The Health Foundation's response to the DHSC mental health and wellbeing plan call for evidence survey

July 2022

About the Health Foundation

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

About this submission

The Health Foundation's analysis on mental health focuses on two key themes – NHS services and upstream prevention. The Health Foundation also funds a wide range of projects that aim to support improvements in mental health services and transform the models and approaches used to deliver care, making them more integrated and person-centred. We have only responded to questions where we have supporting evidence from our analysis and funded projects.

Chapter 1 - Promoting positive wellbeing

Do you have any suggestions for how we can improve the population's wellbeing?

b) Children and young people

The years between 12 to 24 are a critical time in life, as it is a period of rapid brain development, growth and adaptation. The Young people's future health inquiry was set up to explore young people's ability to secure a healthy start in life. The inquiry identified the core building blocks of health: a place to call home, secure and rewarding work, and supportive relationships with their friends, family and community. Being able to access these building blocks promotes good health for young people both now and later in their life.

The inquiry identified specific policy issues which can affect young people's ability to secure a good start in life, working with expert policy organisations to make recommendations in this area. These included:

- Challenges in the school and college environment, such as 'teach to test' culture, which can lead to student wellbeing becoming a lower priority
- Extensive cuts to youth services, which support young people to develop emotional skills and build trusting personal connections with peers and youth workers

- Erosion of the financial safety net for families and young people, which limits the financial and practical support available
- An increasingly insecure rental housing market, particularly for young people excluded from social housing, priced out of home ownership and lacking parental support
- And rising levels of insecure and atypical work, which hinders young people's ability to reach their career aspirations and has considerable effects on their wellbeing.

It is likely that policy interventions across these areas would improve the wellbeing of young people both now, and in a way which would safeguard their wellbeing in the future. This section will focus on the role of education settings and youth services for promoting wellbeing amongst children and young people.

Education and wellbeing

Research by the Centre for Mental Health, commissioned by the Health Foundation, highlights that the wellbeing of school-aged children in the UK is lagging behind other wealthy countries. Education settings play a significant role in shaping young people's mental health: they are not only the first port of call when young people need help and advice for their mental health, but with a significant proportion of their time spent in educational settings, their experience in this environment has a significant effect on their mental health. Low levels of emotional wellbeing may contribute to a range of negative outcomes for learners if left unaddressed, including poor attendance, low attainment, truancy, school refusal, behavioural difficulties and school exclusions.

The Centre for Mental Health report identified the following factors within educational settings that influence young people's wellbeing:

- relationships with staff and peers,
- ability to access mental health support,
- academic pressures,
- transitions between educational stages,
- and opportunities for life skills development and to take part in creative arts.

Educational settings can therefore provide protection against poor mental health, such as creating feelings of connectedness and belonging in school, or they can contribute to poor mental health where young people are exposed to risks such as bullying and academic pressure.

A safe school environment is central to young people's mental health. Adopting a 'whole school approach' to mental health and wellbeing can address many of these challenges, ensuring that wellbeing is embedded across all aspects of school policy, culture, curriculum and practice. In practical terms, this means working with senior leaders in schools and colleges to recognise the value of wellbeing and for schools to be rewarded for their effective approaches to pupil wellbeing, promoting the wellbeing and development of staff to ensure they can perform to the best of their ability, working with parents and carers to support young people's wellbeing, and providing targeted support for young people with particular needs (such as children in care).

UK Education Departments must also play a role in improving wellbeing, including reviewing the impact of the exam system on the mental health of young people, placing health education on a statutory footing, and boosting access to creative and cultural education.

Children and young people's wellbeing should also be considered as part of monitoring for educational settings, not just attainment and performance. Good examples of where this is being done already includes the #BeeWell project in Greater Manchester, which uses a subjective wellbeing framework for children and young people developed by the What Works Centre for Wellbeing. The project identifies groups of young people in school that are more likely to experience lower wellbeing and key areas for action across schools in the city. The DfE and DHSC should work together to make data collection of young people's wellbeing in schools across the UK routine.

The role of youth services in promoting wellbeing

Youth services support good mental health and wellbeing amongst children and young people by enabling them to develop important social and emotional skills that can provide protection against poor mental health later in life.

Research by the Centre for Youth Impact demonstrate the wide-ranging impact that youth services have on young people's wellbeing, including:

- Providing young people with the opportunity to recognise healthy relationships and develop these with their peers, youth workers and wider community
- Offering spaces for young people to develop their social and emotional skills alongside access to emotional support and practical resources
- Targeting support at young people most in need, as well as offering open access to support for young people who may be less likely to access it directly due to perceived stigma
- Delivering services that are centred on young people's needs and supports them as they develop.

