiety experienced by many students prior to their mental health placement, suggesting that this is in keeping with popular stereotypes of the mentally ill, derived from the media, as 'impulsive, violent and uncooperative'.

Halter (2002), an American author, suggests that in understanding the fall in recruitment to mental health nursing, we must acknowledge the negative perceptions and stigmatisation of mental health nursing by nurses and the public generally. She argues that the public is uninformed about what psychiatric nurses do apart from images such as Nurse Ratched from the book and film of 'One Flew Over the Cuckoo's Nest'. Those who work in the field are often thought to be psychologically flawed themselves.

Walker et al (1998), explored perceptions of 100 members of the public on the role of the psychiatric nurse. 29% did not know or were unclear about what the work involved. Although overall responses were more positive and accurate than expected, there was some evidence that stigma remained, with lingering associations with the biomedical model, institutions and subordination to doctors. Only 3% however, mentioned danger and restraint as issues contrary to media perceptions.

Taylor (1989) points out that the care of the mentally ill has never been a popular choice amongst nurses, arguing that the work is 'intellectually and physically demanding....focussed on the outcasts of society'.

Rushworth & Happell (1998), in an Australian study report that mental health is low on the choice of careers for student nurses, being regarded as, 'boring, depressing, slow paced, unchallenging, unrewarding, uninteresting and too difficult' (p324).

Findings

These views are in sharp contrast to those expressed by nurses choosing to do mental health after a period of work experience. A small study by Ferguson (1997) looking at why a group of undergraduate nurses had chosen not to do mental health revealed a number of factors, including 'always having wanted to do general nursing', more career options, preference for practical work, interest in biology and not enjoying the mental health placement.

A national study in Southern Ireland, used focus groups to explore reasons why school leavers were more likely to opt for a course in social care in preference to psychiatric nursing despite the lower pay, status and poorer career structure of social care professions (Wells et al 2000a & 2000b, Wells & Ryan 2000, Wells & McElwee 2000). School leavers tended to view psychiatric nursing as menial and not 'real nursing', and safety was mentioned by some as an issue. Social care students also regarded nursing as lacking in autonomy, being subordinate to doctors and institutional in nature. Psychiatric nurses shared some of these negative perceptions of their role, feeling 'second class' compared to general nursing students. They discussed negative reactions from family, friends and colleagues at their choice of mental health nursing as a career. Participants felt there was insufficient careers information available on psychiatric nursing and that advertising campaigns focussed on general nursing. All students felt that media coverage of mental health served to discourage people from working in that field. Those who had chosen mental health nursing tended to have prior experience or were pursuing it as their second choice. Social care students also tended to have previous work experience in that field (McElwee 1996).

National Initiatives

Cadet schemes

People who do not hold the minimum NMC entry requirements can apply for a new initiative called the cadet scheme. Run by various NHS trusts in England, this scheme enables people to undertake a training programme of up to two years, successful completion of which results in an NVQ level 3 or an Access qualification. Staff can then be seconded to a nearby university to undertake a nursing diploma course. Further details are available from NHS Careers www.nhscareers.nhs.uk

Secondment schemes

The NHS affords opportunities for all NHS employees to access pre-registration nursing diploma programmes providing they have obtained an NVQ qualification in care up to level 3. Staff can then be seconded by their trust to a local School of Nursing. Seconded employees receive 80%

of their salary from the Workforce Development Confederations with the expectation that the balance of 20% is met by the employer. Employers identify the criteria for selection of employees and how they are supported during their secondment.

Further details are available from NHS Careers www.nhscareers.nhs.uk The RVQ Certificate in Community Mental Health meets the current entry requirements for nursing courses. This is a common method of entry in some areas and some trusts, e.g. in Hertfordshire, prioritise sending support workers on this course prior to them later being seconded to undertake nurse training.

Shortened courses

Higher Education Institutions are increasingly providing a shortened course for graduates with a relevant degree. This offers potential to target those with psychology or social sciences degrees to take up mental health nurse training.

Second registration courses

Some Schools of Nursing are now offering second registration courses for qualified nurses who wish to pursue mental health nursing. These were an important source of recruitment prior to Project 2000 (Ferguson 1992).

Open University courses

The Open University offers a pre-registration programme leading to a Diploma of Higher Education (Mental Health Nursing). Presented in partnership with and supported by WDCs, trusts and independent health care providers, the programme is initially aimed at experienced health workers who meet the NMC's minimum requirements for entry into nurse training. The programme enables students to study and qualify while remaining in work and maintaining family and social commitments. The programme involves a structured educational framework that uses the workplace as the site for student learning. It is only open to staff whose employer is involved in the Open University partnership. The programme can be studied over 3, 4, 5 or 6 years although it is expected that most students will take 4 to 5 years.

Further details are available on www.open.ac.uk

Findings from the interviews

Many of the issues raised by the informants reflected those already discussed in the literature review. Below is a brief summary of the key issues that were raised.

Factors attracting people to mental health nursing

The majority of people who are attracted to mental health nursing express a genuine interest in psychiatry, psychology and working with people who have mental health problems.

Many have personal experience of mental health problems, either themselves or friends and members of their family. A considerable number have worked in mental health settings either in a paid capacity or as volunteers and have enjoyed the experience. Often applicants are mature people who have worked in other jobs and now want to work in a more fulfilling, satisfying and interesting area. Applicants frequently say that they want the opportunity to get to know the clients and to spend time with them.

Is there a recruitment problem in mental health nursing?

Many of the respondents did feel that there was a problem in recruiting people to mental health nursing courses. There are fewer applicants generally. People also expressed concern that unsuitable applicants were being accepted onto courses simply to make up the numbers. Considerable time was being spent on a range of recruitment initiatives that involved regular contact with the local WDCs and the mental health trusts. Many of the national initiatives had limited success in attracting mental health nursing students. For example, some felt that Cadet Schemes had not worked for mental health in terms of attracting sufficient numbers to make a difference.

Factors contributing to the recruitment crisis

Large Schools of Nursing where mental health branch students feel swamped by the big groups undertaking the adult and child branches of the course. A general perception that much of the Common Foundation Programme is geared to the needs of students undertaking more physical health orientated courses. Some Schools are not offering mental health placements to all students on the Common Foundation Programme due to placement areas being unable to accommodate such large numbers of students. This may have a knock on effect on the numbers of students requesting to transfer to the mental health branch of the course. The low bursary is off putting to the group of people who had traditionally applied to do mental health nurse training, e.g. mature applicants, men, people with family and financial commitments. There are a greater range of employment opportunities available and mental health nursing has to compete with these. The role of the mental health nurse is less clear with the closure of the psychiatric hospitals. Many feel that the added attractions of mental health nursing such as camaraderie, teamwork and the social life have been eroded as a result.

Ideas for a comprehensive recruitment strategy

- The level of the bursary needs to be reviewed.
- All Schools need to develop an active recruitment strategy that involves the local trusts and the WDC.
- Any future national recruitment campaign needs to focus on the many opportunities available to mental health nurses.
- There need to be more opportunities for registered nurses to undertake a shortened mental health nurse training without being penalised financially.

Findings from the survey of admissions tutors

Responses were obtained from 25 of the 38 Schools approached (response rate of 66%). Of these, six were unable to provide the data for 2003, and a further four could only produce partial data, hence the statistics relate to just 15 Schools.

Mental Health Courses Surveyed

Within the 25 Schools of Nursing, the following mental health nursing courses were offered:

Courses

Diploma courses	25
Degree courses	19
Undergraduate Masters courses	1
Shortened courses for graduates	8
Second registration courses	7
Shortened programme for ACCESS students	1

Total number of courses	61
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Recruitment data for 2003 entry

15 Schools of Nursing provided data on their success or otherwise in recruiting to mental health nursing courses that year, as well as numbers of students rejected and attrition rates. Many of the 38 Schools originally approached were reluctant to provide the data requested for a variety of reasons. A surprising number did not appear to have an accessible record of the relatively straightforward information required to complete the data collection form. See appendix E for figures.

How well are Schools managing to recruit?

Schools were contracted to provide anything between 40-180 places for mental health students per annum, sometimes in two intakes. Whilst numbers of applicants to mental health nursing courses were generally quite high (2-3 times contracted numbers and 5-10 times in London), there was evidence of problems of recruitment of qualified candidates in many parts of the country, both onto degree and diploma programmes.

Findings

Of the eight degree courses for which figures were available, four reported difficulties in recruitment, and of the 21 diploma programmes, 11 had problems recruiting. The shortfall varied between 2-30 students, with four Schools in the North West and the Midlands having a shortfall of between 25-30 students.

As one mental health lecturer said, 'Recruitment is a tough challenge, and taking considerable time and money now'. Many admission tutors commented how recruitment to mental health was slower and continued throughout the year compared to the other branches of nursing, where there tended to be a large number of applicants at the start of the recruitment cycle. As one said, 'We have problems recruiting to mental health. We do usually manage it, but we don't make the numbers till the end. We select for adult and child branch, but recruit to mental health'. One School terminated the learning disability branch two years ago due to low numbers of applicants, and there were fears that the same thing could happen with mental health, with staff being deployed to other areas of teaching.

There were noticeable differences however, between the London Schools and those outside, with all the four London courses being inundated with applicants, and thus having no problem making up the numbers required to fulfil the contract. Due to the larger number of applicants, these Schools were more able to focus on quality rather than just making up the numbers.

No statistics were available specifically for second registration courses, but Thames Valley University reported on the popularity and high calibre of recruits to such a course run on their Berkshire site. A similar course planned for the London site leading to a registered nurse (mental health) qualification and top up to a degree was advertised in the national nursing press and attracted 150 responses from all over the country within two days, plus one from as far away as Sierra Leone.

There were mixed reports about numbers of students transferring from other branches, with one tutor saying they were generally inundated with requests to change to mental health. Another School reported less transfers now, since they had struggled recently to get mental health placements for students doing the Common Foundation. This meant that students were not getting specific mental health experience, which had often influenced their decisions in the past.

Numbers of Students Rejected

Large numbers of students were rejected at the short-listing stage- between one and two thirds of applicants. Some Schools commented that these were mainly overseas students, who did not fulfil the residency requirement of three years, and so were not eligible for NHS bursaries. A number of Schools could not provide statistics on numbers of applicants.

Few students were rejected at interview in most of the Schools. As one tutor joked, 'If they can walk and talk, we take them'. Rejection rates were higher in London, where the high numbers of applicants made it possible to be more selective. Due to the NMAS system of students having to make four choices of School, a percentage of students did not attend or withdrew before the interview.

Attrition Rates

Attrition rates were mostly low, at less than 10%. Just a few Schools had rates that were higher than this, with one at 33%. Another had had attrition rates of 20%, but felt that their improved selection procedures were having a positive impact on improving the retention of students.

Admission Criteria

For diploma courses, most Schools' admission criteria were not above the minimum level specified by the Nursing & Midwifery Council. As one Admission tutor commented, 'We couldn't afford to go over the minimum requirements- there's too much competition'.

- Diploma courses: For the majority of courses, applicants were required to have five GCSEs or equivalents, including NVQ level 3 in care, AVCE double award (formerly Advanced GNVQ), Edexcel (BTEC) National Certificate/Diploma, Access to Nursing/Higher Education. A minority of courses specified GCSEs in maths, English or a science subject, and that grades should be from A-C. One course required applicants to have seven GCSEs. Two courses required that study should have been in the last five years. A few courses required that applicants did numeric and literacy tests at interview.
- Degree courses: For degree courses, there was more variation in terms of requirements, ranging generally from 160-240 points at A level. For some degree courses a science or a social science A level was specified. One course required only two A levels, whilst others wanted three at grades BCC. One course permitted a range of 160-200 points at A level, but the Admissions tutor said she tended to accept 160 points for mental health due to difficulties recruiting. Some courses accepted equivalent qualifications such as BTEC and NVQ level 3.
- Post-Graduate Diploma in mental health nursing courses: Again there was some variation, with one course specifying a 1st or a 2:1 class degree in a health related discipline, whilst another took students with any 2nd class degree, and another would take students with any relevant degree.
- Shortened 2nd registration courses: Applicants were required to have a Diploma in Nursing and be a registered first level practitioner with the NMC.

In addition to academic criteria, students have to satisfy occupational health requirements, police checks and be eligible for a bursary so have to meet Department of Health residency requirements.

Do Schools actively recruit to mental health?

The majority of Schools said they did actively recruit to their nursing programmes, and a considerable number of them had made specific efforts to recruit to the mental health branch. One admissions tutor commented on their difficulties recruiting to mental health, and being 'aware of the need to do something different for mental health'. A wide variety of strategies were employed to attract potential students. Some Schools worked collaboratively with their local trusts on recruitment. Some were closely involved in partnership work with local Further Education Colleges who ran ACCESS courses or the Certificate in Community Mental Health. Several Schools, especially in London, recruited a large percentage of their students directly from ACCESS courses, offering them conditional places dependent on successful completion of the course, thus by-passing the NMAS system. Several Schools also talked about accepting late applications from NMAS after the deadline in December, and also direct applications beyond June, when NMAS had closed for applications for the coming year, as a way of maximising recruitment to mental health.

Many Schools ran regular advertising campaigns or advertised specifically in response to difficulties recruiting to a course. These included adverts in local newspapers, on local radio and on television as well as poster campaigns. Press releases and flyers were also sent to local libraries, shopping centres, careers offices and job centres.

Most Schools organised Open Days often in collaboration with Trust partners. Events were also organised in schools and FE colleges. Existing students were often asked to help at these events, and amongst other things, provided useful advice on juggling home and family commitments. Some Schools were involved in targeted work with local groups, e.g. black and ethnic minority groups, redundant miners, and youth groups. All the Schools had information about the mental health courses on the University website. A couple of tutors in the London Schools actually felt that a significant number of their students, many of whom came from black and ethnic minority groups, had heard of the course through word of mouth rather than any specific advertising campaign. One course organised a two day summer school for prospective applicants. Several courses reserved a percentage of places (up to 50% on one course) for health care assistants working in mental health who were seconded by their employing Trust.

Criteria for Short-Listing

A number of key areas were mentioned by the majority of respondents:

- Bursaries- applicants were required to be resident in the UK for three years to be eligible for an NHS bursary. This applied to all those on diploma level courses.
- Academic requirements- students must meet the minimum level specified. Some courses required study to be recent.
- Insight or experience of mental health. All Schools wanted to see evidence of some understanding and insight into the field of mental health and the role of the mental health nurse. Only a minority of courses required actual experience of work with people with mental health problems and a few required experience of care work generally or with the public. One School specified a minimum of six months experience in care work, either in a paid or voluntary capacity. Most though just needed to see evidence of some understanding and insight into the field of mental health and the role of the mental health nurse.
- Personal qualities- such as evidence of motivation and commitment, reliability, sickness/absence rates. This information was gleaned from the personal statement or references.

Who short-lists applicants?

Most commonly, applications were screened by a member of administrative staff from the Admissions Department to check eligibility academically and for the bursary, and then they were passed onto the Admissions tutor, the head of mental health or the course leader. This often involved following a checklist. In one School, all rejected applications were also passed onto the admissions tutor. Where there were queries, such as a history of mental health problems these were flagged up for further investigation. In some cases, short-listing was done by the Admissions tutor or by mental health staff themselves.

Who Interviews applicants?

Interviewing was usually done by mental health lecturers and representatives from the Trust (15 Schools), although in some cases this depended on availability. In nine Schools, interviewing was done solely by mental health lecturers. One school involved both mental health and non-mental health staff.

Criteria used for accepting/rejecting potential mental health students at interview

Some schools had developed systematised interview schedules as a way of making the interview process fairer and more transparent, and also to try and reduce attrition rates.

Findings

A minority of courses just asked standard questions of all applicants, whilst others had incorporated specific questions for those choosing the mental health branch. One department sent a person and job specification prior to interview to try and increase the transparency of the interviewing process. For one course, applicants were also advised to read nursing journals and were asked questions about topical issues.

As already mentioned, three courses required students to complete tests in literacy and numeracy. Another four ran a group discussion session on which applicants' performance was measured. At least two courses used vignettes as a way of measuring student's awareness of mental health issues. Personal qualities were looked for such as 'self awareness', 'values', 'motivation', 'suitability for the profession'. Evidence of some insight, knowledge and awareness of the field of mental health and the role of the mental health nurse were considered to be very important by all Schools surveyed, as was a commitment to the branch. Students were expected to demonstrate a realistic appraisal of the demands of the course, and one tutor mentioned the importance of critical thinking and an enquiring mind. Applicants had to demonstrate good interpersonal skills at interview and in group discussions.

Why are applicants rejected?

In most Schools, very few applicants are rejected at interview. In London schools, due to the higher number of applicants the numbers rejected were higher. Not all those who were short listed take up the offer of interview, as they may accept places elsewhere.

Reasons for rejection include:

- Lack of awareness of mental health issues, a naivety about the role or inappropriate values, such as being judgmental towards the client group, 'bizarre' or unusual ideas about mental health.
- Poor communication skills or inability to work in a group.
- Failure of literacy or numeracy tests.
- Poor written or spoken English
- Failure to appreciate the demands of the course.
- No recent study.
- Mental illness in the last two years (a history of mental health problems was not in itself seen as a reason for rejection). Two tutors mentioned wariness about applicants who may be seeking 'therapy for themselves'.
- Failure at medical examination.
- Criminal record.
- Falsification of educational qualifications.
- Poor motivation or commitment to the work.
- Lack of substantiation of experience.

What happens to rejected applicants?

Most Schools kept a record of reasons for rejection. In the majority of cases, applicants who were rejected at interview were not automatically offered feedback. However, either oral or written feedback was generally offered to unsuccessful applicants, as was advice on action they could take to increase their chances of success should they reapply, e.g. gaining mental health experience, doing an English as a Foreign Language course (EFL). Two tutors had in the past helped applicants arrange appropriate experience within local Trusts. One tutor said that if students were rejected due to having current mental health problems themselves, that she gave them personal feedback on the day.

Efforts to attract marginalised groups

Some Schools did not make a particular effort to recruit from marginalised groups, but just talked about anti-discriminatory practices. Most students on mental health branches were mature students. For example, the York course had an average age of 27 years. At Thames Valley University, students were reported to be mainly in the over 35 age group, with dependent children. Two Schools ran part time courses, and another was planning a longer course with breaks for the school holidays.

In terms of recruitment from minority ethnic groups, there were variations depending on the locality of the School. Some of the Schools in more rural areas commented that there were low levels of people from minority ethnic groups within their locality, hence their low recruitment from these groups. In the four London courses surveyed however, the majority of students were from minority ethnic groups, with numbers of students born outside Britain being as high as 80-90%, most of them being of African descent, e.g. Zimbabwean, Nigerian. Two of these London Schools in fact reported concerns by their local Workforce Development Confederation and trusts that the profile of the mental health students did not reflect that of the local population, due to low recruitment of people of Asian and Afro-Caribbean origin and white British local people. These Schools had been advised to make efforts to address this issue.

Some specific efforts had been made to try and target particular groups for recruitment, e.g. advertising on the local radio station for people from minority ethnic groups and an Admissions Tutor who was working with an Asian women's group to try and increase access to nursing. Efforts were also being made to attract local people, people with mental health problems, people who are hard of hearing and people with disabilities.

Do the Schools accept overseas students?

All the Schools said that they did not take overseas students due to restrictions in terms of the bursary. The London schools had high numbers of students who were born overseas, but they all fulfilled the three year residency criteria.

