



NWW

New Ways of Working
In Mental health

Enhance, Include, Evolve

**New Ways of Working
For
Allied Health Professionals**

**Supplement A - Key Drivers
October 2008**

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Introduction

During the discussions within the project groups, a number of key drivers and cross-cutting themes became evident, and in many instances, they emerged in more than one project group.

This section provides a summary of these key drivers and cross-cutting themes in the context of NWW.

Also included are links to individuals and/or further sources of information.

A1 Involvement of service users and carers

It is of real significance and deliberate intention that this section on the involvement of service users and carers in New Ways of Working (NWW) for Allied Health Professionals (AHPs) heads this part of the report. The issue is fundamental to the principles and purpose of the NWW programme and underpins the thinking and future practice of each work stream across all age groups (children, working age adults and older people) in mental health services.

Involvement is a constant crosscutting theme that challenges unacceptable traditional approaches where the service user was sometimes seen as an “add-on” to the delivery of their own care, the carer was not recognised for their invaluable contribution, and often both parties were passive recipients of services. NWW is about having the service users and carer at the heart of every aspect of care as equal partners.

Accepting that service users and carers should have the right to be involved in decisions that affect their lives, NWW recognises that they have much to contribute through their experience of a particular disability, illness or care service. In particular, they can relate this from their own viewpoint, expressing their fears, joys and feelings that contribute to a better understanding for all. Effective involvement leads to service users and carers feeling empowered, confident and valued, thereby making them feel more in control, able to make choices and so enhancing the quality of their lives and advancing the potential of a more effective and positive workforce.

NWW is about a big culture change, it is not about tinkering at the edges of service improvement. Only when all service users and carers are genuinely involved in their care, when real choices based on knowledge can be made, and when service users and carers are truly enabled by services led by their needs to move forward on the long journey towards their recovery, will some of the past entrenched methods and practices become the exception, and enlightened inclusive care become the rule.

This report focuses on NWW for AHPs and their contribution to enhancing mental health services that are service user and carer focused. It is about changing individual practice, values and beliefs in respect of service user and carer involvement, and enhancing knowledge and skills to meet more effectively the needs of service users and carers. This is only the first part of the challenge.

The second part is the difficult trick of changing the way services are delivered and the way they are organised. To this end, there is great promise in the changes so far led by so many committed professionals, service users and carers involved in the NIMHE National Workforce Programme to explore and develop those new ways of working that will more effectively meet the needs of its customers and the aspirations of its workers. This promise must not falter, but continue to develop in order to meet future expectations.

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Adult Mental Health Joint Training and Development Strategy Group in Leicestershire has service user and carer trainers working with professionals/workers to deliver training which models good partnership working and hugely enriches training.

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A2 Defining Recovery

AHPs identify well with Recovery Approaches as described by service users below; that of empowering the individual to select and maintain healthy life-style choices, thus enabling them to maximize their level of independence, health and well-being. Viewed in this 'new' way, rehabilitation for example, takes on a whole new meaning and perspective. This can be wide ranging and relate to work, family, education, social life etc. The focus is on working in partnership with service users and carers and by using evidence based interventions, help to motivate, restore and develop their level of functioning.

A recovery approach¹

This can be described as one in which a person makes an individual journey continuing, or towards, a valued life, valued by them and the wider community. This approach is not the same as 'cure' nor does it necessarily mean returning to a previous state. Services working with this approach are those that empower people to make that journey. They:

1. Remove barriers on that journey
2. Help individuals to maximise their wellness and manage their illness
3. Engender hope
4. Point to or provide the opportunities which fulfils that hope
5. Acknowledge and combat the reality of stigma against people who have experienced mental health problems.

This approach and social inclusion are interrelated. For most people this will be achieved by participation in life in the wider community. It will ideally involve facilitation through a multi-disciplinary, multi-agency approach with the individual at the centre. In mental health services, this approach is called 'Recovery', in learning disabilities it is known as 'Person-centred Planning'

What this means in practice is that 'Recovery' is a continuous process/journey. It is not about 'curing' everyone. Recovery is about an individual having a life, which is no longer dominated or centred on their illness or disability. The person's life is determined by enabling them to reach their full potential. Primarily it is the individual who owns their recovery and others such as NHS/Social Services, voluntary sector, cores/family/friends, community, employers, and education provide support.

It enables people to maximise their wellness and manage their illness and/or disability by helping the person have a sense of worth and value - through such things as:

- having a place they call 'home'
- the individual being seen as person not an illness
- having purpose in life such as work, successful relationships, own money, independence, education, goals, ambitions
- enabling the person to be a part of and contribute to society and their community
- enabling the person to have happiness, hope, love and to be able to give and receive these

¹ Based on an improvement event held in September 2005 by Berkshire Healthcare NHS Trust.