Research using the National Child Development Study found that participation in Guides or Scouts was associated with better mental health and narrower mental health inequalities at age 50. This is in part associated with the 'Guide and Scout approach', where young people are encouraged to develop social relationships, be outdoors and physically active, and develop non-cognitive skills that support good mental health in adulthood.

However, recent analysis by the YMCA demonstrates that youth services have experienced a significant decline of funding: from £1.4bn in 2010/11 to £429m in 2018/19, a real terms decline of 70%. The government must recognise the importance of youth services in supporting young people's mental health and deliver long-term investment for the sector, by reinstating and ringfencing youth service funding to 2010/11 real terms levels.

d) Older adults

Analysis of five large ongoing studies in older people show that keeping physically fit is associated with having higher positive mental wellbeing over the next 5-10 years.

Complementary qualitative work in a sample of the same people highlighted “slowing up” and “being less able to do things” as perceived disadvantage of ageing, and also that physical decline was linked to “withdrawal of respect and of being treated as a fully paid-up member of society”. This indicates that supporting people to maintain their physical functioning could have benefits for their mental wellbeing (as well as their risk of physical disease and risk of mental ill health).

Chapter 2 - Preventing the onset of mental ill-health

What is the most important thing we need to address in order to reduce the numbers of people who experience mental ill-health?

Please provide your suggestions in relation to different groups:

b) Children and young people

The impact of the pandemic on young people’s mental health
The COVID-19 pandemic saw some of the worst declines in mental health amongst young people compared to other age groups. Some of the reasons for this include loneliness where young people were no longer able to see friends and family due to social distancing, through to missed learning opportunities from school closures and job insecurity where sectors such as hospitality and retail had to shut down.

The COVID-19 Impact Inquiry found that young people experienced worse mental health outcomes compared to the general population, with higher prevalence of psychological distress amongst 18-24 year olds (44%) compared to all adults (30.6%) in April 2020. Recent analysis from the Office for Health Improvement and Disparities further shows that the psychological impact was not felt evenly amongst this age group. In 2020, young people living in the most deprived areas of the UK experienced increases in psychological distress 3.4 times larger than those in the least deprived areas.

The £17 million funding for mental health support in schools and colleges, announced by the Department for Education, is a welcome step towards improving access to support for young people. In addition to this, the recent £3 million funding commitment from the Department of Health and social Care to address gaps in student mental health services is also welcome. However, the funding does not go far enough to address the urgent situation facing young people in the wake of the pandemic. As part of the COVID-19 mental health and wellbeing recovery action plan, the government should ensure education providers are able to signpost young people to specialist mental health services and that young people are able to access appropriate support in a timely manner.

c) Working age adults

Debt and financial insecurity
The ongoing cost of living crisis has serious long-term implications for health, as families face the biggest squeeze on their living standards in year. The Joseph Rowntree Foundation has highlighted that the basic rate of social security in 2022/23 will be the lowest since 1982, whilst inflation is at a 40-year-high. People who are in

financially insecure situations are likely to experience increased stress during this time and are likely to take on more debt to make ends meet, which can further exacerbate stress.

Young people are more vulnerable to financial insecurity, as they are more likely to be engaged in insecure employment and may have accumulated less resources to weather financial shocks. Recent research by the RSA found in a survey of young people that 47% were in a precarious financial situation – with 61% of this group worried about their mental health. The survey also found that of the young people in work, 51% experienced financial precarity, with only 32% reporting that work provides them with enough money to maintain a decent standard of living. Of this group, 19% also reported that they sometimes have trouble meeting their basic living costs because their income varies each month.

Debt is also a key issue that affects people's mental health, where individuals experience worsening mental health where they have problems with the size of their debt or scale of their repayments. If someone's health or employment circumstances change, it can make people's ability to cope with existing debt even harder or lead to people taking on new debt.

Health Foundation analysis shows that 20% of people in problem debt in Great Britain report 'bad' or 'very bad' health, compared with 7% of those not in problem debt. Moreover, the Money and Mental Health Policy Institute found that people with a mental health problem are three and a half times more likely to be in debt than those without mental health problems, which highlights the vicious cycle between money and mental health problems.

Higher debt burdens are linked to rising inflation – there is a significant risk of problem debt growing during the cost-of-living crisis as rising bills, stagnating wages and insufficient social security support means that families take on more debt to make ends meet. With the pressure of inflation and rising living costs set to continue for at least another year, it is crucial that the government now delivers a longer-term package of support targeted at lower income households.