Examples of good practice

A number of examples of good practice in the recruitment and selection of students to mental health nursing were suggested: These included:

- Secondment schemes for health care assistants
- Development of more structured interview schedules as a means of reducing attrition and also increasing the quality of students. Greater transparency in interviewing, e.g. providing applicants with person/job specification.
- Students offered rapid individual feedback after interview, and help gaining appropriate experience.
- Personalisation of the interview process, e.g. telephone calls to applicants, a named contact for mental health admissions.
- Close work with local colleges, in terms of designing interviews and organising promotional events.
- Specific work to attract marginalised groups.
- Joint work with Trusts in the interviewing process.
- Use of existing students in the recruitment process.
- Close working between the Admissions Department and lecturing staff.

Some specific examples of good practice have been selected from the schools contacted, who demonstrate a number of key features of good practice which may enhance recruitment of mental health students.

Faculty of Health and Social Care Services- Joint Faculty-Kingston University and St. George's Hospital Medical School

Kingston University has no problems recruiting to the mental health branch. Like some of the other London Schools, the number of applications was five times the number of contracted places in 2003. Open Days are organised at the University with existing mental health students present to provide advice. The University has close links with the South West London & St Georges Mental Health Trust and takes between 18-25 health care assistants per annum as seconded students.

The Faculty also works closely with Further Education Colleges running the Certificate in Community Mental Health. Special pathway events are organised at local Colleges by the Admissions Manager together with representatives from the different branches and the Trust, aimed at encouraging students onto the mental health

and learning disability branches. A significant percentage of applicants apply directly from these Further Education Colleges, and a large number of students are recruited via this route. Progressions agreements in place guarantee applicants from local Further Education Colleges an interview.

Most of the students come from traditionally marginalized groups. The majority are mature students with dependent children, and around 80% of the mental health branch is from black and ethnic minority groups. The South West London & St Georges Mental Health Trust also has a support network which encourages people with mental health problems to apply for nursing programmes. There are already a number of students studying nursing who have hearing impairments, and the trust is currently in the process of establishing a group encouraging and supporting deaf and hearing impaired students onto the mental health programme.

Prospective students are invited to a welcome event at the University with live entertainment. Interviews are carried out jointly by lecturers and trust staff. Following interview, rejected candidates are offered feedback. The requirement that candidates should have recent experience of studying means that they are better prepared for the programme. Study skills workshops are offered pre-entry to all nursing students offered a place, which also helps them to prepare for their course. Borderline students may be advised to attend this at interview. All students doing the mental health branch are guaranteed a post within the Trust on completion.

University of West of England, Bristol

The University of West of England ran two mental health nursing courses in 2003, one being slightly under-subscribed, and the other slightly over. The strengths of the admission process lie in the good links with the local mental health trust, the personal attention given to applicants and development of a more structured approach to interviewing. 12 health care assistants are seconded from the Trust each year. Careers events are held in local schools. Six open days are organised each year, which are advertised locally, at which existing students are present. Admissions for mental health are coordinated by a designated tutor from mental health, who is involved in short-listing and interviewing of candidates, together with a trust representative.

In an effort to standardise the interview process, the School has recently adopted a more structured interview schedule, the QINETIC system, which is widely used in the Armed forces. Candidates are scored on a number of criteria- ability to work with others, adaptability, drive, organisational skills, resilience and communication skills. Interviewers have to record their reasons for rejecting candidates. Feedback is given personally or by phone.

Findings

Those students lacking insight into mental health work may be encouraged to undertake a short placement/visit to a mental health unit or to work on the nursing bank. Using her links with the trust, the Admissions tutor can facilitate this. Where applicants have no recent study experience, they are encouraged to send in an essay, which is marked and feedback given. A study skills pack is also sent. The admissions tutor acts as a named contact for any queries relating to mental health.

Department of Health Sciences, University of York

York University was only slightly under the target contract numbers in 2003. They are involved in a number of initiatives to increase recruitment to mental health. These include regular Nurse Education Information Afternoons, which include specific mental health presentations. Regular press releases and flyers are sent to career centres, job centres, libraries and placement areas. Recent specific mental health nursing marketing has included:

- advertising in the Big Issue in the North
- development of a mental health brochure highlighting personal case studies and Trust links
- a new mental health nursing postcard campaign which is distributed to cinemas, libraries, cafes and placement areas
- the University has featured in a TV community service announcement and a job finder TV programme
- the School liaises with advisers supporting redundant miners
- visits to local youth groups
- Adverts for new recruits have been put out on local radio.

Current students take part in Information Afternoons, and offer advice to applicants, such as coping with combining course and family commitments. Interview panels consist of a mental health lecturer together with a mental health service representative. The selection process is organised in partnership with the local Trust. There are clearly stated selection criteria at short listing and interview stage. The interview consists of a group discussion, a written exercise, numeracy tests and an individual interview. A person specification is used and completed, which covers the following areas: experience, knowledge, skills for nursing, skills for academic work, personal characteristics. Where rejected applicants request feedback after short listing, the admissions manager will speak to the candidate, or following interview, this is done by the Admissions tutor. Candidates are given reasons for rejection, and advised of any action they can take prior to reapplication.

The University set up a Cultural Diversity Progress Group four years ago, which has developed a marketing strategy to encourage greater diversity in the intake, which has traditionally been white. This has involved a lot of targeted marketing activities, e.g. role models, talks to black and Asian groups. In addition, the Admission team works closely to link academic and administrative processes.

Thames Valley University

Like Kingston, Thames Valley University has close links with local ACCESS courses, and takes a large number of direct applicants onto the mental health nursing courses, most of who are from black and ethnic minority backgrounds, in particular from Africa. Some phenomenological research has been undertaken at Thames Valley University to explore the particular issues facing Nigerian students from the 2002 mental health nursing intake. African students form the largest single group of students on the 2002 course. In this cohort, there are no students under 25 years. The majority are women aged 35-50 years. They tend to live in South East London, so have to travel a considerable distance to get to University. Many are struggling to meet the demands of the programme, since the majority are single parents and many have complexities in their personal lives. Most of them were recruited from ACCESS courses, and have heard about the course by word of mouth. The course can be challenging in that it forces them to reconsider traditional beliefs and attitudes to mental illness in Africa, which may be very different to models of care in Britain. Many of the students experience racism whilst on placement. Thames Valley University has put a number of strategies in place to try and address some of the particular difficulties these students are facing, such as the provision of more on-line learning to prevent unnecessary trips into the University (Meyler 2004-personal communication).

Trent Workforce Development Confederation with Derby and Nottingham Universities

Trent WDC has set up a recruitment group specifically to address the problems of attracting sufficient numbers of students to train as mental health nurses in the region. The group consists of representatives from the WDC, from Nottingham and Derby universities, and from the three local mental health trusts. The group is looking at ways of raising the profile of mental health nursing in the local catchment area and aims to work on a number of levels. For example, to increase the numbers of inquiries and applications to courses, to change the perceptions of future applicants about mental health nursing and also those who could be viewed as 'influencers' such as family, friends, teachers and tutors.

The group is also increasingly realising that ‘managing’ candidates throughout the admissions process is just as important as the effort put into attracting them in the first place. With the high cost of attraction, efforts are being made to maximise conversion rates and to ensure that the whole experience feels seamless and that the information that supports the process is meaningful and continues to sell the values of the course being offered.

A range of specific activities are being carried out to generate potential students.

These include:

- Targeting colleges and schools. Establishing links with relevant course tutors, sending out posters and information leaflets, providing email contact addresses, keeping in touch with potential applicants via a series of email updates.
- Targeting a local, mature audience with relevant experience. Advertising through the local press and radio.
- Using a local consultancy agency to ensure that the campaign looks professional and to advise on the format and approach to advertising.

Northern Birmingham Mental Health Trust

Northern Birmingham Mental Health Trust has launched a major campaign to recruit Asian people into mental health nursing, as part of their ongoing work to reduce the stigma associated with mental health issues within Asian communities. The recruitment campaign includes a photography show, a briefing pack, and a 15 minute video featuring contributions from Asian nurses already working in mental health services and leaders of Birmingham’s Asian Communities (reported in *Nursing Times*, 2000, 98, 29, 8), (www.mhmedia.com/products/health/html).

Summary of findings

There are problems of recruiting onto mental health nursing courses at both diploma and undergraduate level. These problems are worse in some parts of England than others. It is not simply a question of attracting sufficient numbers of students however, as there are some concerns regarding the calibre and suitability of some students that are currently being accepted onto courses. It is difficult to get accurate data on the numbers of applicants and accepted applicants due to the range of routes into training and the absence of any centralised database. Whilst the practice of Schools taking direct applicants helps numbers, it is a problem for national workforce planning. Although large numbers of applicants are rejected at the short listing stage, the majority are overseas students who do not fulfil the residency requirements of three years and are therefore not eligible for an NHS bursary.

In most Schools, applicants are interviewed by mental health lecturers and few are rejected at this stage.

Although the information obtained from the survey was incomplete, a pattern can be seen regarding the recruitment of mental health student nurses. The Schools of Nursing in London and the South of England are generally recruiting to their commissioned numbers with one exception. The majority of the courses are oversubscribed. In the Midlands, one School in particular is experiencing difficulties recruiting to the mental health branch of their diploma and undergraduate courses despite large numbers of applicants. The picture in the North is less positive with seven out of the eight Schools surveyed experiencing a shortfall of mental health nurse students. The shortfall was 25 students and above in three Schools. It is noteworthy that this pattern does not reflect the pattern of qualified mental health nurse vacancies in England.

There are a range of national and local initiatives focusing on recruitment onto mental health nursing courses. Information gained from both the literature review, interviews and survey provides a wealth of ideas that can be translated into pertinent and focused future recruitment strategies.

Findings: 5. Social Work

SOCIAL WORK

Education and Training

Until 2003 there were four different routes into social work (TOPSSE 2003):

1. Non-graduate college based route leading to a Diploma in Social Work (DipSW) for applicants without formal qualifications. Applications processed through the Social Work Admissions Service (SWAS). (40.2% of awards in 2001-2).
2. Employment based route (part-time) leading to the DipSW. Applications via employers direct to colleges. (20.1% of awards in 2001-2).
3. Post-graduate college based route for applicants with a degree or equivalent. Applications processed through SWAS. (23.1% of awards in 2001-2).
4. Undergraduate college based route (degree course). Applications processed through the Universities and Colleges Admissions Service (UCAS). (16.6% of awards in 2001-2).

From 2003-4, the two year undergraduate Diploma level courses were replaced by three year degree programmes which are recruited to through UCAS (TOPSSE 2000). The post-graduate diploma route remains available via SWAS. Undergraduate programmes are normally of three years duration, and some Universities offer part time and open/distance learning courses. Employment based routes are also available at many institutions, in partnership with local employers. From 2003-4, bursaries are available for all social work trainees, except those sponsored by their employers. Post graduate bursaries are means tested.

The social work programme is a generic one. Students are expected to meet a set of competencies as defined in the National Occupational Standards for Social Work in order to qualify. New standards are being devised to coincide with the rolling out of the new degree programmes and will replace those in use since 1994 for the DipSW (www.topssengland.org.uk). Although the guidance stipulates that there has to be teaching on human growth, development, mental health and disability, the content of the course is left to the discretion of Higher Education Institutions. There is no requirement that the mental health input should be in the form of a specific module and there is also no professional or regulatory requirement to undertake a mental health practice placement, although students may choose to do so. On completion of their course, newly qualified social workers may go on to work in mental health settings.

Practice learning is at the heart of the new social work degree. Students are required to do a minimum of 200 days in work settings over 2-4 separate periods,

depending on course design. The Practice Learning Taskforce, which is hosted by the Training Organisation for Personal Social Services in England (TOPSSE), was launched by the Department of Health in 2003 to help meet the increased demand for high quality practice learning opportunities created by the new three year social work degree. The Practice Learning Taskforce will be working nationally to develop placement experiences until March 2005.

There are opportunities for social work graduates to consolidate their learning or to specialise in particular areas after qualification, which are organised within the post-qualifying framework for social work.

There are a number of awards available:

PQ awards level 1 and 2 (PQSW)

Advanced Award in Social Work (AASW)

Practice Teachers Programme (PTP)

Child Care Award (PQCC)

Approved Social Work (ASW)

Social workers working with clients with mental health problems may be encouraged or required by their employers to do the Approved Social Work (ASW) qualification. The ASW qualification entitles social workers to undertake statutory responsibilities required under the Mental Health Act. ASW education and training programmes normally include 200 days dedicated mental health learning in practice settings, with a minimum practice requirement to work with two different service user groups. Subject areas covered largely focus on legal, ethical and professional issues and examine the major mental health disorders from a critical perspective. Since 2001, students must have the PQ level 1 qualification in order to be eligible for the ASW course (TOPSSE 2003).

ASW courses are managed by a consortium of Higher Education Institutions, which provide registration, mentoring, support, assessment and accreditation. There are 17 PQ consortia in England. According to the Secretary of State's Directions on Approval, as specified in 1986, social workers can only become approved after completing a form of training approved by the General Social Care Council (GSCC) (formerly CCETSW) (DoH 1986). Social workers are sponsored onto the ASW course by the local authority they work for. After completion of this approved course, the social worker is then eligible for approval by the Local Authority. Under the Mental Health Act of 1983, local authorities are required to appoint sufficient numbers of ASWs in their area to meet the service need (however, there is no definition of what 'sufficient' is). Although there is an element of choice in doing the ASW course, numbers of ASWs are ultimately determined by local authority need. Most people working in adult mental health however, would be expected to do the ASW qualification when they were eligible.

Facts and Figures

Sources of Data

It is difficult to obtain precise information on whether there is a shortfall of social workers in mental health. Until recently there have been few robust sources of information on the social work/care workforce, as there was no national register of those in training or in employment. Since April 2003, the General Social Care Council (GSCC) has begun gathering information for the development of a social work and social care register. This is likely to be quite a protracted process due to the large numbers of staff employed in social work and social care in England (Ward 2003).

The Finding & Keeping report describes the data on recruitment to social work as 'highly fragmented' and 'unsatisfactory' (SCMH 2000). Up until now there has also been no central place for collecting numbers of all the students applying for, entering and completing social work courses. The GSCC produces an annual data-pack which provides information on students entering diploma courses via the Social Work Admissions Service (SWAS), but these only make up about 50% of total applications. The Higher Education Funding Council in England (HEFCE) does collect data on numbers of students registered on recognised courses in publicly funded Higher Education Institutions. However, information on social work and social care courses is grouped under the cost centre for health and community studies, so exact details on these particular students cannot be extracted. GSCC also has figures on numbers who have applied for and completed post-qualifying awards, including the ASW qualification (GSCC 2003). As yet, there are no data available on numbers of students registering for the new degree courses in social work yet, although preliminary figures suggest a strong uptake of applications and course enrolments by November 2003 (www.gsc.org.uk/news_story.asp?newsID=87). It is anticipated that GSCC will keep figures on numbers of students applying for and graduating from these courses.

The lack of a co-ordinated system of data collection so far means that at present there are no accurate figures available on total numbers of students who have completed a social work qualification in the last few years. Furthermore, there are no accurate figures available on numbers of staff who are currently employed as social workers/social care staff. Although GSCC holds retrospective figures on how many people have registered for or been awarded the ASW qualification, there are no national figures available on numbers of ASWs in post or of numbers of social workers in mental health settings who do not hold the ASW qualification. This is complicated by the fact that not all those holding the ASW qualification are actually

involved in direct work with clients with mental health problems in their current post.

The development of the GSCC register for the social care workforce therefore represents a significant step forward in workforce planning for social work. The task of compiling the register though is huge, with an estimated 1 million people working in this field, approximately 70-80,000 of whom are qualified social workers. Difficulties of data collection are exacerbated by the fact that social care staff work in such a diverse range of settings. It is estimated that of the million or so workers in social care, 64% work in local authorities, 14% in the independent sector, 13% in other settings, including statutory sector partnerships, 3% as agency staff and less than 1% in the NHS (TOPSSE 2003). Increasingly mental health social workers are transferring employment to the NHS or are seconded to joint NHS/local authority services. Under current legislation, ASWs must remain employed by the local authority, although they may work for integrated Trusts or be seconded into the health service.

TOPSSE is also currently developing a database on the state of the social care workforce in England. Its Workforce Intelligence Unit has recently produced the first annual report (TOPSSE 2003). This contains useful information on the characteristics of staff and on progress in delivery of Modernising the Social Care Workforce (DoH 2000b), although there is little specific information within it on the mental health workforce.

Recruitment to Social Work

Although exact numbers of staff working in social work are not available, there is evidence in social work, as in other public sector professions, of problems of recruitment. Eborall & Garmeson (2001a) suggest vacancy rates for social work posts are running at between 5-16% and turnover at between 7-30%, with the biggest problems in London and the South East. Concern has also been expressed about the steady fall in numbers applying for and entering DipSW courses since 1993 (TOPSSE 1999). For students applying via SWAS, numbers fell from 6254 applicants (2649 successful) in 1998 to 4703 (2315 successful) in 2001. These figures however, do not represent the full picture since DipSW students via SWAS only represented a proportion of total social work students.

In response to concerns about recruitment, the Government has launched a three year initiative to encourage an extra 5000 people to take up careers in social work and social care. Following the campaign, there has been an increase in numbers of students registering for the DipSW qualification with 4771 registering in 2002-3 compared to 4005 in 2000-2001.

Findings

A considerable number of these are seconded by their workplace to do the course (www.doh.gov.uk/pressDec2001.htm). In 2002-3, 2284 Local Authority staff were registered for social work trainee/secondments schemes, and a further 2795 students are planned for this year (TOPSSE 2003).

Recruitment of ASWs

Registrations and awards for ASW have fluctuated over the years from 1998 to 2003. Numbers of applicants for ASW training are smaller than for any other PQ award and a higher number of men apply. See box below:

Registrations for Awards for ASWs in England (GSCC 2003)

Registrations	April -	April -	April -	Sept -	Sept -
	March	March	March	Aug	Aug
	1999-	2000-	2001-	2001-	2002-
	2000	2001	2002	2002	2003
	150	479	424	375	241
Awards	150	246	281	326	209

The Quality Assurance Review by the GSCC reports that there are clear links between candidate selection to programmes and workforce planning, since students are recruited according to local authority need (GSCC 2002). However, recent research in London and a study conducted by the Northern Centre for Mental Health (NCMH) covering Cumbria, the North East, Yorkshire and Humberside reveals shortages of social workers in specialist mental health settings and also of ASWs, although the problem is patchy (Huxley et al 2003, Williams 2002). Huxley et al (2003) report vacancy rates of between 7-18% for mental health social workers (MHSWs) and between 14%-25% for ASWs in London. 25% of managers reported problems recruiting MHSWs, and 72% in recruiting ASWs. Retention problems were also reported for MHSWs by 7% of managers and for ASWs by 26%. There are significant variations between authorities in the numbers of ASWs per 100,000 population in the north of England, but two thirds of local authorities report problems training sufficient numbers of ASWs and concerns about an ageing workforce (Williams 2002). Unpublished research by Gilbert et al (2003) in South Yorkshire reveals similar findings.

There is particular concern around whether there are enough ASWs both to meet current and future demands

in terms of statutory responsibilities, with the new Mental Health Act on the horizon. Under the new Act, the ASW qualification will be replaced with the new Approved Mental Health Practitioner role (AMHP). Existing ASWs will be required to undergo a period of retraining to take on the new responsibilities that come with the new Act and the way will be opened up for other suitably qualified mental health practitioners to also train as AMHPs. As already stated, accurate figures on numbers of ASWs currently in post are not known. TOPSSE (2003) however, has quoted an estimated figure of 4700 ASWs nationally, but the British Association of Social Work (BASW) (BASW 2003a) dispute this, suggesting it is likely to be an over-estimate due to some staff being part time and also because not all ASWs are working in posts where they use their qualification.