This can happen by:

- recognising and building on personal strengths, skills, abilities
- encouraging independence, making own choices
- treating the person with a holistic approach
- working in partnership with the individual and other organisations and support
- treating the person as an equal, giving dignity and respect and ensuring basic human rights are maintained.

The Development of Enhanced Day Therapy (EDT) Services within a Recovery Model is part of a wider service redesign project within the 5 Boroughs Partnership NHS Trust, addressing mental health provision for Adults in the Boroughs of Halton, Knowsley, St.Helens and Warrington.

The EDT teams include Occupational Therapists, CBT Therapists and Psychologists, and form part of Resource Recovery Centres (RRCs). The function of the EDT service is to provide a comprehensive range of therapies and support services that promote service user choice in relation to therapy and activity.

A need was identified to develop a 'whole systems approach', bringing together the work-streams relating to the development of Crisis Resolution/Home Treatment Teams, Early intervention Services, Assertive Outreach services, Access and Advice services, in-patient, community teams and a range of occupational and psychological therapy provision, within a context of enabling Social Inclusion and promoting wellbeing and recovery. Service users/carers were involved throughout, from the consultation stage through to planning and implementation.

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A3 Social Inclusion

Allied Health Professionals are often well placed in the health and social care system to facilitate this key element of care and treatment, as they usually assess the needs of the whole person, within their environment, working to strengths and aspirations and enabling people to manage their own lives in the way which best suits them.

The Social Exclusion Unit (SEU) publication *Mental Health and Social Exclusion*¹ showed that many people with mental health problems experienced exclusion. This means that they do not have equal access to a wide variety of opportunities in modern society, including paid employment and volunteering, health care, housing, education and lifelong learning, financial services, access to civil rights and social participation. This applies to service users and carers of all ages and from all communities. Denial of these opportunities is unjust, and it makes life harder for people, lowers self-esteem and weakens the rest of society.

Improving opportunities for people with mental health problems, and their carers, to be included rather than excluded will enhance recovery, bring hope to relatives and ultimately reduce dependence on the State as people make a positive contribution to society, find some of their personal support through informal social networks, pay taxes and make less use of hospital and community services.

Social inclusion from the earliest age should be prioritised as having a preventative impact throughout someone's life. Social isolation is an even greater problem for older people, post retirement or following bereavement.

Carers also need support and social networks to enable them to continue their vital role without detriment to their own mental and physical health.

The National Social Inclusion programme has recently published *Capabilities for Inclusive Practice*³, which was developed, using the 10 ESCs as a framework, to support and challenge the staff in mental health services to work with users to realise their aspirations as contributors to their communities, advance their choices and empower participation.

www.socialinclusion.org.uk

Since the 2004 report was published, the case for action has been strengthened by further policy statements, including the 2006 White Paper *Our health, our care, our say*²

One aim of an initiative in Barnsley is to promote social inclusion via facilitating football sessions with mental health clients using public facilities. Due to football being an international game, it has provided a means of engaging a variety of asylum seekers in services. Regular football session at Barnsley FC Academy with occasional matches against staff, other mental health teams from the region (Sheffield, Doncaster, Cheadle) as well as occasional tournaments (Millwall, Sheffield)

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¹ Office of the Deputy Prime Minister (2004), *Mental Health and Social Exclusion*, London, ODPM

² Department of Health (2006), *Our health, our care, our say: new direction for community services*, London, DH

³ National Social Inclusion Programme, CSIP (2007), *Capabilities for Inclusive Practice*, London, DH

A4 Improving access to psychological therapies

The Improving Access to Psychological Therapies¹ (IAPT) Programme is sponsored by the Department of Health (DOH) and the Care Services Improvement Partnership (CSIP) and constitutes a series of projects designed to illustrate, and substantiate via the collection of evidence, the well-being and economic gains of ensuring proper access to psychological therapies for people experiencing common mental health problems.

Two national demonstration centres are located at Doncaster and Newham, and designed to demonstrate the practical implementation of IAPT services. In addition, advice on service design and evaluation has been provided by the Expert Reference Group, together with work around workforce planning and education and training through the Workforce Group.

In July 2007 11 new pathfinder projects were announced to allow people with anxiety and depression better access to psychological therapies. They are as follows:

Brighton and Hove PCT
 Buckinghamshire PCT
 Derby City PCT
 Dorset PCT
 Ealing PCT
 East Riding and Yorkshire PCT
 Hertfordshire PCT
 North Tees and Hartlepool PCT
 Salford PCT
 Stoke-on-Trent PCT
 Bury PCT (focus on children and young people's mental health services)

The IAPT programme raises important challenges generally for New Ways of Working, and specifically for the Allied Health Professions. This includes the phased roll out of the IAPT programme and consideration of practitioners delivering low and high intensity interventions providing different therapeutic components of stepped care².