Unstable and poor quality housing

Housing can contribute positively to people's mental health – but all too frequently it does not. There are three key factors that drive poor mental health:

- Quality and condition: issues such as damp and overcrowding are linked to a number of health conditions, including anxiety and depression
- Stability and security: having a lack of (or perceived lack of) control over housing, such as short-term tenancies or risk of eviction can act as a stressor which harms mental health. It also undermines engagement with local services and relationships with the local community.
- Affordability: financial pressures caused by housing payments, both in terms of housing itself and utilities and maintenance, can directly affect mental health by causing stress and anxiety. It can also indirectly affect mental health where people have reduced disposable income on things that promote good health, such as good food or exercise.

Young people are spending increasing amounts of time living in the private rental sector (PRS) compared to previous generations. This is a result of the increasing unaffordability of home ownership and the decline of social housing availability. The Chartered Institute for Housing found that the number of young people aged 16-24 living in the PRS has increased from 322,000 in 2003/4 to 537,000 in 2017/18, representing a 22% increase in the proportion of that age group renting.

Private rental housing can often be insecure, where tenants are at risk of a 'no fault eviction', as well as the housing stock itself being of poorer quality. While young people are not exclusively affected by conditions in the PRS, their work and financial insecurities may push them into lower cost and poorer quality accommodation.

There are important long-term changes needed to improve the housing system, including improving the stock of social housing and delivering improvements to the current housing stock to ensure it is of a good quality, stable, and affordable. The government has taken welcomed steps towards this with the long-awaited Renters Reform Bill, with the extension of the Decent Homes Standard driving better quality housing and the end to Section 21 evictions bringing additional security for those living in the private rental sector.

The government should now look to address housing affordability by boosting the Local Housing Allowance (LHA) in line with the local rental market. The LHA has gone from covering 50% of local rents to failing to cover even 30% of local rents in most areas from 2011 onwards. To improve housing security, this benefit level must now return to meet the 30th percentile of local rent wherever you live in the UK.

Unemployment and low-quality work as drivers of poor mental health

The presence, adequacy and quality of work are key influences on people's mental health. The relationship between unemployment and poor health is well evidenced, with research showing how the stress of unemployment and income loss leading to poor mental health, as well as the loss of social connections and sense of structure and purpose that good quality work can often bring. These effects become more pronounced as the duration of unemployment increases.

There are increasing concerns about the impact of low-quality work on health, particularly where people have less autonomy, security and predictability with their work. The Whitehall II study suggests that people in low-quality work are exposed to greater levels of stress, which over time can be damaging to health. Health Foundation analysis shows that over one-third of employees report being in low-quality work, and of this group, 15% report experiencing poorer health – which is twice as high than for those with no negative job aspects, at 7%. Certain groups are more likely to be in low-quality work, including: younger adults, people in more routine occupations, and members of black and minority ethnic groups. Northern Ireland, Wales, North East and West Midlands had higher rates of low-quality work than other areas in the UK.

Greater numbers of young people are in insecure work compared to previous generations. The Resolution Foundation, as part of the Young people's future health inquiry, found that young people were 66% more likely to be in insecure work in 2019 than they were in 2000. This has been driven by an increase in zero-hour contracts and agency work, a trend that accelerated after the 2008 financial crisis. The rise of

insecure work has considerable implications for young people's mental health: 18-35-year-olds in insecure work were just as likely to rate their mental health as 'poor' as unemployed young people, at 37% for both groups in January 2021. In contrast, the YouGov study showed that only 30% of young people in any other type of employment rated their mental health as poor.

People in poor quality work could be enabled to find better work through skills development and vocational training. This should also include better links between skills provision and local labour market demand, ensuring that people are subsequently able to access local employment opportunities after training.

Do you have ideas for how employers can support and protect the mental health of their employees?

Poor mental health costs UK employers up to £42 billion a year and sickness absence from the workplace due to mental health problems costs £8 billion. Research funded by the Health Foundation suggests that a new 'employment gap' has opened up during the pandemic, where people with a mental or physical disability are more likely to be working reduced hours. Workers with mental health problems are also more likely to work in sectors that had to close during the pandemic, making them more vulnerable to job losses and potentially widening this employment gap.

Employers should offer flexibility as standard so that their workplace is inclusive of employees with poor mental health. This includes flexibility in recruitment, retention and progression practices, by advertising positions flexibly (e.g. job sharing, part-time or condensed hours). The recently announced change to the right to request flexible working on "day one" (removing the requirement to wait for 26 weeks of continuous service) is a welcome step from the government.

However, pre-pandemic, one in three requests for flexible working were turned down. Employers should take proactive steps to develop a list of reasonable adjustments and offer them to employees regularly such as:

- changes to working times, patterns and hours
- changes in working environments
- changes to tasks or the organisation of tasks.