Roger Hargreaves, Chair of the Mental Health Special Interest Group of BASW, discusses the workforce implications of the new Mental Health Act Bill, suggesting that the increased workload will require an estimated 7700 AMHPs to fulfil the statutory requirements. Assuming that there will be a process of natural wastage due to retirement and ASWs who choose not to retrain for the new AMHP role, he suggests that this may require a further 5000 new recruits. Due to the requirement that social workers should hold the PQ level 1 qualification prior to doing the specialist course, a significant number of the new AMHPs may have to be drawn from other professions. There will be extra demands on existing ASWs too, as due to their relevant experience, they are likely to play a major role in training of new staff, which will require cover to be organised (BASW 2002, 2003b). In recognition of these issues, a workshop was held in April 2004 with social work practitioners, academics, employers, and representatives from BASW and the Social Care Institute for Excellence (SCIE), facilitated by NIMHE and the Changing Workforce Programme. Following on from this, a Discussion Document on the role of the social worker in modern mental health services is being drafted which will be circulated nationally for comment and feedback over the summer of 2004.

A target of 300 ASW awards per annum has been suggested by GSCC to cope with natural wastage. However, work pressures and difficulty getting cover for staff on courses presents problems for students in terms of completing awards. There is also an impact on the workload of existing staff acting as mentors (GSCC 2002). In addition, potential ASWs may decide to specialise instead in childcare. A target number of 7000 social workers to complete the Child Care PQ award has been set for 2006-7, and ring fenced funding is available through the Training Support Programme (GSCC 2002).

A shortage of placements and practice teachers may also impact negatively on recruitment of social workers into mental health. Only a small number of students are placed in health care settings for placements (4.4% for the long placement and 2.5% for the short placement), with the majority being placed in local authorities (56% for the long placement and 41.2% for the short placement). As mental health settings are increasingly managed by health services, this may have a negative impact on future recruitment. Whilst 7300 social workers nationally hold the Practice Teachers award, only a small percentage of them actually take students on placement due to lack of workload relief and the low status accorded to practice learning in social work (GSCC 2002). In conclusion, there is some evidence of both recruitment and retention problems amongst mental health social workers and ASWs, although the problem is worse in some areas. Precise figures on numbers of social workers in mental health services or of practising ASWs are not available at the moment. The GSCC register should help provide useful information on the workforce, but will take some time to complete.

Issues identified in the literature

There is evidence from work by Eborall & Garmeson (2001b) that social work and social care are not perceived by the public as desirable career options. Social work particularly has a poor reputation in the media, and is seen as largely to do with childcare issues. A study of coverage of social work in the media by Franklin (1998) found that 67.7% of all the articles on social workers are connected with childcare issues, whereas mental health only accounts for 3.3% of the total. There is a lack of knowledge amongst most members of the general public about what social workers do, since compared to other professional groups, such as teachers and nurses, only a minority of the population will come across social workers in their lives. Pay is also highlighted as an issue, with full time pay for social workers being at the bottom of the range for all professional occupations. Social care is seen as 'worthy work', but something to be done by middle aged women not young school leavers (Eborall & Garmeson 2001b).

The Working Well report by Mentality (DoH 2003a) suggests that public attitudes to social work are not separable from problems of recruitment and retention. Applications to social work are falling, less than 5% of social workers are younger than 25 years old and a high percentage are in their 50s, especially in London and the South East. The profession is not valued, the press are critical and fears of violence provide few incentives to become a social worker. Pay is low and there is increasingly an emphasis on control and gate-keeping as opposed to therapeutic work. These issues have

particular relevance within mental health settings.

It has been suggested that changes to student funding arrangements in Higher Education Institutions and the shift to fee payment and student loans, have also contributed to the fall in the number of applicants to social work. This is a particular problem since traditionally the majority of applicants have been mature students. In addition, the poor image of social work, competition from other courses, lack of clarity regarding career structure and a lack of flexibility in relation to credit for existing qualifications are all cited as possible reasons (TOPSSE 1999).

This is a time of great flux within the social work profession generally, but those working in mental health care have experienced particularly uncertain and challenging times, with a raft of reforms to modernise health and social care over the past few years. As Williams (2004) points out, mental health social workers are suffering from 'constant re-configuration of services' and 'disintegrating infra-structures'. Whilst the dissolving of old barriers between health and social care and more collaborative working has been long awaited, the transfer of staff from local authorities to the NHS or integrated trusts has aroused concerns about professional values and identity. Social workers are in a significant minority in these new integrated teams, and may feel professionally isolated. In September 2002, there were only 119 qualified social workers in the NHS compared to 346,537 qualified nursing and midwifery staff (TOPSSE 2003), although numbers are increasing. Fears have been voiced that social workers and ASWs may not be understood or valued in these new integrated teams, and that this is particularly likely where the manager is not from a social services background. 'The movement of social work and social care staff into Mental Health Trusts may encourage a re-emergence of the medical model of care and a neglect of the social elements, which make up a predominant proportion of the concerns of those who use the service' (Gilbert 2003). All of this change may impact negatively on recruitment of newly qualified social workers into the field of mental health.

There is evidence too that morale amongst social workers in mental health is low. A survey by Onyett et al (1995) of people working in Community Mental Health Teams found more than half the staff members to be 'emotionally exhausted'. Social workers had the lowest level of job satisfaction compared to any other discipline and the lowest sense of accomplishment. Lack of clarity about their role in relation to other team members was a problem. Whilst positive aspects of the job were identified, including working in a multi-disciplinary team and therapeutic work with clients, low morale of existing staff is likely to be off-putting to potential recruits.

Findings

Williams' (2002) survey of ASW services in 28 Social Services Areas in the north of England, revealed problems in the recruitment and retention of mental health social workers. Two thirds of local authorities reported having insufficient ASWs to meet their need, although significant variations in numbers of ASWs per 100,000 population were identified between different regions. The main reason for the shortfall was lack of suitable candidates. The total ASW workforce for the 28 authorities surveyed was only 700. On average 14% of them were part time (as many as 46% in some areas). 30% of ASWs were over 50 years (in some areas as many as 56%), and there was evidence that the workforce tended not to reflect the composition of the populations they served. The average length of service of ASWs was 11 years, with 6 years as practising ASWs, indicating a relatively stable workforce. Williams suggests however that the age profile of ASWs has worrying implications for the future, as does the continued dependence on non-mental health professionals to maintain the service. Problems of recruitment and retention were related, amongst other things, to uncertainty about the impact of the proposed reform of the Mental Health Act, and the integration of health and social care. In terms of retention, during the previous year, approximately 12% of the ASW workforce had moved on, and one third of these had left mental health altogether. Strategies to address recruitment and retention had met with limited success, but additional measures were under consideration in a number of authorities. Several of them had made improvements to pay and conditions. Issues are raised though about the need for a collective approach by authorities to pay, to prevent poaching of staff from authority to another, and also about parity with other mental health professionals.

There was evidence of difficulty recruiting sufficient candidates to ASW training, and concerns were raised that if numbers leaving continued at the same rate, the numbers of ASWs would be even less in the next two years. Nearly two thirds of authorities reported difficulties in providing cover for staff doing ASW training. Satisfaction with training courses was high however.

Of concern in terms of recruiting more ASWs is the fact that few DipSW students did placements with ASWs, although there was considerable variation between authorities. Williams suggests that addressing this issue could be an important step in increasing numbers of social work students considering mental health as a career option. He argues too that recruitment of ASWs should not just be seen as a social services issue, but that a number of key stakeholders including training providers and Mental Health National Service Framework Local Implementation Teams need to be involved in addressing these issues (Williams 2002).

The study of ASWs in London by Huxley et al (2003) also found evidence of an ageing workforce, with 42% of the sample being over 50, and only 8% under 30. ASWs complained of work overload and had poor morale. 63% of staff reported that they were doing additional work to cover for absent colleagues. Pressure of work and vacancies meant they were unable to take time back. Their General Health Questionnaire (GHQ) scores were high (60% of ASWs and 45% of mental health social workers scored above the threshold). 43% of the sample felt under-valued and 70% that their current grade did not reflect the work that they did. Only 17% felt positive about the place of social work in modern mental health services, and 28% had a strong desire to leave the profession. ASWs were more dissatisfied than MHSWs generally with their job, due to the stress associated with the statutory work. Social workers wanted parity with their health colleagues in terms of opportunities for training and research. Again, these findings may have important implications for recruitment of social workers into this field.

The BASW Mental Health Special Interest Group (2002) sets out the particular difficulties facing ASWs at present, and argues that the new Mental Health Act will only exacerbate these problems, with a deleterious effect on recruitment. The past 10 years have seen a 64% increase in the number of mental health assessments, whilst numbers of ASWs have remained static or fallen. Assessments have become more protracted and stressful, carrying an increased risk of violence and legal exposure. With closure of wards and under-resourcing of acute services, ASWs are often caught between finding themselves under pressure to respond to the needs of carers/other agencies, but there being no beds available. In addition, there are concerns about the impact of the proposed new Mental Health Act on the future role of mental health social workers and on recruitment of ASWs (BASW 2003b, Williams 2002).

A study conducted in the north of England by Blinkhorn (2004) looked at how mental health social workers were adapting to the modernisation of health and social care, at a time of 'unprecedented change for the profession'. The study revealed that social workers in mental health suffered from an inadequately developed professional identity and also had difficulty articulating their distinctive professional role to others. Interviewees felt strongly that they did have a unique role in mental health care, and stressed the importance of maintaining this socially driven perspective in the NHS, although there were concerns that it may become lost in the process. Although there was an appreciation of the need for integration, some staff felt 'hived off' by the local authorities, without proper consideration.

Professional isolation within Community Mental Health Teams and a lack of proportional representation for social care management in the proposed structures were problematic. The lack of career structure for social workers in mental health was also identified as an issue, and there were concerns about leadership and direction within the new integrated teams. The extension of the AMHP role to other disciplines under the new Mental Health Act was seen to represent both a threat, in terms of loss of a role specific to social work, but also a possible opportunity for developing more therapeutic roles.

During the 2000 inspection, the Social Services Inspectorate (2002) found that staff were generally positive about the new partnerships with health, and the inspectors were impressed by their enthusiasm for dismantling what has been like a 'Berlin wall' between the sectors. However, their report echoes this uncertainty over the new structures and anxiety about the potential domination by health. These may be particularly pertinent issues for newly qualified social workers who may prefer the support of a larger professional team.

BASW (2002) suggests that there is current dissatisfaction amongst ASWs due to too much focus on the care management and legal aspects of their role. This leaves them with insufficient time for direct contact with clients and use of therapeutic skills which used to be part of the role of the mental health social worker, such as family therapy and running groups. Gilbert (2003) discusses too how in recent years, a number of aspects of the ASW role have been taken over by other professionals, e.g. counselling, befriending, and argues that the therapeutic role of social workers has given way to a predominantly statutory one.

National Initiatives

Social Work Recruitment Drive

In October 2001, the government launched a three year initiative to encourage more people to enter social work and to improve its public image. This followed on from the work by Eborall & Garneson (2001b) on public attitudes to social work and social care, which revealed a poor public image, reinforced by bad press. £1.5 million has been allocated for a series of newspaper and radio adverts (DoH press release 2001/0486). The aim of the advertising is to promote the positive work done by social workers and to highlight the variety of situations they work in. Case material used as part of the campaign includes mental health issues. In addition, an information line has been set up, and also a website at www.socialworkcareers.co.uk. In 2003, there were 14,000 calls to the information line and 11,000 people visited the website. The target is to increase the number

of applicants to social work by 5000 over the three year period. The Government is also working with local authorities to increase recruitment and retention, and is encouraging them to run their own targeted awareness campaigns.

The Practice Learning Taskforce

The Practice Learning Taskforce (PLT) has been set up to increase the number and diversity of placements and practice teachers available to support the new degree in social work. Although it does not have a specific mental health brief, since placement experience appears to be so critical to students' decisions to enter mental health work, increasing placement opportunities is central to increasing recruitment into the field. The work of the PLT Change Agents has involved developing regional maps of placements available, and also targeted efforts to increase placement opportunities available within a range of settings. There are efforts too to involve more social workers in practice teaching. The setting up of 'banks' of 'off site' practice teachers will be particularly important in the health and voluntary sector, where social work practice teachers may not be available to supervise students.

The Practice Learning Taskforce in Yorkshire & Humberside is aiming to increase the number of practice learning days available by 104% by 2006-7. They are especially keen to find placements in health, in the voluntary and independent sector and in multi-agency and inter-professional teams. They also hope to increase practice assessors by 50%. Strategic work is also being done to increase managers' understanding of the social work role and training, which will also be important as mental health social work moves into health care settings (Crawford & Balman 2004).

The Social Perspective Network (SPN)

This is a recently formed group of users, professionals and other interested parties who have come together to promote a social perspective within mental health.

The network is independent of any service agency or professional body, but has just entered into a formal arrangement with NIMHE to work in partnership with them. They aim to influence the development of the research agenda, and of policy, and also to contribute to research and multi-disciplinary teaching.

More information about SPN is available on spn@scie.org.uk

The Approved Social Work Interest Group (ASWIG)

ASWIG is an independent professional group, whose membership is open to all social workers approved as ASWs under the 1983 Mental Health Act or those interested in promoting ASW practice through teaching or research.

Findings

All Social Services departments in the North West and Wales have signed up to a corporate membership agreement, and the group also has members in Yorkshire, Humberside and the North East. ASWIG is concerned with the promotion of good practice amongst ASWs, providing peer support, a forum for discussion of mental health issues, monitoring and research into ASW practice, as a campaign group and to provide professional advice to relevant organisations. ASWIG organises regular conferences and events to consider issues of concern to ASWs. More information can be obtained from

www.aswig.uk.users@btopenworld.com

Other Recruitment Initiatives

The TOPSSE report (2003) also reports on a number of other recruitment initiatives that have been fairly widely adopted by social services departments which could be applied in an effort to attract social workers into mental health. These include flexible working practices, improving working environments, 'Grow your own' strategies by seconding social work assistants onto training programmes or employing staff as apprentices, recruiting local people, bursaries and sponsorship, distance learning, 'Golden Hellos', job fairs, 'career for a day' and promoting a positive media image. They also make suggestions on other strategies which could be used to increase social work recruits generally such as, diversifying the social care workforce by recruiting more men, older people, people from black and minority ethnic groups, and refugees. Fast track and return to social work courses may also be useful. Mail-shots, local radio and partnerships with local colleges, e.g. those doing the Certificate in Mental Health courses are all avenues worth exploring.

Secondment Schemes

The Social Worker Recruitment Study (IFF Research 2002) suggests ways of decreasing barriers to qualification, such as unpaid leave, managerial support and more part time courses. Local authorities are increasingly training existing staff or recruiting staff to social work trainee positions. Such schemes are beneficial in that they attract local people, who are more likely to stay and may be more committed. The Social Services Inspectorate has set targets for funding into social work trainee schemes. In 2003, their Spring monitoring for indicator 3121 (Funding for Trainee Work Schemes) shows that, whilst 2284 social work employees were registered in 2002-3, the number was planned to reach 2795 for 2003-4. Kent County Council in partnership with Canterbury Christchurch College has a training scheme for local people to enter the generic social work programme, with a council salary available. More than 1000 people came forward for the 28 places available (IFF Research 2002).

The Open University has been running a distance learning course leading to a social work qualification since 1997, which local authority staff working in a range of social care settings can be seconded onto (www.open.ac.uk). Specific recruitment onto such schemes from mental health settings could be an important source of recruitment.

Local responses and examples of good practice

Specialist Mental Health Courses/Modules for Social Workers

Until recently, the University of Manchester ran a specialist post-graduate mental health social work course despite 'insurmountable odds', as the tide changed to genericism and other similar courses folded. With the inception of the new generic degree programme, this course has now been discontinued.

Some courses have developed specialist modules as part of the new Degree in Social Work, e.g. Anglia Polytechnic University is running a module on Innovation in Mental Health, focussing on examples of good practice in mental health. A number of high quality mental health placements are also offered as part of the course in Community Mental Health Teams, in primary care and in user led services (Ramon 2004-personal communication). In addition, a number of Higher Education Institutions are now running multi-disciplinary Masters courses in mental health for qualified practitioners, including social workers, which provide the opportunity for mental health professionals to refine and develop their therapeutic skills.

Practice Learning Conference- Manchester Mental Health & Social Care Trust/Practice Learning Taskforce

A day conference was organised in Manchester for mental health service providers, to look at ways of developing practice learning opportunities. Suggestions were made for the development of a database of new and existing placement opportunities, with a profile of placements to help students choose. Other ideas included development of induction packs, audit tools and a support network for practice teachers. (<http://www.practicelarning.org.uk/taskforce>)

Practice Learning in Mental Health Workshop, York, May 2004

This seminar, to which representatives from the Practice Learning Taskforce, key national figures, service staff, Workforce Development Confederations and Higher Education representatives were invited, was organised in May by Colin Williams from NIMHE Northern Region.

It aimed to address issues relating to the provision of sufficient high quality placements in mental health for the new social work degree. Discussion centred around the difficulties surrounding the role of social workers in mental health teams and the provision of practice teaching in mental health settings. Participants reported that there were insufficient placements for students, and this was exacerbated by pressure for placements for nursing students in the same teams. The need to raise the profile and value placed on practice learning within organisations was emphasised. The need for closer working with Higher Education Institutions was also recommended to raise the profile of mental health in social work programmes. There was potential for practitioners to get more involved in developing and supporting placements, teaching and programme development. Action plans were drawn up for NIMHE and the PLT to raise the profile of practice learning in mental health settings.

Positive Action Scheme

Tower Hamlets, in East London, has introduced a 'Positive Action Scheme' to encourage local people from its large Bangladeshi and Somali communities to work for social services and become qualified social workers. The scheme provides several routes into the profession, including a secondment programme for unqualified care managers and social work staff, work-based training for graduates who join as family support workers or assessment and review officers, and work experience for people before they are seconded on to a diploma course. Since its launch in 1998, 70% of the Positive Action recruits have been from the Bangladeshi community and 16% from the Somali community (see further details on www.SocietyGuardian.co.uk/socialcaresaff).

Findings from the interviews

Factors attracting people to mental health social work

Respondents identified either personal or work experience in mental health care (paid or voluntary), either prior to or during the social work course as the most important factor in attracting new graduates to this area of work. One manager revealed that in five years, they had never managed to recruit a social worker to the mental health team via external adverts, but that all their staff had decided to stay after a placement or after doing agency work with the team. Gap years for students were felt to be important in attracting people to mental health work. Students were often motivated by political concerns to get involved in community projects, such as night shelters and refuges. Once working there, 'you get hooked into mental health'. Some respondents talked of their own fascination with and passion for the subject.

It was felt that the new degree may have enhanced the position of mental health in the curriculum, in that the guidance stipulated that mental health was covered, but institutions varied in whether they offered mental health as a separate module or whether it was just integrated throughout the course. The importance of showing the relevance of mental health work throughout the course was emphasised, as was the provision of good quality placements and specialist modules, e.g. Innovations in Mental Health, Family Therapy, Loss and Bereavement in order to attract more students into mental health work.

Is there a recruitment crisis in mental health social work?

The difficulty in obtaining definite information on numbers of mental health social workers was highlighted. Most respondents felt that there were problems of recruitment and also retention, but that the problem was patchy. Counting numbers of ASWs was complicated by the fact that not all ASWs had an active role in mental health, but may work for the Emergency Duty Team or in childcare, 'and still hold the ticket'. It was noted that experienced ASWs 'have a high market value in adult or child care services or probation', so may be lured into other specialities. In some areas, where there was a stable workforce and retention was not a problem, it was felt that the problem of few recruits had not yet surfaced. Concerns were expressed about the disproportionately large numbers of ASWs who were now over 50.