Alongside an extension of the right to request workplace modifications, information and enforcement mechanisms are needed. Employers should be educated about the benefits to staff retention and employees should be supported to access their rights and articulate their needs.

There are existing schemes in place that employers could better utilise to support employee mental health. This includes Access to Work, which is provided by the Department for Work and Pensions and is aimed at supporting disabled people to take up or remain in work. This includes a dedicated Mental Health Support Service which provides work-focused mental health support, including help to develop a personalised support plan and suggestions for reasonable adjustments in the workplace. The DWP and DHSC could work more closely with employers and people in work to raise awareness of the scheme.

Chapter 4 - improving the quality and effectiveness of treatment for mental health conditions

What needs to happen to ensure the best care and treatment is more widely available within the NHS?

b) Children and young people

Existing data suggest that the prevalence of mental health conditions among children and young people has been rising over the last two decades. Mental health services across the UK were struggling to meet demand even before the COVID-19 pandemic, which has exacerbated mental health issues among children and young people. Although NHS mental health service capacity has been expanded over recent years, it is still vastly outstripped by need. While the overall number of children and young people in touch with services has increased, our analysis of openly available data has shown that access to support has not widened: In 2020, 27% of children and young people who needed support were receiving it, compared to 25% in 2017.

Assessing the progress made so far

A first step will be to review not just the progress but the ambition of the existing 10 year commitments made in the Long Term Plan for the NHS in England in 2019. For both adults and people under 18, the Long Term Plan promised to increase the numbers accessing NHS services by specific amounts: by 2023/24 an 'additional' 345,000 children and young people accessing NHS mental health support and an additional 380,000 adults and older adults using Improving Access to Psychological Therapies (IAPT), the NHS talking therapy programme. But even if these targets are met, these services would only reach a modest proportion of people with potential mental health needs.

The Long Term Plan committed to invest in mental health services at a faster rate than the overall NHS budget. Services and staff have expanded, but only meet the needs of a fraction of people with mental ill health.

A key task for any review of mental health treatment services is to assess the scale of the ambition behind any renewed access targets and plan increases in staff and other investment. In 2018, the Health Foundation and Institute for Fiscal Studies modelled the implications of extending all kinds of mental health services from treating just under 40% of adults with probable mental health problems, to 70%, bringing services closer to the 'parity of esteem' between physical and mental health services which has been a longstanding policy goal. In 2018, this have required doubling the mental health budget to £27bn a year by 2033/34, raising the proportion of the NHS budget spent on mental health from 9% in 2018/19 to 12% in 2033/34.

Improving access to specialist mental health care

The Long Term Plan promised that 'over the coming decade the goal is to ensure that 100% of children and young people who need specialist care can access it.' While the overall number of children and young people in touch with specialist NHS mental health services has increased over time, our analysis of openly available data has shown that access to support has not widened. In 2020, 27% of children and young people who needed support were receiving it (based on the most recent prevalence data), compared to 25% in 2017. Not all children and young people with mental health problems will need NHS services, and the government has promised to expanded

mental health support in schools and in the community. In 2021, the Health Committee concluded that all forms of mental health support, including NHS and non-NHS services, are failing to expand quickly enough, meaning that 'more than half of young people do not receive the support they need.'

Evidence and data gaps

Expanding services to meet the needs of all children and young people is an urgent priority. Until this happens, services remain tightly rationed, meaning that it is even more important to understand who is getting access and who might be falling through the gaps. But not enough is known about who receives mental health support (including the NHS and other services) and who might be missing out.

The Health Foundation's Networked Data Lab (NDL) is a collaborative network of analytical teams across England, Scotland and Wales, and led by the Health Foundation. The NDL's recent analysis of trends in mental health presentations across primary, specialist and acute services highlighted three key areas for urgent investigation:

- rapid increases in mental health prescribing and support provided by GPs
- the prevalence of mental health problems among adolescent girls and young women
- stark socioeconomic inequalities across the UK.

Recommendations to improve mental health data for service planning and delivery

To inform national policy decisions, the quality of data collection, analysis and the linkage of datasets across services and sectors need to be improved.