Respondents also feared that there may be insufficient numbers of ASWs to meet the demands of the new Mental Health Act when the AMHP role comes on line. The heavy workload of ASWs was also noted, 'Trusts may have filled all the vacancies, but are there really enough ASWs?'

Factors contributing to the recruitment crisis

Recruitment to mental health work generally was felt to be adversely affected by media horror stories. In addition, this was felt to be the 'Cinderella speciality' within social work. Mental health social workers have always been a minority group within social work (around 5-7% of the total qualified workforce), so it was felt that important issues such as recruitment have been overlooked nationally. In addition, it was pointed out that recent media attention and consequently funding has been mainly focussed on childcare. The 'internal market' in social work means unfortunately that these two areas of work are likely to find themselves in competition for social workers who would like to specialise and enjoy a challenge. It was noted that there is more money around in childcare social work, hence they can offer better financial incentives.

Findings

It was suggested by most respondents that the basic generic training of social workers disadvantages students in terms of mental health. Generic social workers are likely to be inadequately prepared when they encounter people with mental health problems, even within the context of general adult or childcare social work. The lack of specialist modules and the low profile given to the subject in some institutions (exacerbated by uncertainties about the future role of ASWs) may put students off entering mental health social work. Over 10 years ago, there were opportunities within certain social work courses for students to specialise in mental health as part of their basic training. It is felt by some that the move by CCETSW at that time to only offer generic training was a retrograde step for mental health care.

Experience in a mental health setting was felt to be the most important factor influencing recruitment to the speciality. A shortage of placements and practice teachers was identified as a problem, with ASWs tending to be given priority over generic social work students. Practical issues such as lack of space or desks were mentioned as a factor, as well as work overload for potential practice teachers. It was felt that the move to Trusts may affect placements negatively. DipSW courses had named contacts within the Training Section of local authorities who were responsible for organising placements. Social workers in Higher Education Institutions may be less familiar with placements in the health service or the voluntary sector. The fact that social workers would be in a minority in Trusts may also impact on availability of placements, since smaller teams mean taking students involves a greater burden on individuals. Multi-disciplinary teams may be less committed to social work training.

It was noted that mental health social work was 'in a time of turmoil', as staff move over to NHS Trusts, where the medical model tends to dominate, and social workers are in a significant minority compared to nurses. Some social workers were reported to be happy with the transition, but it depended how it was managed. Others have felt abandoned by Social Services, creating a morale problem, which may impact on recruitment, 'uncertainty creates restlessness'. It was felt that the social perspective that MHSWs brought was not always valued by colleagues, although they had useful skills to offer mental health teams in terms of assessment skills, a holistic perspective and knowledge of welfare systems. The move to Trusts also meant mental health social workers within them may feel 'cut adrift' physically from their fellow social workers. It was felt that not being in the same location might also impact negatively on students choosing placements within mental health. In the past, students may have made a decision to do a mental health placement, after working in another team within the same office.

It was suggested that many social workers post DipSW go straight into agency posts (as many as 30% are agency staff in some parts of London), but their ability to work in mental health is restricted by legal problems around ASW status. In addition, these workers would not be eligible to do the ASW course. Lack of the ASW qualification also means staff are less likely to move over from other specialisms into mental health than they are to go the other way.

It was felt that social workers in mental health settings were often reluctant to do the ASW qualification, having observed their colleagues being so 'bogged down' with the legal aspects of the job. Workload, health and safety, legal risks, problems getting hold of doctors/ police/ beds and uncertainties over the new Mental Health Bill were all mentioned as factors conspiring to put people off working in this field. Nowadays, mental health social workers seemed to have much less chance to develop their therapeutic skills than other professions, an aspect of the job that in the past has been highly valued. In addition, there were concerns that their particular skills in social interventions, working with individuals in the context of their families and communities had been eroded in recent years.

It was felt that other mental health professions such as nursing had a better career structure, e.g. nurse consultants and management opportunities. MHSW was felt to lack professional leadership. One respondent argued that social work 'has singularly failed to articulate its own evidence compared to the nursing and medical workforce'. Supervision and management was often by other professionals.

Ideas for a Comprehensive Recruitment Strategy

Respondents stressed the need to be pro-active in recruiting potential staff into mental health at a number of levels. It was recommended that key players should be brought together to formulate strategies to increase recruitment and to share examples of good practice.

Whilst it was acknowledged that the general recruitment campaign into social work will help, it was suggested that Government messages explicitly advertising mental health social work and the role of the ASW are also necessary. It was suggested that more media coverage of the work of mental health social workers could have a positive effect, such as a TV programme about the work of a crisis resolution team.

Experience in mental health was seen as central to attracting social workers into mental health work. It was felt that efforts by the Government to get young people into voluntary work would be valuable. Increased exposure to mental health work during training was also felt to be vital.

The separation of mental health social workers physically from their colleagues means that they need to be more pro-active in encouraging students to take up mental health placements. The Practice Learning Taskforce is committed to improving the quantity and quality of practice learning opportunities. Issues such as funding, skilled practice teachers and assessment have to be considered. Specific work needs to be put into identifying existing new placement opportunities in mental health, both within statutory services and the voluntary sector.

The development of specialist mental health modules was felt to be important in encouraging an interest in this field. This should incorporate teaching on the role, contribution and strengths of the voluntary sector. Social perspectives on mental health should also be actively promoted throughout the course, and there should be an emphasis on mental well being in teaching, not just on mental illness. Service users and enthusiastic practitioners need to be involved in teaching and curriculum development to ensure teaching is contemporary and relevant. Students with experience of mental health work need to be encouraged to draw on their experience. Research canvassing student views on why they do or do not choose mental health was also felt to be useful.

It was felt that careful management of the transition into the NHS was necessary to encourage social workers to work in mental health. Efforts need to be made to involve current practitioners and to address their anxieties and concerns about their work, and to seek out a modern role for mental health social work. Whilst multi-disciplinary working was valued, it was felt that the important and distinctive contribution of each profession needed to be emphasised. Social workers in Community Mental Health Teams need to feel that their skills are valued. Account needs to be taken of workforce balance, and to avoid professional isolation of social workers.

It was argued that to promote interest in mental health, emphasis needed to be placed less on the legalistic aspects of the ASW role and more on the social intervention aspects of the social work role. The latter is increasingly important in the light of the recent Government report on social exclusion (Social Exclusion Unit 2004). Mental health social workers also need to have more opportunities to develop their therapeutic skills e.g. in family therapy, health promotion work and group work. Students need to be made aware of career opportunities within mental health care and what training is available. In addition, better opportunities for career progression need to be provided for mental health social workers. 'Social Work Consultant' and 'Social Work Director' roles need to be developed to allow parity with nursing and medical colleagues in integrated services. Other developmental opportunities such as research and specialist training also need to be considered.

More efforts could be made to 'grow your own', by the provision of opportunities for secondments onto training courses for unqualified staff working in mental health settings. More flexible and part time courses would help encourage mature students to work towards qualification.

In terms of the shortage of ASWs, it was argued that, efforts needed to be made to retain the current ASW workforce as well as attract new recruits. It was felt that additional increments may help stem losses from the profession, as may guarantees about retirement pension entitlements. However, there was a need for more collaborative working on pay and conditions between neighbouring authorities and Trusts to achieve a real growth in numbers.

Summary of findings

There is growing evidence of problems recruiting mental health social workers and also ASWs within some localities. There is an ageing workforce and retention of staff also seems to be a key factor. At present, there is a lack of sound data on exact numbers of staff in employment. There are concerns that recruitment problems may worsen, (although the workload may increase) with the inception of the new Mental Health Act, and also as mental health social workers move from the local authority to work for NHS/integrated Trusts. A number of issues are identified as possibly impacting on recruitment, most notably the limited opportunities to gain experience of this sort of work, either during school years or whilst on placement. Work overload, low morale and lack of opportunities for career progression amongst mental health social workers may also affect recruitment. The need to listen to staff views and respond to their concerns around their changing role and location are emphasised. A concerted effort needs to be made by key players to encourage potential recruits into mental health social work.

Findings: 6. Clinical Psychology

CLINICAL PSYCHOLOGY

This section focuses on clinical psychology as opposed to the other applied psychology groups. It is important to acknowledge that some of the following information has been taken from the work of Tony Lavender, Ian Gray and Anne Richardson, who have recently completed a detailed survey of the applied psychology workforce on behalf of the British Psychological Society and the Home Office. Although their work does not specifically relate to mental health, their findings are highly significant and all three have been key informants for this project (Lavender et al 2004).

Education and Training

According to the NHS Careers website, people wishing to pursue a career in psychology in the NHS should have a good honours degree in Psychology.

(www.nhs.uk/careers) More specifically, the primary route to a qualification in clinical psychology is via a University training course which has been accredited by the British Psychological Society. There are currently 30 accredited training courses in the UK, 25 of which are in England. The courses are over subscribed and approximately 1000 applicants per year do not gain places, although many in subsequent years are successful in securing places (Lavender et al 2004).

The alternative route to qualification as a clinical psychologist is by being awarded a Statement of Equivalence (SOE) by the British Psychological Society. To go through the SOE route, the Committee for the Scrutiny of Individual Qualifications (CSICQ) determines the further training requirements of Psychologists who hold a qualification which partially fulfils the qualification requirements for registration as a Clinical Psychologist. This would include people;

- seeking lateral transfer from another branch of applied psychology
- who hold a research degree in a clinical subject
- who possess a qualification in clinical psychology obtained overseas which does not fully meet UK training requirements

Clinical psychology training is at postgraduate level and normally undertaken on a full time basis for three years. Currently there is no legal requirement to register with the British Psychological Society to practice, although the Society is required to maintain a public register of Chartered Psychologists under the terms of its Royal Charter. To practice as a Chartered Psychologist in the UK, membership of the British Psychological Society is

compulsory and to achieve Chartered status Psychologists must have completed a Society accredited postgraduate training course (www.bps.org.uk).

Clinical Psychology trainees are funded by Workforce Development Confederations and are paid approximately £18,000 per annum. Their course fees are also funded.

Applications for clinical psychology training go through a central Clearing House based at the University of Leeds.

Facts and Figures

Statistics over the past nine years from the Clearing House show that the numbers of applicants to University accredited training courses for Clinical Psychology substantially exceed the number of places. Over the past ten years, there have been 3-5 times as many applicants as places. There was only a 3% increase in 2004, the lowest increase for over two decades. The box below illustrates the number of applicants accepted over the past nine years and also shows the annual growth in the number of funded places. Since 1994, there has been a 9% increase year on year in numbers of commissioned places for Clinical Psychology.

Number of applicants accepted onto training courses (Source-Clearing House, Leeds)

Year	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Applicants	1224	1398	1645	1642	1597	1556	1538	1486	1670	1968
Numbers	222	263	289	314	347	378	413	454	489	537
% accepted	18.1	18.8	17.6	19.1	21.7	24.3	26.6	30.6	29.3	27.3
Annual % increase in number of training places		18.5	9.9	8.6	10.6	8.9	9.3	9.9	7.7	9.8

The recent survey of the applied psychology workforce by Lavender et al (2004) describes the characteristics of applicants to clinical psychology courses. 75% of applications are received from people in the 20 -29 age group. Over the last two decades, the proportion of men applying has been slowly declining, and consequently the overall growth in training places has been entirely taken up by women. Of the total number of applicants, only 10% are classified as non white and only 7% of these are actually accepted onto courses.

Whilst there appears to be no problem recruiting students onto clinical psychology courses, there are concerns that the student profile does not reflect that of wider society. Lavender's report highlights the need to have a workforce that is representative of society in terms of gender, age and ethnicity. The report also suggests that the SOE route appears to be a significant contributor to the clinical psychology workforce in the UK and may go some way towards creating a more balanced and representative workforce. Current data from the BPS reflects that some 36% of SOE qualifiers are men in contrast to 20% from accredited University courses. SOE qualifiers also tend to be older as they already have an existing Psychology qualification (Lavender et al 1994).

With regard to retention and attrition on University training courses, Lavender et al's (2004) survey collected data from 12 out of a possible 30 Universities comprising 983 clinical psychology trainees over the period 1980 - 2002. The findings reveal that pass rates are high and that attrition of graduates from the profession is low. A consistent picture emerged reflecting a 96.6% pass rate (average over the 12 years). Reasons for non completion were cited as health related problems and academic failure. 93% of trainees took up their first post in the NHS as Clinical Psychologists. However, there is currently

no accurate information about how many of these posts were in mental health. Lavender has also been carrying out a longitudinal study of trainees from the Solomons Canterbury Christ Church University College course about the proportion going into mental health (personal communication). This study is now in its 23rd year. Data analysed from a 90% return rate indicates that for first jobs 46.2% were in adult mental health specialities (34.4% adult, 2.9% primary care, 4.7% rehabilitation/continuing care, 3.6% forensic and 0.6% addiction), 21.6% were in child, 15% in learning disability and 9.7% with older people. Thus, taking a broad definition of mental health, 92.5% take jobs in the area. These percentages reflect the availability of posts. It is therefore important to be clear about what is included in mental health. Most child, learning disability and older people psychologists are working in mental health, with those client groups.

Although recruitment and retention on clinical psychology courses appears to be healthy, there are reports of difficulties filling vacancies in the NHS and concerns about a shortage of psychologists. There is disagreement though between the profession, the NHS, the Department of Health and the Workforce Development Confederations on the extent of the problem, and the figures are disputed. This difference is reflected in the variations in national vacancy rates figures (Lavender et al 2004) and the workforce annual census (DoH 2003g), which is used by the Department of Health and Workforce Development Confederations to determine workforce planning needs. The reason for the difference in vacancy rates is that the Department of Health census figures are based on posts being unfilled for three continuous months as evidenced by the placement of consecutive adverts.

Findings

It is unusual for posts to be advertised in consecutive months to avoid appearing as a Department where there are recruitment difficulties, and also to wait for a new field of potential recruits to become available. Indeed sometimes an assistant will be brought in on a short-term contract. Psychology managers when asked directly, will be able to identify vacancies that have been advertised but have not been filled (Lavender – personal communication). Recently the BPS has begun to challenge the Department of Health's approach to gathering census data in an attempt to promote more accurate and robust workforce planning. The BPS recently carried out a national survey of vacancy rates for all clinical psychologists in the UK not just mental health, and these suggest a current level of 20% (BPS 2003).

Overall commissions for clinical psychology training have been steadily expanding over the past decade, and it is anticipated by the profession that, in terms of the Mental Health modernisation agenda, continued increases in applied psychologists will be needed to meet the demands and targets of the mental health and older people's NSFs. The WAT report highlights that mental health trusts have experienced difficulty in recruiting clinical psychologists because of a shortage in the numbers being trained (WAT 2000). The growth in trainee places is largely welcomed by the profession, and may begin to resolve this issue. However, although the Department of Health has planned and prioritised a significant expansion in training numbers for allied health professionals, it is revealed in a discussion paper prepared for the NHS Executive by the BPS in 2003, that there will not be any further sizeable increase in clinical psychology trainees beyond the current 9% annual growth (BPS 2003).

Issues identified in the literature

Early work aimed at clarifying clinical psychology roles and establishing appropriate staffing levels was first published in the Trethowan Report (DoH 1977). More recently the Management Advisory Service Report (1989), the Manpower Planning Advisory Group Report (1990), and the Workforce Development Directorates of the Strategic Health Authorities have highlighted the need for adequate staffing levels and accurate workforce planning. Psychological care is a key theme that threads through the NHS Plan (DoH 2000a) and the need to ensure robust workforce planning for clinical psychology also appears within the action plans set by the NSF for mental health (DoH 1999a).

It has been argued that the changes that have occurred to the commissioning arrangements for the clinical psychology workforce over recent years have had a significant and negative effect on workforce planning for clinical psychology. According to Lavender et al (2003),

the introduction of Education and Training Consortia and more latterly Workforce Development Confederations have led to considerable confusion for managers and clinicians delivering the services as well as for staff in Higher Education responsible for the training of clinical psychologists. Despite this the Mental Health Care Group Workforce Team has recommended a 15% increase for the last two years (2003, 2004) and for the coming year (2005) the Workforce Numbers Board have recommended a 15% increase to the Strategic Health Authorities.

The SCMh report identifies a shortfall of Clinical Psychologists in the NHS, although precise numbers are unknown (SCMH 2000). Whilst the literature points out that training courses are oversubscribed and that recruitment in terms of numbers of training applications is unproblematic, the need for an increase in training numbers is highlighted in several papers (Kinderman 2001, Gray 2001). Clinical psychologists are perceived though by some WDCs as an expensive resource to train, requiring courses fees plus their salary. Consequently, any further expansion of training commissions would require significant investment. Arguably Workforce Development Confederations are more likely to focus their resources on the expansion of other allied health professional groups (BPS 2003).

Another key issue that threatens the continued expansion of training places is the need for increased numbers of good quality supervised clinical placements. The British Psychological Society's response to this has been to review its accreditation guidelines to facilitate a core competency model of training. Within this model trainees can acquire core competencies in a variety of settings. A recent study of the views of 255 clinical psychologists on the provision of training placements has been carried out in the former South West Thames Region. Positively facilitated placement learning resulted in benefits to trainees particularly in relation to client work. Factors that hindered placement learning included supervisors feeling too burnt out to supervise appropriately (Adams et al 2003).

Co operation between stakeholders and good partnership working is also a significant factor in the delivery of quality training for clinical psychologists.

Lavender et al (2004) clearly specify that it is important for practitioners and trainers to work together to ensure that adequate and increasing numbers of Clinical Psychologists are trained. This will involve securing adequate funding and utilisation of placement and supervision resources as effectively as possible.

National initiatives

A workforce planning model is currently being developed to help mental health services estimate demand for clinical psychologists. This will include assistant and associate clinical psychologists (Tony Lavender – personal communication).

The Sainsbury Centre for Mental Health and NIMHE are currently undertaking a scoping project to establish the extent of the demand for clinical psychology in the mental health workforce (www.nimhe.org.uk)

Local responses and examples of good practice

Lancaster University hosted a national conference in June 2004 to look at the selection methods onto clinical psychology courses to try and address the issue of attracting applicants from more diverse social backgrounds to ensure a more representative workforce for the future (Ian Gray – personal communication). A similar conference was organised by Dave Green at Leeds University, Widening Access to Clinical Psychology in July 2003.

The Division of Clinical Psychology has produced a video designed to encourage applicants from diverse backgrounds. This is to be sent to all University career advisory services and postgraduate courses. The video is aimed mainly at recruiting more diverse groups in terms of ethnicity, disability and men.

Findings from interviews

Is there a recruitment crisis in Clinical Psychology?

Although recruitment onto clinical psychology courses was good, interviewees did feel that there was a shortage of clinical psychologists in mental health. They referred to the difficulties though in getting accurate figures regarding the shortfall of clinical psychologists.

Key informants pointed out that clinical psychology is a relatively small profession and existing workforce information has to date been unreliable. One key issue that was raised was how information about the clinical psychology workforce is recorded and categorised. The debates around the accuracy of some of the workforce statistics has already been alluded to. Historically under the Whitley Council, clinical psychologists were grouped with clinical scientists and for some recording purposes this is still the classification used. However in other forums clinical psychologists are classed as allied health professionals. This is not popular amongst the profession as clinical psychologists do not fit neatly into the allied health professional model particularly in terms of workforce planning issues. One example of this is that

the funding arrangement for commissioned training places is different.

Factors contributing to recruitment problems in psychology

A number of factors were identified which could explain the high vacancy rates and problems with workforce planning. It was argued that Workforce Development Confederations are not always aware of the priority areas and future developments for mental health in terms of clinical psychology services. The implementation of Shifting the Balance of Power, which introduced changes to commissioning arrangements and more recently Trust reconfigurations have further compounded this. Concerns were expressed about the lack of clinical psychology representation on local and national workforce planning groups.