1. More regular collection of robust and granular prevalence data would allow services to expand in line with need and better target support. Prevalence estimates should also contain detail on those likely to be at highest risk of mental illness, or most disadvantaged from accessing services.
2. More national action is needed to improve the data quality for NHS mental health services and data coverage for mental health support provided outside the NHS. There must also be improvements in data quality for specialist services and closing of data gaps along the emergency crisis care pathway. Without this, national policymakers and local areas are not able to get reliable measures on some of the most critical and challenging pathways, including transition from CAMHS to AMHS. There is also a significant blind spot about services outside NHS specialist mental health services. While specialist mental health services are under pressure, it is vital that those planning and designing services understand what happens to the children and young people turned away from specialist services. This includes whether they are able to access alternative services or other forms of support outside the NHS, or whether they deteriorate to the point of needing more intensive care.
3. Linked data sources and data sharing across sector and organisational boundaries are essential to improve services.

c) Working age adults

Improving Access to Psychological Therapies (IAPT)

The IAPT programme is for the treatment of adult anxiety disorders and depression in England. The NHS Long Term Plan promised to expand access to IAPT from an

existing target, of at least 1.5 million people accessing IAPT each year, to 1.88 million by 2023/24. But 1.5 million represented meeting the needs of 25% of adults who were thought to have common mental health problems, based on community prevalence estimates.

Analysis by the QualityWatch programme, funded by the Health Foundation and Nuffield Trust, has shown that although number of people being treated by IAPT has doubled since 2011/12 and 2020/21, the 2020/21 target was missed by 32% (equivalent to nearly 500,000 people). IAPT would need to considerably expand the numbers in treatment to meet the 1.88 million target by 2023/24.

COVID-19 brought a drop in referrals and numbers starting treatment, and is also likely to have generated additional mental health need. Analysis by the Health Foundation in 2021 estimated that COVID-19 could bring between 300,000 and 730,000 additional referrals for NHS mental health services (including IAPT).

Inequalities in access to mental health services

While IAPT is an ambitious programme to deliver psychological therapies at scale within England, there are inequalities in access for patients from socioeconomically deprived areas. They are less likely to receive a course of treatment and less likely to complete treatment. There is local variation in thresholds for accessing treatment and our analysis suggests thresholds may be more stringently applied for patients in deprived areas. There are also inequalities in outcomes, with recovery rates being lower for patients in the most deprived areas, although rates are improving year-on-year.

Health Foundation analysis also shows that a high percentage of people with depression and anxiety have additional long-term health conditions. Initiatives that recognise this, such as the IAPT pathway for people with LTCs, are important to tackle this. Our work also shows that a combination of depression and anxiety and socioeconomic deprivation is associated with higher medication prescribing and with more unplanned secondary health care use but not with higher primary care consultations or planned secondary care use. It is unclear whether this is due to problems with the availability or suitability of services in deprived areas or differences in treatment-seeking behaviours but this warrants further investigation.

New initiatives (such as digital mental health service innovations) will need to consider inequalities at the design, implementation and evaluation stages and ongoing monitoring of services across social groups will be needed.

Better workforce planning

The 2017 Stepping Forward paper set a target for 21,000 new mental health posts (professional and allied) by 2020/21, to be filled by 19,000 new staff by 2020/21. In 2019, the NHS Mental Health Implementation Plan went beyond this, providing indicative workforce requirements of 27,460 staff across different programme areas by 2023/24. Three transformation areas are projected to experience the greatest growth by 2023/24: Children and Young People (CYP), Improving Access to Psychological Therapies (IAPT) and People with Severe Mental Illness (SMI). Each of these areas require the total relevant workforce profile to at least double between 2021/22 and 2023/24, while those required for SMI care required to triple to reach over 10,000.

Analysis carried out the British Medical Association (BMA) in 2019 indicated that not only were these commitments not on track to be met, but also that better progress reporting would require robust and frequent workforce data collection.

Though the overall mental health workforce has grown by 17,778 since 2016 and met the targets set for 2021, there has not been sufficient growth in key staffing groups, such as mental health nurses and consultant psychiatrists, in line with the targets set out in 2019, with these deficits demonstrating unequal growth.

Though vacancy data on the overall mental health workforce is limited, there is sufficient information available on vacancies within the registered nursing workforce, both nationally and across England. Not only have overall nursing vacancies increased between June 18 and December 21 by 27% but they have grown more significantly since March 21, by over 35% (see figure 1).