Several respondents felt that finance was a big issue. For example, clinical psychology students are paid approximately £18,000 per annum. This salary plus the course fees are paid by the Workforce Development Confederations who perceive them as an expensive resource.

Another of the factors which may affect recruitment was felt to be the strong professional identity of clinical psychologists. Recruitment was reported to be more successful in Mental Health Trusts that have large psychology departments. Such departments provide peer support and increased opportunities for research and continuing professional development.

In addition, the profile of the clinical psychology workforce is changing and now includes a high proportion of women working part-time. It is currently acknowledged that clinical psychology courses need to attract more men and people from black and ethnic minority groups.

Ideas for a comprehensive recruitment strategy for clinical psychology

Key informants suggested however, that there is evidence that workforce planning for clinical psychology has started to improve recently. This is reflected in the following initiatives:

- Additional money for training has been identified by Workforce Development Confederations.
- Training commissions to University courses have increased.
- Members of Local Implementation Teams are more actively involved in workforce planning.
- Clinical psychologists are now advising at national level about workforce issues.

Findings: 7. Psychiatry

Assistant/Associate Clinical psychologists

Although clinical psychologists have a strong professional identity, many are concerned about their future role in the rapidly changing mental health services. Current thinking is that there should be three tiers of clinical psychologists: assistant clinical psychologists, associate clinical psychologists and clinical psychologists.

The concept of Assistant Psychologists was first introduced by Trethowan in 1977. Trethowan recommended that Psychology Assistants would be employed by services whilst learning on the job under supervision from a Chartered Psychologist. However to date it is unclear about the career pathways and progression through the NHS workforce for this group and their roles and responsibilities in the absence of any national guidance.

Key informants for the Project were keen to see this initiative developed further and taken forward but they acknowledged that some areas of the profession had mixed views. A number of services were cited as piloting this model and employing Assistants/Associates on a salary of between £13800 - £15500 as opposed to a Clinical Psychology trainee whose salary would be anything between £16100 and £18200. There were some differing views amongst Key Informants regarding career progression for Assistants/Associates. Some felt they could eventually progress onto Clinical Psychology training and undertake a shortened course applying AP(E)L to their previous work experience. Others were concerned that they may wish to go on to do other professional training and be lost to the Psychology workforce. They did however recognise that this flexibility reflected some of the key and current workforce agendas and that Psychology may also in turn attract people who had come from Assistant roles working primarily with other professional groups such as mental health nursing.

Summary of findings

To date there has been a lack of accurate workforce data about clinical psychologists who work in mental health, and figures largely refer to applied psychologists generally. Although there has been additional financial investment to increase the number of training places for clinical psychology there are currently no systems in place to ensure that the required numbers of clinical psychologists will eventually work in mental health to meet service developments and workforce demands. Approximately 1000 applicants for clinical psychology training do not gain places each year and more work needs to be done to consider the career opportunities for this group. Work in adult mental health services is a popular option for clinical psychologists. Fewer chose to work with older people or in learning disability services. The way workforce data is recorded and utilised is a key

issue and opinions vary considerably on how this should be resolved.

Applications to clinical psychology training are high. The profession and Higher Education Institutions are increasingly keen to work towards ensuring trainees are more representative of society, and that they are attracting more applications from men and people from ethnic minority groups to meet the diverse needs of services. Assistant psychologists have a significant contribution to make to the workforce. The roles, responsibilities and career progression for these workers within the context of the Changing Workforce Programme (DoH 2002) have yet to be clearly defined.

PSYCHIATRY

Education and training

There is no specific statutory or professional requirement to undertake psychiatry as part of undergraduate medical training. However, all medical students will gain some experience in psychiatry, both practical and theoretical during their course, in order to meet the attributes required of newly qualified doctors required by the General Medical Council (GMC), i.e. that all student doctors study environmental and social, as well as biological determinants of disease, learn the importance of good communication with patients, relatives and professionals and are able to carry out a mental health assessment (GMC 2000, 1993, 1987). However, individual schools are autonomous with respect to the way their curricula are developed, so the time spent on psychiatry and what is taught varies on different programmes. Sometimes mental health is integrated with other areas, sometimes taught as a discrete module. The Education Committee of the Royal College of Psychiatrists has developed a core curriculum in psychiatry to act as a guide for curriculum planners (Royal College of Psychiatrists 1997). The World Psychiatric Association (WPA) and the World Federation for Medical Education have also recently published internationally applicable guidelines for developing core curricula in psychiatry for medical students (Walton & Gelder 1999).

Following undergraduate education at medical school and completion of MB exams, newly qualified doctors are required to do a period of mandatory pre-registration training before full registration as a medical practitioner with the GMC. This Pre-Registration House Officer (PRHO) year generally consists of six months each in medicine and surgery (GMC 1997). In two schools (Sheffield and London) students have the option of doing three four month house officer jobs, one of which may be in psychiatry (O'Dwyer 1999, Herzberg et al 2003).

Following the PRHO period and full registration with the GMC, doctors spend around three years at Senior House Officer (SHO) grade during which they decide which aspect of medicine to specialise in. A percentage choose to do an SHO post in psychiatry, although 25% of those who do so are GP trainees (Mears et al 2002a). After one year as an SHO, students are eligible to sit the MRCPsych Part 1 exam, which is awarded by the Royal College of Psychiatrists and after another 18 months, they may sit MRCPsych Part 2. On completion of Parts 1 and 2, doctors may apply for Specialist Registrar (SpR) posts. Some psychiatrists at this point will opt for non-consultant career grade posts. Further higher specialist training leads to the award of Certificate of Completion of Specialist Training (CCST) which entitles a doctor to have their name included on the Specialist Register, giving them eligibility to apply for Consultant posts. Psychiatrists may opt to specialise in one of six areas, e.g. forensic, old age, adult psychiatry. Some may do dual training. Flexible training schemes are available for those psychiatrists who wish to do their training part time (Mears et al 2002b).

Changes in Medical School Training

There have been major changes in medical training recently and more are to come. A GMC report, *Tomorrow's Doctors* recommended a reduction in core teaching in the medical curriculum by 65%. This has made time available for a range of Special Study Modules (SSMs), which allow students the opportunity to electively explore areas of interest to them in more depth (GMC 1993). In relation to psychiatry, there has generally been a reduction in length of theoretical teaching, with a greater emphasis on problem-based and self-directed learning (GMC 1993). A revised version of *Tomorrow's Doctors* was published in 2002, which restates the GMC's commitment to modernise medical education. It retains the emphasis on attitudes as well as knowledge and skills, on early clinical experience, problem based learning, communication skills and public health perspectives. However, the 2002 version has moved to competency-based (rather than experience-based) learning outcomes (GMC 2002).

Modernising Medical Careers (DoH 2003f) also recommends changes to post-registration medical education, which may have implications for recruitment into psychiatry. It advocates that all post graduate medical training be organised in structured programmes, with progress monitored against clear curricula, guided by UK-wide standards and with competency based assessment. Programmes should be designed and managed to ensure that trainees complete them in the minimum amount of time. Flexibility should be increased to cater for those who make their career choice early on, and those who need more time to do so. High quality

careers advice and support should be available during training. Opportunities should be available for those who wish to train part time.

In addition, from the year 2005, the PRHO year will be replaced by a 2 year Foundation Programme, in which newly qualified doctors will be offered a range of different experiences with competencies attached. At the end of the first year of the Foundation Programme, trainees will be expected to demonstrate the learning outcomes for full registration with the GMC. The second year aims to help newly qualified doctors to gain the basic practical skills and competencies required for practice. Psychiatry is likely to be an optional elective here. It is also possible that other electives such as paediatrics will have a mental health component. Experience gained in electives chosen here may be used towards the Certificate of Completion of Specialist Training.

Facts and figures

The past few years has seen growing concern about the problem of recruitment and retention in psychiatry overall, and in particular about the shortage of consultant psychiatrists (Pidd 2003, Brockington & Mumford 2002, Mears et al 2002b). Vacancy rates for consultant psychiatrists nationally stand at 12%, in some areas being as high as 20%. There are also problems recruiting to SHO and SpR posts, although again, there are regional variations (SCMH 2000). Appleby (2002) suggests that these figures are likely to be an underestimate if locum psychiatrists and unadvertised posts in Trusts are taken into account. There are particular concerns about the decrease in popularity of general adult psychiatry, which represents about half of all specialist registrar and consultant posts (Thompson & Sims 1999).

The number of medical graduates choosing psychiatry has always been relatively low, but has remained stable at around 2.9-4.2% (mean 3.6%), with slightly more females choosing this speciality (4.3% on average compared to 3.5% males) (Lambert et al 1996a,b). Brockington & Mumford (2002), in their review of the literature on recruitment and retention, expressed concern, based on numbers of medical students at that time, that if percentages choosing psychiatry remained stable, this would only produce 105-152 new recruits each year, well below the required number to replace staff being lost. They suggested that the required number lies in the region of 250-300 per year to fill both new consultant posts and to replace those retiring.

Findings

One of the issues of concern in terms of recruitment is that students at different medical schools in the UK show markedly different rates of choosing psychiatry as a career. Variations between different medical schools were observed in cohorts between 1961 to 1970 (Brook 1983), and in the Parkhouse studies (Parkhouse & McLaughlin 1976; Parkhouse & Palmer 1977; Parkhouse 1991; Faragher et al 1980; Parkhouse 1983). This data is summarised in the paper by Brockington & Mumford (2002). Whilst the authors warn that it is necessary to consider figures over several years before any conclusions could be reached, they do acknowledge that there appear to be some medical schools which have consistently higher rates of students entering psychiatry and others with consistently low rates. There has been no regular data collection of this sort for the past 20 years, although there is a renewed interest in these

longitudinal studies. Dr Goldacre is currently following up Dr Parkhouse's cohorts and starting new ones for 1993 and 1996 (Lambert et al 1996a,b).

One positive development in recent years has been the huge increase in medical school places to be phased in between 1999-2005 (WAT 2000). A recent report, Medical Schools: Delivering the Doctors of the Future revealed that by 2003, two years ahead of schedule, the target of increasing numbers of doctors in training by more than 2000 had already been achieved (DoH 2004a & b). This increase in applicants and accepted applicants to medicine is detailed in the box below:

UK applicants and accepted to medicine 1999-2004

Year of entry	1999	2000	2001	2002	2003	2004
No of applicants	8996	8506	8563	10071	12728	15013
No of accepted applicants	4871	5229	5675	6287	6287	6953
Ratio	1.8:1	1.6:1	1.5:1	1.6:1	1.8:1	9.3

(Source: UCAS Department of Research & Statistics)

The figures show a dramatic increase in numbers of applicants and entrants to medical school over the past 5 years. With 15,013 applicants in autumn 2004, this is 19.7% more than at the same date the previous year, and 76.5% more than the total number of applicants for 2000. Accepted applicants in 2003 are also up by 60% since 1997 (DoH 2004a & b). The increased number of students graduating from medical schools should make a significant difference to the recruitment problem in psychiatry, providing that the percentage rate of recruitment to the speciality remains the same or increases over the next few years. However, there will be a considerable delay before these increases will translate into consultant posts.

Medical schools have also made significant steps forward in attracting applicants from a broader social base. Opportunities have been created now for students to enter medicine who do not have the traditional science background. The report, Medical Schools: Delivering Doctors for the Future (DoH 2004a) highlights some examples of good practice. These include two year foundation degrees targeted at people already working

in the NHS and summer schools and road shows for local schools, which are aimed at introducing school students of all backgrounds to the idea of studying medicine. In addition, there has been a major increase in four year graduate entry courses, and these are proving very popular. In 2003/4, there were 622 entrants to courses for graduates in England, which exceeded the target number of 558 by 64 (11.5%). The total number of applicants with a UK degree entering medicine has increased from 879 in 1994 (of whom 281 were accepted), to 3,346 for 2003 entry (of whom 1303 were accepted). Since 2000, four new medical schools have opened, and four new centres of medical education have been developed, three of them in collaboration with existing medical schools (DoH 2004a). Widening access to include students who do not just have a traditional science background and also to more mature students with relevant work experience may mean potentially larger numbers of medical students who would be interested in psychiatry as a career.

As well as the problem of recruiting new graduates into psychiatry, the road to becoming a consultant is a long one, involving further training, and many doctors will drop out on the way. Hence work on recruitment and retention in psychiatry has tended to focus on the whole career pathway from aspiring students to post retirement consultant psychiatrists, looking at what Brockington & Mumford (2002) refer to as 'nodal points' in the career of doctors. For example, the Career Intentions in Psychiatric Trainees and Consultants (CIPTAC) study done by the Royal College of Psychiatrists' Research Group revealed that only 56-73% of those who have done the Part 1 MRCPsych exam go on to take Part 2 (Mears et al 2002). A significant number of those dropping out go on to become General Practitioners. In addition, as many as 18% of those who passed Part 2 fail to enter higher specialist training, leading to a shortage of Specialist Registrars (Pidd 2003). Although an increase in training numbers has been negotiated, it has not been matched by 100% occupancy. There are additional problems in that some doctors do their training over an extended period or part time. In addition, having obtained College membership, increasing numbers are opting for non-consultant grade posts, thus reducing the pool of consultants. There has also been a marked increase in early retirement of consultants (Kendell & Pearce 1997, Mears et al 2002b).

Appleby (2002) suggests that most solutions to these problems are likely to be long term, and argues that models for workforce development are needed, which show precisely how increases in recruitment and retention of psychiatrists will carry through to the consultant workforce. In the shorter term, as in other areas of the NHS, there is a focussed effort on international recruitment of psychiatrists, although this raises issues of appropriate training, experience and language, which need to be addressed.

Issues identified in the literature

The literature reveals that the recruitment and retention of psychiatrists is a source of concern within mental health services, and there are fears that unless the situation is remedied this could threaten achievement of proposed reforms and developments such as Assertive Outreach, Crisis resolution and Home Treatment Teams (Pidd 2003). Brockington and Mumford (2002) comment on the dearth of research into this area, with over half the studies reviewed being more than 20 years old.

Pidd (2003) suggests that psychiatry has always been seen by doctors as a 'Cinderella speciality', with too few young doctors seeing it as a viable career option. Critical stages are identified in the career pathway of psychiatrists, from aspiring students to post-retirement doctors, where recruitment and retention issues are

paramount, and suggestions are made for remedying them. She refers to a vicious circle of staffing frustration in psychiatry (SCMH 2000), with difficulties in recruitment, staff shortages, reliance on locum and agency staff, overspending and financial constraints, lack of resources for development, pressure on staff, low morale, high turnover and further problems of recruitment.

What attracts people to psychiatry and what puts them off?

Social background, personality and values seem to be influential in choice of speciality, with students from lower social classes and who are politically liberal more likely to be attracted to psychiatry (Eagle & Marcos 1980). Walton (1969) found students choosing psychiatry to be more reflective, responsive to abstract ideas and more tolerant of ambiguity. Many psychiatric trainees had at least one non-science A level (Donnan 1976). Students often appreciate the more holistic approach and the opportunity to get to know patients in greater depth (Scher et al 1983). However Cameron & Persad (1984) warn that students with such interests and attitudes may actually be indirectly discriminated against in the selection process for medical school, which traditionally favours a background in biological as opposed to social sciences or the humanities.

Firth-Cozens et al (1999) did a follow up study of a group of 4th year medical students over an eight year period. Of the few students who chose to do psychiatry (13/238), the main reasons given for their choice were: fewer hours, less stress, the nature of the work and more autonomy. Ironically, on follow up, career satisfaction was found to be lowest in those who had chosen psychiatry, and they were experiencing the highest stress.

Prins (1998) describes a retrospective study of 30 consultant forensic psychiatrists to discover what had attracted them to psychiatry. Several of them mentioned personal experience of or exposure to serious illness. The dominant theme however, was an interest in people rather than in illness. Whilst most of the respondents had made an early decision to enter medicine, the decision to do psychiatry was made later on. Cameron & Persad (1984) similarly, in a retrospective study found that 58% of psychiatric residents said they had decided to opt for psychiatry after graduation, compared to 28% as medical students and only 14% before they started medical school. The evidence both from Britain and America shows that the majority of doctors chose psychiatry after graduating, and that experience in the field during training can improve attitudes and increase interest in psychiatry as a career (Brockington & Mumford 2002). However, there is some concern that these positive attitudes are often not sustained as the course progresses (Wilkinson et al 1983).

Findings

A study by Creed & Goldberg (1987a) of 265 medical students demonstrated improved attitudes towards mental health during their psychiatry clerkship. The improvement though was short-lived, with house officers displaying significant negative change in attitudes towards psychiatric treatment and patients and a decline in interest in pursuing psychiatry as a career. Most frequently mentioned as influencing their decision was their perception of mental illness as chronic and unresponsive. Psychiatry was seen as unscientific, different from the rest of medicine and also having low status within the medical profession.

In a further study, Creed & Goldberg (1987b) interviewed 50 PRHOs, all of whom had been recommended for honours on the basis of the psychiatric clerkship, to elicit their attitudes to psychiatry as a career. Those who had also gained honours in other subjects were less likely to choose psychiatry as a career. Negative attitudes by other doctors in psychiatry were mentioned as a major deterrent. In addition, psychiatry was seen as making little use of medical skills and being unscientific. A study by Furnham (1986) of 449 London medical students also found that psychiatry was compared unfavourably with eight other specialities on 26/50 items. It was felt to be the most ineffective and unscientific speciality, echoing the public stigma of mental illness.

In an interesting study, Maidment et al (2003) reported on the career intentions and attitudes to psychiatry of 819 sixth formers attending a conference for prospective medical students. A much higher proportion of respondents expressed favourable attitudes to psychiatry as a career than might have been expected- 12.2% of them stated an intention to do psychiatry, almost equivalent to those intending to do general medicine(12.4%). This is in marked contrast to the 1.4% of 4th year medical students expressing a definite intention to do psychiatry as reported by McFarland et al (2003) (although after their attachment, this rose to 4.7%). Maidment et al (2003) suggest that prejudice, poor information and 'badmouthing' within medical schools about the speciality may all be influential factors. They suggest that schools need to be proactive in providing information, career choice and positive role models to encourage undergraduates to maintain students' interest in psychiatry.

It appears then that medical students' career preferences are not stable, and do not predict their final career decision (Last & Stanley 1968, Egerton 1983).

Whilst clinical experiences can make a difference to attitudes to mental health and psychiatry as a career, these will be maintained only if positive attitudes are supported and reinforced by the medical school as a whole (Rezler 1984, Sierles & Taylor 1995).

The Psychiatric Curriculum and Quality of Teaching

The research suggests that the quality of teaching of psychiatry within the undergraduate curriculum may also have a significant impact on recruitment.

Ring et al (1999) describe a survey of medical schools in the UK and Ireland, exploring current local views and practices in relation to the teaching of psychiatry in the undergraduate curriculum. Significant variations were noted in content and the way that psychiatry was taught between in different medical schools. For example, the length of the main psychiatry teaching block can vary between individual schools from 6-12 weeks, with a mean of 7.6 weeks. In some schools, this time is reserved exclusively for psychiatry, but in others it may also include related subjects such as neurology. Some schools teach psychiatry in relative isolation, whereas others integrate it through the course. Problem based learning is increasingly used as a teaching method. Whilst the GMC does offer guidelines on assessment, there is great variation in methods of assessment employed, and there is no agreement on how attitudes should be assessed. A further study of the content and nature of psychiatric teaching in medical school curricula is planned for summer of 2004 by the Association of University Teachers in Psychiatry (AUTP) led by Dogra et al (Personal communication with Dr Nisha Dogra, University of Leicester 2004).

Cottrell (1999) argues that there is evidence that positive attitudes towards psychiatry at the end of undergraduate education influence career choice, and that a major determinant of positive attitudes is the quality of undergraduate teaching. He suggests that the GMC guidance on undergraduate education provides many opportunities for psychiatrists to increase the exposure of medical students to psychiatry, and that these opportunities should be seized if we wish to increase recruitment to psychiatry. The demand for more integrated teaching offers opportunities for closer working with other specialities such as general medicine and paediatrics, as well as for work with neuroscientists and behavioural scientists on developing clinically relevant material. The emphasis on public health, holistic care, social perspectives and community care also offer opportunities for input in almost all areas of the curriculum by psychiatrists. In addition, the Special Study Module programme offers great opportunities for psychiatrists to offer a range of interesting and stimulating projects for students to work on. Cottrell recommends that given the current shortage of doctors, academic departments should embrace these opportunities and ensure that 'today's students have a positive experience of psychiatry, and become tomorrow's psychiatrists' (Cottrell 1999).

Some concern has been expressed however by the Royal College of Psychiatrists (2003a & b) that the reduction in core curriculum in medical education, will diminish teaching of undergraduate psychiatry to such a point that it fails to equip newly qualified doctors, particularly non-psychiatrists for their future careers. It could also adversely affect recruitment to psychiatry. It is suggested that the development of a well structured psychiatry curriculum with clear aims, and which emphasises the transferability of skills, attitudes and knowledge will contribute to challenging negative attitudes towards psychiatry and a more rational understanding of the client group.

They argue too that there are disadvantages to delaying introducing mental health until the end of the medical course, in that this may perpetuate its marginalisation and allow for stigmatising attitudes to develop. It is suggested instead that the teaching of psychiatry should be vertically integrated within the curriculum, commencing at some early stage in the course. Problem based learning is acknowledged as a useful way of helping students to integrate what they have learnt within psychiatric practice into other areas of medicine. It is suggested that assessment strategies should reflect this integrated approach, and occur at stages throughout the course, rather than just at the end in a final exam.

There is evidence from a comparative study by Singh et al (1998) that a shorter problem based learning curriculum was as effective as the longer didactic course in promoting more positive attitudes to mental illness and treatment, and did not affect career intentions adversely. Students had positive attitudes prior to their psychiatric attachment, and these became more positive after the attachment in students from both curricula. A follow up study is planned to see if these positive changes are more enduring than has been found following traditional psychiatric placements.

The Impact of Stigma

Some interesting work has been done on the impact that negative attitudes of fellow doctors, both towards psychiatry and psychiatrists may have on recruitment and retention to this speciality. Brockington & Mumford (2002) note that psychiatry is generally not a popular career option amongst medical students, as it is perceived to be low status and unscientific. They suggest that potential recruits may also be deterred by stressful working conditions and patients who are seen as difficult, frightening and untrustworthy.

A recent report by the Royal College of Psychiatrists et al (2001) notes that, despite significantly improved attitudes towards people with mental health problems and improvements in the status of psychiatry as a profession over the last century, there remains

widespread evidence of negative attitudes and discrimination by doctors themselves against people suffering from mental health problems. Psychiatrists are also perceived negatively by their medical colleagues. Buchanan & Bhugra (1992) found these prejudices to be rife too amongst medical students. Whilst psychiatrists were thought to be interested in people, they were also described as 'unclear thinkers' and 'emotionally unstable'. Psychiatry as a career was felt by students to be unscientific, imprecise, ineffective and low in status. Psychiatric patients were regarded by students and doctors alike as 'not easy to like'.

The Royal College of Psychiatrists' report recommends that the Government, NHS Trusts, the GMC, BMA, medical Royal Colleges and other health care organisations should campaign to promote better awareness about mental health issues and work to combat stigmatisation by medical staff. Guidance is also needed on selection of medical students, particularly those with a history of mental health problems. Students and doctors who develop mental health problems need to be dealt with sensitively

Research on Retention in Psychiatry

Other research has considered problems of recruitment and retention at different points during the career of psychiatrists. As Clarke-Smith & Tranter (2002) note, although it is anticipated that the overall increase in medical student numbers will make a difference, attrition also needs to be addressed. In a qualitative study across Wales, involving interviews with medical students, PRHOs and psychiatrists they revealed the importance of high quality training experiences in psychiatry and enthusiastic teachers to maximise recruitment. They too found that stigmatisation of psychiatry by colleagues was evident, and it was felt to be an inferior branch of medicine. Problems retaining staff were also apparent, with demoralised consultants, pressure on the service and lack of resources. The authors conclude that, 'Students on clinical attachments in psychiatry are exposed to wards which are often dirty, unpleasant and under-staffed. They see the service as under-funded and subsequently staff with low morale and burn-out. It is hardly surprising that staff pursue alternative careers' (Clarke-Smith & Tranter 2002).

Deahl & Turner (1997) discuss factors contributing to the particular problem of recruiting staff to general psychiatry, with consultants being exposed to increasing responsibilities combined with a reduction in resources. They suggest that consultants, as the 'responsible medical officer' are treated as scapegoats, being expected to accept unlimited responsibility for everything that goes wrong with the management of patients in the community.

Findings

The move of general psychiatry from district general hospitals to stand alone community bases is also felt to have an adverse effect on recruitment. They suggest that there is a need for psychiatrists within adult psychiatry to be given more opportunity to do specialised training such as cognitive therapy and to implement evidence based practice. The Royal College of Psychiatrists has expressed concern too that the proposed Mental Health Act reforms, with its greater emphasis on a coercive role for mental health professionals, and on work with people with personality disorders, may impact negatively on morale and job satisfaction. All of these issues could have a knock on effect on recruitment and retention rates (Pyott 2002).

A project undertaken by the Royal College of Psychiatrists (2002) to look at Career Intentions of Psychiatric Trainees and Consultants (CIPTAC) highlights the factors that encourage psychiatrists at all stages of their career to stay or to leave the speciality. Recruits to psychiatry tend to be attracted by the holistic and multi-disciplinary emphasis in psychiatry, and it is these same factors that encourage them to stay. Undergraduate experience is said to be the most important factor affecting their choice to do the speciality. Poor relations between consultant and trainee, poor quality training and supervision and inadequate support for exams were all cited as reasons for disaffection with psychiatry. Perceived training quality varies between regions. The report concludes that there is no single cause for attrition, but that it is a complex interaction between a range of factors. A number of recommendations are made, including better training and supervision for SHOs, alterations to consultants' style of work, and addressing stigma in schools and medical schools (Mears et al 2002a).

Recommendations from the literature for improving recruitment and retention in psychiatry

Thompson & Sims (1999) suggest that recruitment must be improved at all levels. They recommend a properly structured experience in psychiatry in the PRHO year, arguing that it would be beneficial to all doctors, as well as having a positive impact on recruitment to psychiatry. There should be closer integration of general psychiatry with the rest of hospital medicine.

Pidd (2003) makes a number of suggestions for improving recruitment to psychiatry, but also stresses the importance of improving retention. The expansion in medical school places and of graduate entrants to medicine is regarded as a positive step. She suggests that attracting students into psychiatry is a two stage process, in that firstly more students who are psychologically oriented need to be targeted, and secondly that once at medical school their interest needs to be maintained and

cultivated. Students showing an interest in psychiatry should be encouraged to take Special Study Modules in the subject, with mentoring by enthusiastic consultants or Specialist Registrars and encouragement to enter training. She also welcomes the development of more PRHO posts in psychiatry as potentially having a positive effect on recruitment, as seems to have been the case in Sheffield (O'Dwyer 1999). Selling the merits of 'flexible family friendly working practices within the speciality' is also recommended.

Suggestions are made too on ways of reducing the attrition rate of SHOs. It is argued that trainees need good well varied and supervised posts, and that good role models are important, as is support from older peers and preparation for exams. Feeling safe at work is also an important issue, and the conditions in psychiatric units need improving both for the sake of staff and patients (Griffiths 2002). The Royal College of Psychiatrists is continuing their rigorous inspection of training schemes, and the Department of Health has provided resources to improve the state of in-patient units. Trainees also need to see a future in 'do-able jobs' at the end of their training.

O'Connor & Vize (2003) discuss the difficulties they experience as medical directors recruiting and retaining consultant psychiatrists, and how this is exacerbated by conflicting imperatives from the Royal College of Psychiatrists and the Department of Health. The Avon & Wiltshire Mental Health Partnership reveals a growing number of consultant vacancies. It is suggested that there is a need for more flexibility in terms of recruiting appropriate mental health professionals, rather than having to try and fill consultant posts. It is suggested that the asynchronous development of medical staff at the expense of other mental health workers is wrong. In addition, the artificial ceiling put on recruitment of SHOs is a problem. Since the decision to pursue a career in psychiatry is often made at SHO rather than undergraduate level, they argue that it is vital that we secure SHO expansion, particularly within general psychiatry. In addition, medical students and SHOs being taught need to have good role models who are not exhausted and demoralised.

National Initiatives

There has been considerable activity within the profession to try and address problems of recruitment and retention of psychiatrists. In 2001 a small working group was set up under the joint chairmanship of the National Director of Mental Health, Louis Appleby, and the then Dean of the Royal College of Psychiatrists, Cornelius Katona.

The Recruitment & Retention Working Party was a sub-group of the Mental Health Care Group Workforce Team and the Education & Training Committee of the Royal College of Psychiatrists, with the aim of increasing the number of consultant psychiatrists in England. This group identified problems across the whole career pathway from initial recruitment of medical graduates through to time of retirement of consultants, and has recently produced a report making recommendations for action (DoH 2004a).

These cover the whole career pathway from initial recruitment of graduates into psychiatry through to retirement. Specific suggestions are made on ways of increasing recruitment of medical graduates into speciality training in psychiatry:

- The need to try and identify reasons for the 3-4 fold variation between medical schools in the percentage of students they attract into psychiatry.
- The need to identify, disseminate and support good practice in promoting psychiatry as a career option was emphasised. Suggestions include career fairs, dissemination of booklets, leaflets and videos produced by the Royal College of Psychiatrists, updating Royal College of Psychiatrists' leaflets and the website, promoting good teaching practice, and Royal College of Psychiatrists' awards for medical students.
- Action should be taken to reduce stigma against psychiatry amongst other doctors.
- It should be ensured that psychiatry posts are adequately included in the PRHO year and the new Foundation Year 2. The reform of the SHO grade under Modernising Medical Careers (DoH 2003f) also provides an opportunity to increase numbers of newly qualified doctors taking up psychiatry. The Royal College of Psychiatrists, the DoH and the Lead Dean for Psychiatry need to work together to ensure there are adequate numbers of SHO places.

Further recommendations are made to maximise retention of SHOs and Specialist Registrars in psychiatry by improving their learning and supervision experience, and to retain Non-Consultant Career Grade doctors and consultants, particularly those considering retirement. In addition, proposals are made to improve the recruitment of psychiatrists from overseas.

The Royal College of Psychiatrists provides a central national focus for the advancement of knowledge within psychiatry. It is a centre for research in mental health issues, promotes effective teaching of psychiatry to undergraduates and post graduates, is engaged in work on recruitment and retention within the profession, provides information and aims to foster positive attitudes amongst the public about mental health, as well as advising on policy. The RCP has a dedicated team working on career, recruitment and retention issues,

which has recently expanded. The team has focussed on developing more up to date publicity materials and increased its presence at career fairs for school students considering medicine as a career and also for medical students. Efforts have been made to present a more modern, scientific and attractive image of psychiatry. Information packs for school students and medical students have been developed. Enthusiastic young trainees are recruited to talk with students at careers events.

The Royal College of Psychiatrists has also been a focus for research into the issue of recruitment and retention, including:

- Research into the psychiatric component of medical schools' courses
- Research on stigma amongst doctors in relation to psychiatry
- CIPTAC study by the Royal College of Psychiatrists looking at career intentions and attrition amongst psychiatric trainees.
- Research into public knowledge and attitudes towards common mental health problems – the Changing Minds campaign.
- Research is planned to look at what makes medical school better/worse at recruiting psychiatric trainees.
- The Royal College of Psychiatrists has also been responsible for developing competencies for psychiatric electives in the Foundation year.

There is optimism that the increase in overall places at medical school and also the change in the profile of entrants, may have a positive impact on recruitment into psychiatry (Pidd 2003). There has been no formal evaluation yet of the impact of these changes on recruitment to psychiatry, as these initiatives are still very much in the early stages. Medical Schools: Delivering Doctors of the Future reports on the success of medical schools in expanding the number of training places into medicine and in opening up access to students from more diverse backgrounds than traditional entrants (DoH 2004a). A wide range of initiatives have been developed to widen access, including four year courses for graduate entrants from other disciplines, new foundation years for non-traditional entrants, Foundation Degrees and projects reaching out to local communities who have tended not to apply for medicine in the past. St George's Medical School has developed a new two year Foundation Degree in Health & Medical Science, delivered largely by distance learning, and targeted at people already working in the health service. Peninsula Medical School has developed a selection strategy with a particular emphasis on identifying attributes which will make for caring doctors. The resulting intake is reported to be more diverse than usual (DoH 2004a).

Findings

Local responses and examples of good practice

A scheme has been running in Sheffield for many years now, which provides opportunities for newly qualified doctors to do a mental health elective during their PRHO year. A follow up study of 50 students who had completed this elective evaluated the course well, and revealed that a large number of students had gone on to enter psychiatry (36%) or General Practitioner training (48%). 58% of them felt that their pre-registration experience had influenced their choice of career, and overall the training was regarded as a very positive experience. A number of suggestions are made for improving the posts, including better induction and supervision (O'Dwyer 1999). A similar scheme has also been developed in London (Herzberg et al 2003). Plans for the Foundation Year following the PRHO should provide more junior doctors with the opportunity to do a psychiatric elective following graduation (DoH 2003). Several medical schools have run residential and non-residential summer schools, road shows with local schools and more sustained community outreach initiatives, aiming to kindle interest in medicine amongst young people aged 13-16 years (Bendall 2004 – personal communication). There is scope for psychiatry to increase their profile here too.

Findings from the interviews

What attracts students to psychiatry?

A number of issues were identified:

A small number of medical students are interested from the start. However, experience in the field appears to be a critical factor in influencing the decision to do psychiatry. Some have prior work experience in the field or relevant life experience, this is likely to be more common amongst the increasing number of graduate entrants. Experience in medical school in mental health settings is also very important, and there is evidence that the quality of teaching and charismatic teachers are influential. Good role models, mentorship and support are also important. Those choosing psychiatry like the holistic multi-disciplinary approach to care.

Is there a recruitment problem in psychiatry?

The problem of recruitment and retention of psychiatrists was recognised by all those interviewed. It was acknowledged though that numbers of students entering psychiatry have always been relatively low. However statistics show large variations between medical schools in numbers of students recruited, with some schools being traditionally higher recruiters. The reasons for these differences are not altogether clear, although anecdotally

the quality of the teaching and overall culture of the medical school and the status and standing of psychiatry within the school were felt to be important, as was having good psychiatrists in senior positions.

Factors contributing to the recruitment crisis

There are a number of factors operating at each stage which influence recruitment. Psychiatry has always been seen as something of a Cinderella speciality. It has not been seen as a desirable career option. There is a pecking order in medicine, and psychiatry tends to be looked down on. Students are also likely to be influenced by wider society's views, and the stigma attached to mental illness and the profession of psychiatry. Bad publicity and a poor media image add to the unpopularity of the speciality, and a blame culture is apparent in recent homicide and suicide enquiries. Being a psychiatrist is stressful work, and the stress is exacerbated by impossible expectations from the public. Students may share the public's fears about mental illness. Too many new roles and tasks may put potential recruits off. Arguably insufficient doctors are being trained, even though there has been an increase in medical school places. Also more medical students are women, and it is important to take account of the fact that they are likely not to work for so many years. The increase in medical students will take 12-15 years until they are in a position to fill consultant posts.

Negative attitudes are rife within some medical schools towards psychiatry, and have a damaging effect on student enthusiasm for studying this speciality over a period of time. Some respondents mentioned research which shows that, whilst many students feel quite positively about psychiatry at the start of their career, their interest and desire to pursue it as a career diminishes as students progress through medical school.

Ideas for a Comprehensive Recruitment Strategy

A number of suggestions were made for improving recruitment to psychiatry. A multi-modal strategy was recommended, focussed on the whole career pathway from initial recruitment of medical students, attrition of SHOs to early retirement of consultants. Suggestions for increasing recruitment onto training programmes included:

- Positive role models in the media. Action needs to be taken to decrease the stigmatising of mental health and psychiatry as a profession by the public.
- Psychiatrists need to be proactive both locally and centrally (via the Royal College of Psychiatrists) to promote the career to young students and to older individuals.
- Generally improving promotional materials.
- Opportunities for work shadowing of psychiatrists.

- Getting enthusiastic young trainees to promote the speciality at career fairs.
- Developing promotional material specially targeted at graduate entrants.
- Developing recruitment initiatives for those already working in mental health.
- Increase in medical school places will help - 4 new medical schools by 2005.
- Begin with very young students entering medicine. Need to target students with positive attitudes to psychology and psychiatry, maintain and cultivate interest at medical school. Identifying and nurturing interested students through to SHO posts.
- Developing Special Study Modules in psychiatry and promoting them to students - mentored by enthusiastic Consultants or Specialist Registrars.
- Ensuring that undergraduate experiences are positive. Well organised and well taught psychiatry programmes- appropriate learning outcomes, making it relevant and interesting. Getting across the message that although we may not be able to cure, that major advances in pharmacological and psychological treatments mean that there are now things that we can do to make a difference.
- Ensure that opportunities are created for psychiatric electives within the new Foundation programme.
- Develop more positive attitudes to psychiatry as a speciality within medical schools and amongst doctors. Development of liaison psychiatry services may help.
- At Deanery level, ensuring there are enough placements and good quality supervision. Need an awareness and exposure to a variety of mental health issues during undergraduate training- across the spectrum from prisons to community, children to old age, severe and possibly violent to minor mental health problems. Placements within psychiatry and within general hospitals. Cross regional work with other specialities e.g. paediatrics.
- Integration of mental health issues across the curriculum so students can see its relevance across the board. Want to leave them with the message that mental health is important, that it is about teamwork and that it occurs in many situations.
- Cross fertilisation of experiences, e.g. paediatrics and psychiatry making it easier for doctors to move from one speciality to another.
- Maximise opportunities for flexible training and flexible posts, including at consultant level, encourage recruitment of more women.
- Preventing attrition of SHOs- need good, varied well supervised posts during training, help with exams, mentoring. Now no longer a restriction on how many times the exam can be taken.
- Expansion of SHO numbers. The lack of funding for recently released posts is a major problem in some areas.
- At all levels, need to pay attention to depressing conditions, understaffing, working in unsafe situations with challenging patients, work overload.
- Selling the benefits of family friendly working practices- there are good models in Australia and Canada (Weintraub et al 1999).

Summary of findings

The last few years have seen concerns about rising numbers of vacancies for consultant psychiatrist posts. Numbers of medical students entering psychiatry have always been relatively low. However, there appear to be significant variations between medical schools. Experience in the field seems to be the most critical factor in encouraging recruits to the profession. Charismatic teachers and high quality teaching appear to be important, as are certain personality traits. Reasons for not wanting to do psychiatry include a belief that it is unscientific and ineffective. There is evidence that devaluing and stigmatisation by peers may have a negative impact on recruitment. The Royal College of Psychiatrists and Department of Health Working Party on Recruitment and Retention has suggested a number of strategies to address the problem of recruitment and retention in psychiatry, at a number of key points during a doctor's career. Recruitment may also be positively affected by the overall increase in medical students, by the widening of access and graduate entry schemes in medical schools. The two year Foundation Programme, with options to study psychiatry electives on qualification is also be a positive development.