Figure 1: Mental health nursing vacancies 2018-21

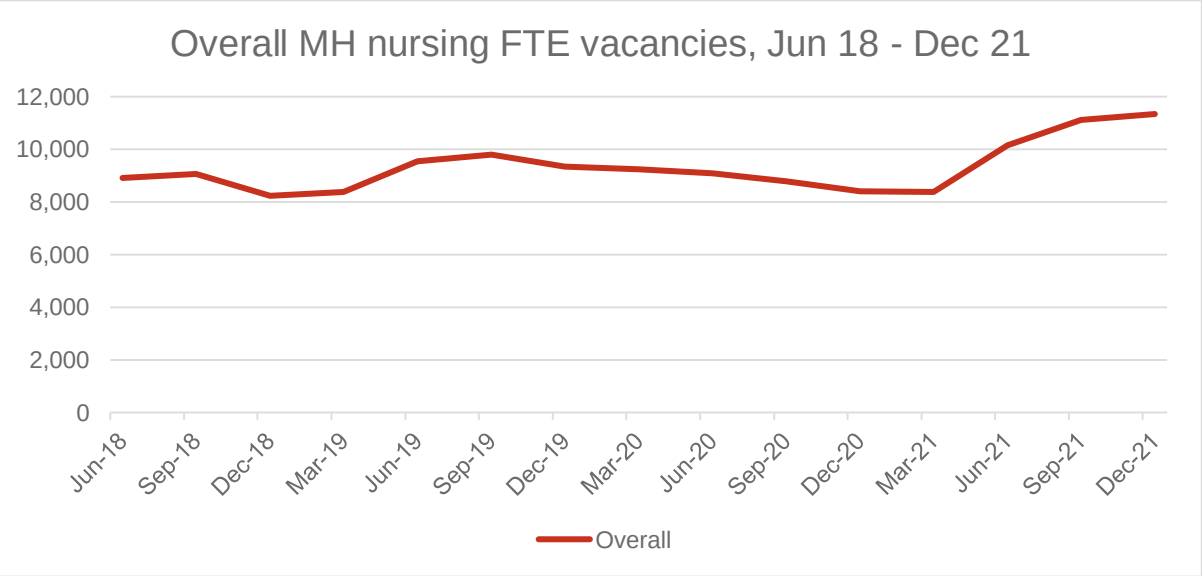
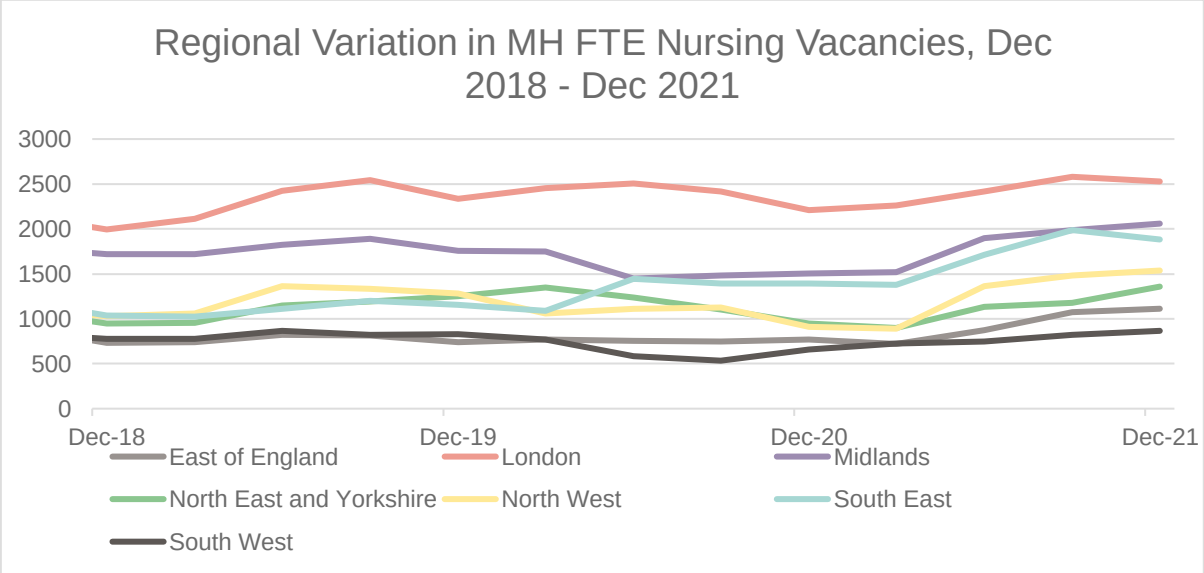


Figure 2 shows the extent to which there is regional variation in mental health nursing vacancies, in particular how they are consistently higher in London compared to the other regions.

Figure 2: Regional variation in mental health nursing vacancies 2018-21



Data on vacancies within the medical workforce is shared by a workforce census carried out every two years by the Royal College of Psychiatrists (RCP) in 2019. This indicated that there were over 700 total vacant consultant posts, with almost 1 in 10 (9.9%) consultant psychiatrist posts being vacant in NHS England. The RCP reported this to have increased over the years, growing from 4.9% in 2013, to 6.8% in 2015, and 9% in 2017. Their analysis also indicates regional variation, with higher than the national average vacancy rates (9.9%) reported in the West Midlands (12.55%), Northern & Yorkshire (11.17%) and the South East (10.47%). Vacancy rates also differed across the devolved nations and other sectors: Scotland (9.66%), Wales (12.74%), Northern Ireland (7.47%), Independent and third sector.

Though the mental health workforce has experienced increasing year-on-year growth from December 2017 onwards, there was a noticeable decline in this growth between 2020 and 2021, a possible indication of the impact of the COVID-19 pandemic on meeting workforce growth targets given delays in training completion. The pandemic has also been cited as worsening burnout and overworking, potentially increasing staff departure risks and further threatening service delivery. Citing 'insufficient numbers in the workforce' to ensure service delivery, the Health and Social Care Committee report assessing the Government's commitment to growth the mental health workforce reported unequally distributed growth and a 'disproportionate focus on the number of staff within the workforce, rather than working practices and working culture within mental health services'.

Finally, despite clear indications of the requirements of workforce growth across different staffing groups and programme areas, and recently proposed mental health access standards, noticeably absent from the additional NHS funding announced in the 2021 Spending Review was any extra investment allocated to mental health services. Given commitments within the Long Term Plan to increases in mental health funding being a priority, and an increase in demand for mental health services following the pandemic, there are wider calls for long-term, fully funded mental health workforce

plans to improve and increase access to mental health services as required by growing population demand. The Health Foundation have consistently emphasised that a comprehensive long term and fully funded workforce strategy is urgently needed to address endemic NHS workforce shortages, including in mental health services.

Stronger supply routes

Across each of the staffing groups, the training pathways differ in their duration and complexity, ranging from 7-8 years among nursing and 12-15 years among medical staff (figures 4 and 5).

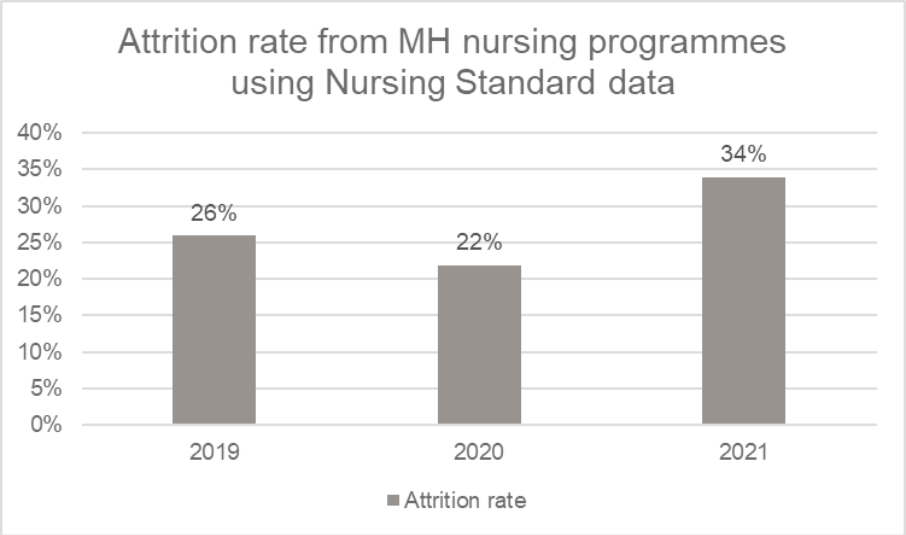
Figure 3: Medical training pathway

Figure 4: Nursing training pathway

Among both pathways, there are multiple opportunities for the risk of attrition, the earliest of which occurs during under-graduate education. Though subject to data limitations[1], analysis carried out by the Nursing Standard on the rate of attrition from nursing programmes indicate a rising rate of attrition among mental health nursing students over the last three years, growing from almost 1 in 4 in 2019, to over 1 in 3 by 2021 (Figure 5).

Figure 5: Attrition rate from mental health nursing programmes

[1] In the absence of standardised data on attrition in pre-registration courses, the Nursing Standard has used freedom of information legislation to obtain data on attrition to calculate institution level and national rates. Using this approach, attrition is defined as the percentage not completing their course in the expected timeframe. See our report on the Nursing Workforce for more information.



Along the medical training pathway, the RCP reports various areas that risk growing attrition, particularly: the rate of core psychiatry training places filled by a trainee, the transition rate between core to higher specialty training, and the employment of qualified consultant psychiatrists by the NHS. Core psychiatry training fill rates (round 1) have increased over the last three years, from 92.5% in 2019, 99.4% in 2020, and 99.3% in 2021, with the final fill rate position for the 2020/21 recruitment rounds with 100% of 477 possible posts accepted.

Currently, there is not enough information available on the extent to which international recruitment of mental health staff contributes to the mental health workforce, with very little publicly available data on the number of non-UK trained mental health staff employed each year by the NHS. There is no hard evidence to suggest that international recruitment is being considered as way to supplement the mental health workforce, but there are indications that individual Trusts are able to recruit internationally by working alongside healthcare agencies to increase nurse supply. While this may contribute to addressing staff shortages at a trust level, improvement in the frequency of data collection and publication on international recruitment of NHS mental health services staff is much needed.