Findings: 8. Occupational Therapy

OCCUPATIONAL THERAPY

Education and training

Occupational therapists (OTs) undertake a generic pre-registration training that reflects holism and focuses on both physical and psychological care. Programmes are at undergraduate level (full and part-time routes) and candidates apply through UCAS. On completion professional registration is regulated and maintained through the Health Professional's Council. Membership of the College of Occupational Therapists is not obligatory for practice. Programme planners are guided by two key documents; the College of Occupational Therapy Curriculum Framework (COT 2003) and the World Federation of Occupational Therapy Minimum Standards for the Education of Occupational Therapists (WFOT 2002). Neither document stipulates that mental health must be included in training programmes. Currently there are no professional regulatory requirements or national standards to reflect competencies in mental health care. Exposure to mental health teaching and learning rests with individual Higher Education Institutions and the national picture varies considerably. Previously the World Federation specified that fieldwork placements should be divided between physical and mental health (WFOT 1998). These guidelines were revised in 2002 and the new criteria do not specify that any mental health field placements should be undertaken (WFOT 2002). Entry requirements are determined by individual Higher Education Institutions. They tend to specify more academic and vocational qualifications for applicants under 21 years and place more emphasis on experience and accreditation of prior learning for older applicants.

Facts and Figures

The number of commissions to Higher Education Institution courses is identified through workforce planning processes. Mental health trusts provide figures based on projected need normally identified as a result of service developments or staff retirement. These figures are collated as an integral part of the overall commissioned numbers by Workforce Development Confederations who advise on the required number of places for occupational therapy courses in any given year. There are currently no systems in place to ensure that the numbers of occupational therapists identified by mental health services will end up working in mental health. Courses are generic in nature and Higher Education Institutions recruit to numbers and not specialist areas such as mental health. Nationally commissions to occupational therapy have risen steadily and Higher Education Institutions report that recruitment to courses

is not problematic. However the number of overall applications is down significantly and this has been the trend since 1998 (SCMH 2000).

There are currently 20 Higher Education Institutions that offer pre-registration occupational therapy training in England. According to the College of Occupational Therapy there were approximately 2,026 training places available in the UK in 2003.

Meeting the Challenge: A Strategy for the Allied Health Professions (DoH 2000c) highlights workforce planning issues for allied health professionals. This report recommended a 40% increase in the number of training places for occupational therapy. Although key informants suggest that there is no problem recruiting to commissioned numbers, there is reported to be a 10.2% vacancy rate for full time occupational therapists across the NHS, and applications for courses are down by 46% in the last ten years (SCMH 2000).

Issues identified in the literature

Widening access to Higher Education and a commitment to fieldwork opportunities for occupational therapy students in mental health are a priority for all educational providers in the UK (DoH 2000c). The practice of occupational therapy in mental health is changing as a result of government legislation, service developments and the move from institutional to community care. The role and changes for occupational therapy in mental health have recently been investigated by the College of Occupational Therapists. The outcome was the Mental Health Project, which was established with the remit to develop a position paper on the way ahead for research, education and practice in mental health (Craig 1998, Craig et al 1998a and b, 1999, Craig and Austin 2000). The findings, which were derived from surveys and literature reviews stated that, whilst occupational therapy courses continue to attract sufficient numbers of students, there remains a shortage of qualified occupational therapists working in mental health particularly. This finding is supported by Richards (1998) and the problem is worst in urban areas (SCMH 1997).

One of the surveys of 137 occupational therapists working in the UK mental health services identified a number of reasons for choosing to work in the mental health field (Craig et al 1998a). These related to the nature of the work, e.g. variety, diversity, a range of therapeutic approaches being used, opportunity to develop deeper relationships, uncertainty, challenge, creativity and flexibility. They preferred the less formal atmosphere of the working environment and having more autonomy and support. Personal experience of mental health, interest and aptitude were also important factors.

In conclusion, Craik et al (1998a) stress the need to clarify and define the core skills of occupational therapists working in mental health, and then to market and promote the profession. Potential recruits should be made aware of career opportunities within mental health in today's services. Atkinson & Steward (1997) showed that choice of first posts in occupational therapy was influenced by under-graduate and post-graduate education, locality, fieldwork experience and opportunities for professional development.

A further survey of occupational therapy educators and occupational therapists working in the mental health field identified a range of factors which may discourage future practitioners from choosing to specialise in mental health (Craik & Austin 2000). The respondents felt there was a lack of clarity regarding the specific role of the occupational therapist particularly in the community, and that they were often isolated and unsupported. The move towards community care had also meant that there were fewer mental health placements available for students. The drift towards generic working had resulted in fewer good mental health occupational therapy role models. Some respondents felt that their course was too biased towards physical care and 63% of those surveyed felt that their training had been only partly sufficient or wholly insufficient to prepare them for work in contemporary mental health care. In conclusion, Craik & Austin (2000) stressed the importance of good quality, positive mental health placements in avoiding future recruitment problems.

The problems of recruitment and retention in mental health occupational therapy have also been identified in reports for the Department of Health (Lynam and Walker 1999) and the Sainsbury Centre for Mental Health (SCMH 2000). Lynam and Walker's study highlighted a number of issues in the recruitment of occupational therapists including poor response rate to advertisements, difficulties in attracting staff of sufficient experience, a lack of experienced staff in mental health and a trend towards promoting junior staff to senior grades before they had the relevant clinical experience.

The identified variables that influence occupational therapists in applying for a post or remaining in post include:

- The quality of clinical placements (Cracknell 1981)
- Personal and social factors (Phillips et al 1997, Toulouse & Williams 1984)
- Geographical location (Bentley 1985)
- A friendly and supportive department and good working relationships (Bentley 1985)
- Multiprofessional teamwork, further training, support and supervision (Borikar & Goodban 1989)

- Lack of professional status and an unrealistic/changing workload are often cited as reasons for leaving the profession (Greensmith & Blumfield 1998).

A recent systematic review by Hunter & Nicol (2002) looked at whether continuing professional development influenced the recruitment and retention of occupational therapists in mental health. The review of 13 papers that met their inclusion criteria identified that there was little evidence of the influence of continuing professional development on staff recruitment.

The only pertinent research identified that focused on the student experience was that conducted in the USA by Hulse et al (2000). This was a longitudinal study that examined the factors that influenced occupational therapy students' choice of practice placements. At the start of the course, students were influenced by prior volunteering experience or paid work in occupational therapy related fields. After fieldwork experience, all the students rated their experience as influencing their choices. The number of students opting for mental health placements dropped at this point, and the trend was for students without a previous preference to prefer the physical disabilities practice area. The majority of respondents stated a preference to work in the physical disability area on completion of their course. Availability of job was cited as the most influential factor, as were salary and benefits which tend to be better in the field of physical disabilities in the USA.

National initiatives

Seconded training places

There is a growing national trend for Workforce Development Confederations to fund seconded places to courses. This tends to be for part time courses and Higher Education Institutions report that this practice is popular amongst both new recruits and local trusts. Recruits through this route are normally employed as assistants or helpers and have undertaken in house vocational training to gain the entry requirements to professional Occupational Therapy courses.

Opportunities and competencies for mental health occupational therapists

The Northern Centre for Mental Health has commissioned a piece of work which was carried out in conjunction with York St John College. It specifically focuses on the occupational therapy agenda in adult mental health. The work has two strands. The first identifies the mental health competencies for newly qualified occupational therapists exiting training programmes.

Findings

The second explores the current challenges for Senior 1 occupational therapists working in adult community mental health services. Some of the issues raised in the final report are pertinent to the future role of occupational therapists working in mental health. For example, it highlights that there are currently no competency documents stating the skills and knowledge needed by occupational therapists working in mental health and that this is a gap in pre registration training programmes. The report also highlights the important role that educationalists have in influencing the content of training programmes. They need to place a stronger emphasis on the core competencies identified in the report to prepare future practitioners to work effectively in modern mental health services (NCMH 2004).

Modernisation project

The University of Salford in partnership with Cumbria and Lancashire Workforce Development Confederation have developed a two year Foundation Degree that started in February 2004. The course provides a flexible pathway for students who wish to eventually access a professional training course in occupational therapy, diagnostic radiography, podiatry or physiotherapy. Although the course clearly reflects the Department of Health modernisation agenda, it does align occupational therapy with a range of professional groups traditionally associated with physical health care. This may have future consequences for the local mental health workforce in terms of recruitment (www.salford.ac.uk).

Local responses and examples of good practice

There are a number of local initiatives in England that have been developed to enhance the numbers of occupational therapists choosing to work in the mental health field. These include:

- Oxleas NHS Trust in South East London has created a recruitment and retention post specifically to attract occupational therapists to consider a career in mental health.
- Consultant mental health occupational therapists have been appointed in Middlesbrough, Dorset and Gloucester with a future post planned for London. This reflects opportunities for career progression and development and promotes strong leadership for the occupational therapy workforce within an organisation. The College of Occupational Therapy welcomes this development but stresses that more are needed to make any significant impact on workforce development.
- Both Brunel and Southbank Universities offer popular part time courses that are funded by their local

Workforce Development Confederations offering secondment opportunities for Occupational therapy helpers to access professional training.

Findings from the interviews

A number of common themes emerged from the interviews that have clear implications for the recruitment of occupational therapists to the mental health workforce. These are summarised below:

Rotational posts are an integral part of the culture for newly qualified occupational therapists. Historically rotational posts have been across trusts providing the newly qualified occupational therapist with experience in both physical and mental health services. It is during this period that many occupational therapists make their career choice to work in mental health. The reconfiguration of specialist mental health trusts has impacted on the opportunities for many newly qualified occupational therapists to experience mental health practice. Nevertheless this reconfiguration has resulted in bigger clusters of occupational therapists in the mental health workforce and this was viewed as an important factor in recruitment.

Despite increased commissioned numbers and more robust workforce planning, there is no guarantee that mental health services will attract the numbers of occupational therapists required. This is due to the generic nature of the training, the introduction of the Modernisation Project, no specific requirements for programme planners to include mental health field placements in training programmes, and that WDCs commission numbers to courses and do not have ring fenced mental health student places to reflect specific workforce demands.

Good quality mental health field placements are very influential in terms of occupational therapists making a career choice to work in the field. Some students already know that they want a career in mental health from the start of their course and this is either confirmed or not during their training as a result of their experiences in practice. The professional background of the tutors also tends to be influential in how much emphasis is given to mental health in the course.

The key factors that attract occupational therapists into the workforce include strong professional leadership, clear evidence of career opportunities such as joint appointments and consultant posts, opportunities for continuing professional development, and strong multi professional team work. Professional identity is important to occupational therapists. Recruitment tends to be better in trusts where there is strong professional leadership and bigger clusters of occupational therapists working together as a team. This is perceived as leading to more opportunities for accessing continuing professional development and research. Adverts for mental health professional that say the applicants could be either nurses, social workers or occupational therapists are off putting.

There is a general view that occupational therapists are more closely aligned with physical health orientated allied health professionals in both pre-registration training and NHS policy, as opposed to other professions associated with mental health. Occupational therapists often think that they have fewer career choices in the mental health services compared with the physical health environment.

New mental health services, such as Crisis Resolution Services, require staff to work flexible hours. It is part of the occupational therapy culture however to work Monday to Friday 9–5, and opportunities to continue with these traditional working practices are more available in physical health orientated services. As the OT workforce is largely women with family responsibilities, many may wish to continue working office rather than more flexible working hours.

The respondents made a number of suggestions for improving the numbers of occupational therapists opting to work in the mental health field. These include:

- Ring fencing places on occupational therapy courses for mental health services to reflect workforce demands.
- More part-time funded secondment opportunities on training courses for mental health Trusts who have dynamic in-house activity in vocational courses for OT helpers. This should include co-operation and collaboration across MH Trusts.
- OT service heads to work collaboratively to develop rotational posts that go across health communities to include experiences in mental health.

Summary of findings

Occupational therapy courses are generic and there are currently no professional regulatory requirements or national standards to ensure that mental health practice placements are included in training programmes. The emphasis placed on mental health issues rests with individual Higher Education Institutions and possibly on the particular interests of the teaching staff.

Consequently many students feel inadequately prepared to work in the mental health field when they have qualified. This situation should improve once the Ten Shared Capabilities for all staff (NIMHE 2004), the National Continuous Quality Improvement Tool for Mental Health education (NCMH/NIMHE 2003), and the Opportunities and Competencies for Community Mental Health Occupational Therapists (NCMH 2004) begin to influence the future commissioning of courses by the WDCs.

Whilst occupational therapy courses continue to attract sufficient numbers of students, there remains a shortage of qualified occupational therapists working in mental health. Those who do choose to work in the field value the variety and diversity of the work, the opportunity to

use a range of therapeutic techniques, the chance to develop relationships with clients, and the friendly and supportive atmosphere. Staff are positively influenced by good quality practice experiences in mental health, personal experience of mental health problems, supportive relationships with their peers, and strong professional leadership.

Rotational posts are an integral part of the culture for newly qualified occupational therapists. Historically rotational posts have been across trusts offering experiences in both physical and mental health services. It is during this period that many occupational therapists make their career choice to work in mental health. The reconfiguration of specialist mental health trusts has impacted on the opportunities for many newly qualified occupational therapists to experience mental health practice. The reconfigurations have however resulted in bigger clusters of occupational therapists in the mental health workforce and this is viewed as an important factor in their recruitment and retention.

Despite increased commissioned numbers and more robust workforce planning, there is no guarantee that mental health services will attract the numbers of occupational therapists required for service developments and workforce needs. This is largely due to the generic nature of the training, that there are no specific requirements for programme planners to include mental health placements in training courses, and that WDCs commission overall training numbers to courses and do not have ring fenced mental health student places to reflect specific workforce demands.

Conclusions

PART THREE: Conclusions

CONCLUSIONS AND RECOMMENDATIONS

Mental health services are undergoing substantial change. There has been a major re-structuring of NHS and social care infra-structures, major reforms in mental health care, expanded and improved mental health services, and significant financial investment in health and social care. Workforce issues represent the most significant challenge to the implementation of the NSF and the NHS Plan as there is a need for increased numbers of staff with enhanced skills and competencies in order to deliver the new agenda. There are major problems with the recruitment and retention of mental health staff in some regions and the situation is worse in inner city areas. There are concerns about the ageing of the existing workforce, high levels of stress and low morale amongst mental health staff, and the impact of new Mental Health Bill on the recruitment and retention of professional staff.

The problems of recruiting and retaining mental health staff are reflected in the rest of the public sector in the United Kingdom and in other Western countries. Factors affecting recruitment and retention include workload, long hours, staff shortages, inadequate resources, low status of work, lack of role clarity, violence and pressure of work. There are a number of national initiatives to attract staff into the NHS, including efforts to recruit black and ethnic minority workers, refugees, people from the local community, mental health service users, and mature entrants. The particular issues facing social work, psychiatry, occupational therapy, clinical psychology and mental health nursing are summarised below

Social Work

The move to undergraduate or postgraduate social work courses took place in September 2004. About 20% of students in 2001-2 were on employment-based routes, and these remain an important source of recruitment. The social work course is generic (although there have been opportunities in the past to specialise in mental health within basic training). Teaching prepares students to meet the National Occupational Standards for Social Work. There are options to do a mental health placement and to work in mental health on qualification. There is a body of opinion which feels that the current generic training does not prepare students adequately for mental health social work and that it may be sidelined as a speciality area. After two years experience and completion of post qualification training in the form of PQ level 1, social workers can be nominated by their employing authority to do the ASW qualification,

which prepares them to take on a statutory role under the Mental Health Act. It is the responsibility of the local authority to ensure that they have adequate numbers of ASWs.

There is little precise information on numbers of social workers in training or working in the field, as until recently, there has been no central and co-ordinated system of data collection. The GSCC is currently in the process of establishing a register of all the social care staff (qualified and unqualified) in the country. However, this is a daunting task, considering the large numbers of staff and the variety of settings in which they work. Not all those with the ASW qualification are actually practising in a mental health setting.

There are problems with recruitment and retention in some areas. High vacancy rates and turnover of MHSWs and ASWs have been identified particularly in London, but similar problems are reported in other parts of the country. Social work is in a time of great flux, with local authorities being disbanded and new agencies being reconfigured, with an emphasis on partnership working. Mental health social workers are increasingly employed by or seconded into NHS Trusts or work in integrated Trusts. There are fears that the move to health dominated teams may mean professional isolation and a de-valuing of the social perspective in mental health care, which may have implications for recruitment. There are also concerns that there will be insufficient numbers of ASWs to carry out the legal requirements of the new Mental Health Act. There is evidence of low morale amongst MHSWs and ASWs due to heavy workload and being 'bogged down' with legal responsibilities. Much of the therapeutic work they used to do has been taken over by other professionals. The lack of a career structure and professional leadership are felt to be contributing factors.

There have been concerns too about a drop in the overall number of social work applicants. The past few years has seen a concerted effort by the Government to increase the number of applicants through an advertising campaign. Innovative local strategies include distance learning programmes, flexible and part time courses, efforts to recruit local people, job fairs, and secondment of unqualified staff.

The poor public image of social work is likely to impact on recruitment. Mental health social work may be doubly stigmatised. Experience in mental health settings prior to or during training is felt to be the most influential factor in attracting newly qualified social workers into mental health. However there is a shortage of placements and practice supervisors in mental health settings. The transfer of mental health social work to health dominated multi-disciplinary teams within the NHS may exacerbate this problem. The Practice Learning Taskforce is working to increase the number and variety of practice placements for students doing the new degree in social work.

Recommendations

- A proactive stance needs to be taken to both recruitment and retention of mental health social workers and Approved Social Workers that brings together key stakeholders to develop national and local strategies.
- Experience seems to be the critical factor in encouraging people to take up a career in mental health. More opportunities for work experience, paid and voluntary work in mental health services both within the statutory and the voluntary sector need to be made available and promoted.
- The shortage of placements for social work students in mental health services also needs addressing. Collaborative work between Higher Education Institutions, service managers and the Practice Learning Taskforce is important in developing a supply of high quality placements and adequate numbers of practice teachers to support them.
- Mental health needs to have a high profile within social work courses and to be promoted as an innovative and interesting area of work. Social work courses need to offer specific modules on mental health issues, as well as integrating it throughout the curriculum, with teaching input from inspiring practitioners and also from service users.
- Increased opportunities need to be provided for flexible and part time training. Social services agencies need to do more to encourage and support social care workers from mental health areas onto training programmes.
- The transition to the NHS needs to be carefully handled, with efforts to ensure that the social perspective is valued and to prevent professional isolation of social workers. Efforts need to be made to promote and develop the role of mental health social work in social interventions and promoting social inclusion. Professional groups at national and local level, such as the Social Perspectives Network (SPN) and the Approved Social Work Interest Group (ASWIG) have an important role in providing mutual support and a sense of professional identity for mental health social workers.
- There is a need for more accurate data on recruitment and retention of mental health social workers and Approved Social Workers nationally to enable accurate workforce planning. There is also a need for research to establish the quantity and quality of mental health teaching in social work courses nation-wide, issues relating to obtaining placements, examples of good practice in attracting students into the mental health field, career destination studies and exploring barriers to working in this field.

Psychiatry

All medical students gain some theoretical and clinical experience in psychiatry during their training in order to meet the GMC competencies. Although guide core curricula have been developed for psychiatry, individual Schools are relatively autonomous with respect to exactly what is taught and for how long. There have been radical changes to the pre and post registration training of doctors in recent years, and more are yet to be implemented. These include a substantial reduction in core teaching, the introduction of Special Study Modules, which allow for elective study of areas of interest, and a growth in problem based and self directed learning. The Post Registration House Officer experience will increase from one year to two, with opportunities to do electives in psychiatry in some places. Post-graduate medical education is becoming more structured, with curricula based on UK wide standards and competency based assessments. There will be greater flexibility and careers advice.