Chapter 5 - Supporting people living with mental health conditions to live well

What do we (as a society) need to do or change in order to improve the lives of people living with mental health conditions?

b) Children and young people

Improving access to employment opportunities

Analysis by the Resolution Foundation found that in 2010/11 following the 2008 financial crisis, young people with a mental health condition were more likely to be out of work four years later than those without a mental health condition, at 14% and 8% respectively. In light of the pandemic, there needs to be focused interventions towards supporting people with a mental health condition to access secure employment.

Existing UK programmes should be adapted to better support the mental health of jobseekers. Employment programmes such as JETS and RESTART are new schemes to help reduce unemployment, focussing on short- and long-term unemployment respectively. These programmes should target making improvements in the mental health of participants, given the great likelihood that they will experience poor mental health and that this will be a barrier to employment.

Individual Placement and Support is a specialist employment service offered by the NHS for people with a mental health condition, which provides people support to find and stay in employment. Research has shown that this service is very effective, with IPS users being twice as likely to gain employment compared to other vocational rehabilitation services. IPS clients were also significantly less likely to be hospitalised. The NHS has committed to extending IPS so that it can support 55,000 people by 2023/24 but this could be taken further and fully integrated into UK employability provision. This would provide greater access to specialised intensive support for people with poor mental health and help improve employment outcomes for this group.

Strengthening the safety net for people with mental health issues

Reforming the statutory sick pay (SSP) system should be addressed in the first instance to support people experiencing poor mental health to stay in work. Currently, people are only entitled to SSP once they have been off work for three days. Mind have highlighted that the system does not allow for phased returns to work after being unwell, which can pressure people to return to work too early and may result in them needing more time off. People on SSP are also only entitled to £99.35 per week, which for many people is too low and is causing financial hardship, which in turn worsens their mental health. The DWP should strengthen the system to ensure that people receive sick pay from their first day off unwell and that they receive sick pay that matches the minimum wage.

The social security system as it currently stands is not fit-for-purpose for people with a mental health condition. Applying for welfare can be a stressful experience, from navigating the complex paperwork and Work Capability Assessment through to the threat of sanctions for people deemed fit for work.

In the first instance, the Department for Work and Pensions (DWP) should look to remove sanctions for disabled people and people with a mental health condition. As well as having an often-devastating impact on their mental health and financial security, the National Audit Office have shown that sanctions do not increase the likelihood of disabled people and people with mental health conditions from moving into work.

The DWP must also address wider issues with the Work Capability Assessment, including:

- The complexity of the Employment Support Allowance application process, with difficulties navigating the application and assessment regime, which in turn exacerbates mental health problems.
- Ensuring that assessors have an appropriate understanding of how mental health conditions affect people's ability to undertake work.

- Assessments should also take greater consideration of evidence from appropriate medical professionals, such as GPs or psychiatrists, with assessments structured around how the person's mental health condition affects them.

By improving the welfare system to ensure that people with a mental health condition can access support in a timely and efficient manner will in turn alleviate some of the stress of unemployment and provide the space to focus on getting better.

Additional questions

How can we improve data collection and sharing to help plan, implement and monitor improvements to mental health and wellbeing?

There are currently efforts underway across the health and social care system to improve data collection and sharing. Below we highlight both some general principles that apply to all efforts to improve data collection and sharing – including the area of mental health and wellbeing.

- *Seek to avoid increasing the data collection burden.* More data is not always the answer. A focus on data quality is also important, as is joining-up existing data sources, with less emphasis placed on new data collection unless really needed, can also help minimize the data collection burden.
- *Ensure data measures the outcomes that matter.* For example, outpatient administrative data frequently lacks information about diagnosis, because the primary purpose of this data is operational (including ensuring hospitals get paid and managing resources), for which diagnosis is not always required.
- *Consider wider sources of data beyond the NHS.* Data collected, and held, beyond the NHS – including that held by the wider public sector and by the private sector could help fill gaps in NHS data about a patient's health in between interactions with the health service, and provide a more complete picture of individual and population health and wellbeing.
- *Demonstrate trustworthiness and provide transparency to the public.* Whilst there are many advantages to sharing data to improve the health and care of the population, it is essential that this is done in a clear and transparent manner, including engaging with the public and health care professionals to build trust and show people how their data can be used to improve the health and social care systems.
- *Consider who is not represented in the data.* Unequal access to health services means the experience of some groups are less well represented in datasets relative to the level of need that they have. Those missing may be those who have the greatest health need.