There has been considerable concern recently about recruitment and retention in psychiatry, with high vacancy rates for consultant psychiatrist posts. There are fears that the number of medical students choosing psychiatry is insufficient to replace the number of consultants leaving. The process of becoming a consultant psychiatrist is arduous involving lengthy post-graduate training, and there are high attrition rates at various points along the way. Work on recruitment and retention therefore needs to focus on the whole career pathway.

A wide range of activities have been undertaken within the profession to address the issue of recruitment and retention in psychiatry, led nationally by the Recruitment and Retention Working Party, under the auspices of the Royal College of Psychiatrists and the Department of Health. The past five years has seen a Government initiative to substantially increase the number of medical school places, with the formation of a number of new medical schools in England. Targets to increase the number of new students were reached a year ahead of schedule. As part of this drive considerable efforts have been made to widen access to medicine, with the recruitment of mature students, people from ethnic minority groups and non-science graduates. It is hoped that these changes may have a positive impact on recruitment to psychiatry. Innovative programmes include two year foundation courses, opportunities for staff within the NHS and four year graduate entry programme courses. The Royal College of Psychiatrists has done a lot of work at careers fairs and in schools.

Conclusions:

There are markedly different rates of recruitment into psychiatry between different medical schools and the Royal College of Psychiatrists Recruitment and Retention Committee has recommended that research is conducted into this issue. Medical students are attracted to psychiatry for a number of reasons, most notably having experience in the field either during or prior to training. Social background and personality characteristics also seem to be important such as being liberal, reflective and tolerating ambiguity. A high percentage of medical students display negative attitudes to psychiatry, seeing it as chronic, unresponsive, ineffective, unscientific and of low status. Although psychiatry may be quite popular early on during training, students appear to lose interest in it as a career option as their course progresses. Negative attitudes in medical schools as well as in society at large may have an impact. Whilst placement experience and charismatic role models are important, there needs to be positive attitudes towards the speciality within medical schools. The quality of teaching has a significant impact on whether or not students elect to do psychiatry. Research is underway to explore variations in terms of content and how psychiatry is tackled in different medical schools. Problem based learning does not seem to negatively affect attitudes to psychiatry. Poor quality environments, lack of resources and low morale amongst existing staff impact on recruitment to psychiatry. Negative opinions about mental health and psychiatrists in the media may be influential, as may fears of public recriminations. The growing emphasis on a coercive role, particularly under the proposed new Mental Health Act, and the consequent limiting of a therapeutic role is also an issue.

Recommendations

- Recruitment and retention initiatives should focus on the whole career pathway. Students with an interest in psychiatry should be targeted, and their interest maintained and cultivated. There are various 'nodal points' which require particular attention to attract students and also to prevent wastage.
- The Royal College of Psychiatrists provides a vital focus for advancing knowledge in psychiatry, promoting positive attitudes and also acts as a centre for research and sharing ideas about teaching. It has recently expanded its team of staff working on recruitment and retention, which has developed promotional material, information packs and promotion of the speciality at careers fairs. This expertise should be capitalised on by Medical Schools, sixth form colleges and schools.
- The widening of access to medicine to attract more mature students with work experience and those with non-science backgrounds is welcomed as potentially increasing future numbers of psychiatric trainees.
- Opportunities for medical students to gain experience in mental health settings should be maximised via Specialist Study Modules, in the new Foundation programme and by integrating psychiatry with other aspects of the curriculum.
- Training experiences in psychiatry need to be of high quality and well supervised. Charismatic role models are important in inspiring interest in the subject. It is important too that a culture is fostered within Medical Schools where psychiatry is afforded high status and a positive image.
- Research is needed to look at different recruitment rates into psychiatry from different medical schools and the influencing factors.

Occupational Therapy

Occupational therapists undertake a generic pre-registration training at undergraduate level. There are currently no professional regulatory requirements or national standards to ensure that students receive a mental health placement during their training. Although courses do include some teaching about mental health issues, the extent to which this is done rests with individual Higher Education Institutions and in many cases with the interest and expertise of the teaching staff.

Courses for occupational therapy are currently oversubscribed although there has been a fall in the number of applicants in recent years. There are no systems in place to ensure that a given number of occupational therapists are employed in mental services on completion of their course. There remains a shortage of qualified occupational therapists working in mental health nationally.

There are a range of factors which may discourage occupational therapists from choosing to work in the mental health field. These include a lack of clarity regarding the specific role of the occupational therapist particularly in the community, fewer mental health placements available for interested students, a scarcity of good role models, few large clusters of occupational therapists working together with the resultant loss of a professional role identity, and feeling that their training had inadequately prepared them for the work. Occupational therapists working in mental health value the informal working atmosphere, the autonomy and the opportunity to develop therapeutic relationships with clients.

There are some national and local recruitment initiatives but compared to those that have been done in psychiatry, social work and nursing they are fairly limited.

Recommendations

- The Health Professional's Council should consider making recommendations that all students should have the experience of working in at least one mental health placement during their training. Recommendations could also be made about the type and amount of mental health teaching that needs to be included in the course. This should reflect the key documents that have recently been published including the Capable Practitioner (SCMH 2001), the National Continuous Quality Improvement Tool for Mental Health Education (NCMH 2003), the Ten Essential Shared Capabilities (NIMHE 2004), and the Opportunities and Competencies for Community Mental Health Occupational Therapists (NCMH 2004).
- Workforce Development Confederations and Higher Education Institutions need to work together to find a way of ring fencing a dedicated number of mental health training places on occupational therapy courses to reflect mental health workforce demands.
- Workforce Development Confederations, Higher Education Institutions and mental health trusts need to consider ways of increasing the full and part-time funded secondment opportunities for staff interested in training as occupational therapists and then returning to work in the mental health service.
- There needs to be an increase in the number of rotational posts that go across health economies to ensure that newly qualified occupational therapists gain experiences in mental health.
- Mental health services, Workforce Development Confederations and Higher Education Institutions need to actively pursue the development of more joint appointments to promote the profile of mental health in training programmes.
- Mental health trusts should consider ways of ensuring that occupational therapists working within their service retain their professional identity.

Clinical Psychology

The clinical psychology course is a postgraduate programme at doctoral level and usually takes up to four years to complete as a full-time student. The 25 courses are heavily oversubscribed and approximately 1000 students per year do not gain places, although many are successful in subsequent years. The pass rate for courses is high and the attrition rate low. Although working in adult mental health services is a popular choice for graduates, there are difficulties in filling vacancies and concerns about the shortage of clinical psychologists in mental health services generally. Precise figures for numbers of clinical psychologists working in mental health and the vacancy levels are difficult to ascertain. The figures from a range of sources refer to clinical

psychologists generally rather than those working in mental health specifically.

A detailed survey of the psychology workforce has recently been commissioned by the British Psychological Society (Lavender et al 2004). Whilst this does not specifically relate to mental health, it does contain recommendations regarding recruitment to the field. The profession is also considering ways of attracting applicants from more diverse backgrounds to ensure a more representative workforce for the future.

Recommendations

- There are differences in the way workforce data are recorded and utilised nationally. There needs to be a consistent approach and agreement amongst key stakeholders for determining future workforce planning needs.
- Clinical Psychologists should be included in discussions about workforce planning issues at both a national and a local level.
- There needs to be greater collaboration and partnership working between Workforce Development Confederations, primary care trusts and mental health organisations across the country to ensure priority areas for psychological services are recognised and then informs workforce planning.
- Further work is needed to explore the workforce, professional and financial implications of developing the Assistant/Associate psychologist role as a national initiative.
- Further work is required nationally to consider the available career opportunities and retention of the 1000 applicants who are unsuccessful each year in accessing clinical psychology training courses.

Mental Health Nursing

Mental health nurse training can be undertaken at diploma, undergraduate or postgraduate level. Although most of the training is undertaken in mental health settings and focuses on mental health issues students share a Common Foundation Programme with students undertaking the other branches of nursing (adult, child and learning disabilities). Access to programmes is through NMAS for diploma courses and UCAS for undergraduate courses. Many Schools also accept direct applicants usually from Colleges of Further Education or seconding trusts. The Nursing and Midwifery Council currently sets minimum requirements for entry to courses although this is currently under review.

There are problems with recruitment to mental health nursing courses nationally, although the picture is mixed. The courses in London and the south of England are oversubscribed and Schools generally meet their commissioned numbers.

Conclusions

The situation in the midlands varies with one large School experiencing considerable problems recruiting students despite having a high number of applicants. Schools in the north of England have the greatest difficulty in recruiting sufficient numbers. There is little evidence to support the commonly held view that poor recruitment is a result of over zealous short-listing using inappropriate criteria, candidates being interviewed and then rejected by non-mental health lecturers, or of Schools setting academic requirements above the Nursing and Midwifery Council minimum standards.

It is difficult to find precise figures for the shortfall in recruitment to mental health nurse courses. The NMAS figures suggest a shortfall of 916 diploma students in 2003. This figure however does not take into account the large number of students that Schools accept as direct applicants in addition to those recruited via NMAS. The UCAS statistics does not give figures for nursing specifically so the numbers of students on undergraduate courses is unknown. Some Schools are reluctant to divulge sensitive information about their recruitment and attrition figures.

There is a wealth of literature on the problems of recruitment to mental health nursing. Experience in the field of mental health either prior to the course or as part of their training seems to be crucial in influencing people to choose this as a career. Other factors include personal experience of mental health problems; being older; and having an interest in human behaviour, psychology and psychiatry. Mental health nursing is perceived as more challenging than the other branches of nursing and offers autonomy, the scope to be creative and an opportunity to develop long-term and meaningful relationships with clients. People are dissuaded from considering mental health nursing because of the stigma associated with mental health work; a perception that the work is boring, depressing, slow paced and unrewarding; and the fact that it is not regarded as 'real nursing'.

There are a number of national and local initiatives that have been developed to improve recruitment into mental health nursing and there is considerable evidence to suggest that the Department of Health, the Workforce Development Confederations, the mental health trusts and the wider community are working hard to resolve some of the difficulties. Some of these initiatives are striving to attract those from non-traditional sources such as school leavers, black and ethnic minority groups, people from local communities, service users, mature students and refugees. Many Higher Education Institutions have also made great efforts to improve recruitment and there are several examples of excellent practice. Rather than repeat many of the previous recommendations and examples of good practice

highlighted in this report, the following recommendations focus on a few key issues.

Recommendations

- Public awareness of mental health problems and the services provided needs to be raised. It is important that the images portrayed are accurate and informative and attempt to reduce stigma. Mental health nurses need to make their role and functions more public.
- Opportunities for paid and voluntary work within mental health care need to be expanded as a way of dispelling myths and promoting interest in the field. More opportunities for work experience from schools and colleges need to be facilitated.
- Efforts need to be made to maximise interest in mental health amongst a wide audience. Recruitment campaigns need to differentiate mental health nursing from other branches of nursing. Mental health nursing needs to shed its 'institutional, middle-aged' image, and to be marketed as a 'non-institutional, autonomous, varied and dynamic occupation'.
- Workforce Development Confederations and mental health trusts should consider ways of increasing the numbers of staff that could be seconded to undertake their mental health nurse training. Many Higher Education Institutions and the Open University offer flexible training programmes that can accommodate students with family and caring responsibilities. Higher Education Institutions also need to review their AP(E)L arrangements. If these were robustly and universally applied this could reduce the length of training thus lowering costs and providing qualified nurses more quickly.
- Further research needs to be undertaken to gather accurate figures on recruitment to mental health nursing courses. Such research should include recommendations of how such figures could be collated centrally for the use of future workforce planning

Final Comments

Although we have discussed and made recommendations regarding recruitment to each of the professions separately, a number of common themes have emerged from the literature review and our discussions with a wide range of informants. There remains a pressing need to attract students to train as mental health professionals by cultivating and then maintaining their interest. Students who are attracted to the field are often older with past work experiences. A personal experience of mental health problems or contact with the services through employment or as a volunteer is often a key factor in generating interest in the area.

Many of our informants were enthusiastic and passionate about mental health and there was a strong desire to pass this on to a new generation of workers. The impact of high quality teaching and supervision, and inspirational and charismatic role models cannot be underestimated.

There is a need to address the stigma against people with mental health problems and to dispel myths about the nature of mental health work. For example, the commonly held view that the work is unscientific, depressing and that mental health problems cannot be treated. Mental health work needs to be promoted as interesting, innovative and dynamic.

There is considerable activity being undertaken to address the current recruitment problems. Although we have attempted to highlight many of the initiatives, there is a need for much more dissemination of good practice both within and between the professional groups. Finally there is a pressing need for robust and easily accessible systems of data collection on recruitment to aid future workforce planning.

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APPENDIX A

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Recruitment to Mental Health Professions Study

APPENDIX B

RECRUITMENT TO MENTAL HEALTH PROFESSIONS STUDY

Question Guide for National Contacts

Introduction to the Study

We are undertaking a national study on behalf of Trent NHS Workforce Confederation funded by the Department of Health on recruitment to mental health professions. The study focuses on recruitment at point of entry to the five key professional groups who work in mental health, i.e. nursing, social work, psychiatry, occupational therapy and psychology.

We hope to gain some insight into the views of some key informants nationally, from each professional group, on this issue. We would appreciate it if you would be willing to act as an expert informant for the study, and provide us with some information and ideas on this subject.

We are interested in a number of different aspects:

- a. when and how individuals are recruited to mental health within each profession
- b. whether recruitment to mental health is a problem in your field/generally and if so, what you see as the factors contributing to this problem
- c. ideas on strategies for improving recruitment to mental health
- d. knowledge of any work being done to improve recruitment to mental health in your field/generally, and any other useful contacts you could suggest.

Question Guide

- Can you begin by talking through the process involved in a new entrant to (nursing/medicine/social work/occupational therapy/psychology) becoming a qualified mental health professional.
- What qualifications/other criteria are required on entry?
- When and how do students make the choice to enter mental health?
- What theoretical and practical experiences will they have during their professional training in the field of mental health? Will any of this be prior to making the choice?
- Are these experiences dictated by national professional standards/guidance or are they left to the discretion of local Higher Education Institutions?
- Do you feel that recruitment into mental health is a problem in your particular field/generally)?
- If there is a problem with recruitment to this area of work, what are the factors that you think contribute to this?
- What do you see as the key elements of a cohesive and comprehensive recruitment strategy to mental health in your field/generally?
- We are interested in hearing about any examples of good practice nationally or locally where efforts have been made to recruit students to work in mental health within your professional field/generally?
- Can you talk about any specific work on recruitment/projects that you have been/are involved in?
- Are there any other people or organisations that we should interview?
- Any other comments on this issue?

Thank you for your help

Appendix C

Good Practice Examples

Title of Project

Contact details

Name of project coordinator:

Address:

Telephone:

Email:

Why was the project initiated?

Description of the project
*(project aims, how long it has been running,
numbers of students involved)*

How successful has the project been?

Have there been any difficulties with the project?

Is there any formal/written evaluation of the project?
If so please obtain details

Any other relevant information

The Recruitment of NHS & Social Care Mental Health Staff

Appendix D

What and where exactly are the problems in Schools of Nursing?

Name of School:

Name and job title of informant:

Titles of pre-registration mental health courses,
e.g. diploma, degree, shortened courses etc:

What are the admission criteria for the above courses?

Are the admission criteria above the minimum required
by the profession for the diploma course?
If yes, what are they?

Do you actively recruit potential mental health
branch students? If yes, how?

What criteria are used to shortlist mental
health candidates?

Who is involved in the short-listing of mental
health candidates?

*(recruitment administrator, mental health lecturers,
non-mental health lecturers)*

Who interviews the mental health candidates?

What criteria are used to accept or reject potential
mental health candidates at interview?

Why potential mental health candidates rejected?

(Is a record kept of this?)

Appendix D

What happens to those that are rejected?
Are they given advice, feedback and an opportunity to reapply?

What efforts are made to attract students from traditionally marginalised groups such as those with dependants (children, elderly relatives etc), those with disabilities (physical and mental health), and those from black and ethnic minority communities?

Are overseas students accepted onto mental health nursing courses? If yes, what are the funding arrangements?

Identify any examples of good practice in selection and recruitment.

For each of the pre-registration mental health nursing courses identified can you please give us the following information for 2003:

How many mental health training places were there?

How many mental health candidates applied?

Were all the places filled? If not what was the shortfall?

How many candidates were rejected at the short-listing stage?

How many were then rejected at interview?

What are the attrition rates to date for the 2003 mental health branch intakes?

Data on recruitment to mental health nursing courses, 2003 entry

Appendix E

School	No of contracted places	No of applicants	Shortfall	Rejections at short-listing	Rejections at interview	Attrition
London & South						
School 1	50 diploma 10 post-reg diploma	168	8	No data	No data	2 students
School 2	66 diploma 8 degree	No data – diploma 12 degree	No data diploma 3 degree	No data	No data diploma 4 degree	No data diploma 3 degree students
School 3	No data	No data	No data	No data	No data	No data
School 4 (London)	22 degree 78 diploma	50 degree 583 diploma	No	190	100 plus student withdrawal	5%
School 5 (London)	70 (total)	361	3 students over	182	51	0.03%
School 6 (London)	110 (total)	500	No	No data	No data	45/220 students in past, no data for 2003
School 7	No data	No data	No data	No data	No data	No data
School 8 (London)	166 centre a 29 centre b	482 centre a 289 centre b	3 over centre a 1 over centre b	147 centre a 204 centre b	58 centre a 29 centre b	6% centre a 0% centre b

Data on recruitment to mental health nursing courses, 2003 entry

Appendix E

School	No of contracted places	No of applicants	Shortfall	Rejections at short-listing	Rejections at interview	Attrition
Midlands						
School 9	69 (total)	140	4	30	Few rejections, 10% non attendance	6%
School 10	174 diploma 10 degree	382 diploma 2 degree	29 diploma 10 degree	99 diploma (61 did not meet residency requirements)	30 plus student withdrawal & non attendance	May 15%, Sept 8%
School 11	40 diploma 25 degree	No data	No data	No data	No data	No data
School 12	No data	No data	No data	No data	No data	No data
School 13	50 diploma 15 degree	92 diploma 19 degree	0 diploma 4 degree	No data	No data	No data
School 14	No data	No data	No data	No data	No data	No data
School 15	108 (total)	No data	0 diploma No data-degree	No data	No data	No data
School 16	47 (total)	175	No	126	2	No data
School 17	104 (total)	No data	3 over	No data	No data	1 student

Data on recruitment to mental health nursing courses, 2003 entry

Appendix E

School	No of contracted places	No of applicants	Shortfall	Rejections at short-listing	Rejections at interview	Atrition
North						
School 18	220 (total)	No data	25	No data	No data	No data
School 19	100 (total)	223	30	26	12	6.06%
School 20	64 diploma	176	No	55	57	8.1%
School 21	29 diploma 5 degree	69 diploma 40 degree	4 (total)	14 diploma 6 degree	13 diploma 12 degree	2 diploma 1 degree
School 22	120 diploma 12 degree	435 (total)	7 diploma 4 degree	248	38	5.1% diploma 4.6% degree
School 23	127 diploma 20 degree	242 diploma 117 degree	30 diploma 0 degree	90 diploma 50 degree	8 degree 8 diploma	2 diploma students
School 24	60 diploma 10 degree	136 diploma 19 degree	5 diploma 0 degree	30 diploma 2 degree	3 diploma 2 degree	33% diploma 20% degree
School 25	58 (total)	172	2	50	17	10%



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