Stress management workshops delivered by the Primary Mental Health Service throughout Gloucestershire in partnership with colleges of further education. They are led and supervised by an occupational therapist.

The courses form a significant part of the Stepped Care Approach offering treatment options in the community preventing referral into Secondary Mental Health Services, or assisting people back into the community following admission to mental health secondary care service. All adults may self refer, although GPs and CMHTs routinely signpost people to courses as a first intervention for managing anxiety and depression.

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¹ Department of Health (2004), *Organising and Delivering Psychological Therapies*, London, DH

² Care Service Improvement Partnership (CSIP) (2006), *Primary care Services for Depression: A guide to best practice*, London, DH

In addition, the IAPT programme has liaised with Skills for Health around a scoping exercise involving National Occupational Standards for Psychological Therapies, and preliminary discussions around the regulation of psychotherapy and counselling³ (see section 2.7). Future work will involve creating dialogues with education providers and training commissioners about the future training requirements needed to fill the skills and competencies gaps in psychological therapies that have been identified, if IAPT is to be fully implemented.

With respect to Allied Health Professions, three issues emerge:

- The first concerns the extent to which pre-registration training prepares practitioners to contribute to mental health services. A number of these are considered in the report of the education and training project report (see section 1.1).
- Secondly, many allied health professions seek post-qualification training in recognised schools of psychotherapy. If IAPT is to be realised, it will be important that the existing workforce have access to quality training in evidence-based psychological therapies, especially CBT. It is also appreciated that it will be important to address issues surrounding career pathways that embrace a multi-professional approach to the delivery of services (see A5 AHP Competency-based Career Framework).
- Finally, many AHPs are in the process of, and should be supported in, increasing the evidence base for psychological therapies (see Report 1.1).

³ Department of Health (2007), Trust, Assurance and Safety – The regulation of Health Professionals in the 21st Century, London, The Stationary Office (TSO)

A5 AHP Competence-based Career Framework

The UK-wide Modernising AHP Careers project started in 2005. The resulting competence-based career framework was launched July 2008. It responds to the need for a flexible and responsive approach to allied health professional careers that maximises their potential to contribute to transforming patient care and promoting health and well-being through highlighting the competences (generic, common, shared and specific) that AHPs have in order to deliver the functions that patients and the public require. The competence-based career framework allows individuals to articulate the skills they have, the skills they need to develop and the support they need to achieve this.

The following set of web-based tools has also been produced:

- A web-based framework of competences that can be used in a number of ways, for example for personal development planning by clinicians
- A web-based resource of allied health professional and support worker roles already mapped to the career framework for use in workforce planning and service redesign
- Learning design principles that can be applied to pre-registration and post-registration training to promote flexible learning. For example, one of the principles is to recognise attainment at a variety of levels and from a variety of learning approaches such as formal, work based, experiential, informal and theoretical. Work is ongoing with the Council of Deans, who were part of the project Strategy Group, to identify how the learning design principles will be implemented in AHP education.

The tools can be used by:

- **service managers and planners/commissioners** to define the competences that services, teams and individuals must have in order to meet patient needs and develop roles, teams and services to reflect these.
- **clinicians and support staff** to define their current competences and skills, and identify areas for development and potential career pathways
- **education planners and education commissioners** to identify the development needs of AHPs, and plan and provide training and development to meet these.

The framework is based on a substantial database of competences that were extensively field tested over a 2½-year project. The competences include:

- **generic** competences (such as management) performed by any number of staff across sectors
- **common** competences (such as health and safety) undertaken by the majority of health staff
- **shared** competences (such as assessment) undertaken by a number of AHP staff
- **specific** competences (such as environmental and social support in the community) performed by specific groups of staff.

The Web link is:

<http://www.skillsforhealth.org.uk/page>

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A6 New Roles under the Mental Health Act/Mental Capacity Act

The Mental Health Act 2007 (MHA'07) received Royal Assent on 19th July 2007. It makes a number of important changes to the Mental Health Act 1983 (MHA '83), most of which will be implemented from 3 November; (some have already been implemented.) The Act introduces new roles of Approved Mental Health Professional (AMHP) and Responsible Clinician (RC).

Prior to these changes, under the MHA'83 it was the Responsible Medical Officer who had overall responsibility for a person's treatment whilst subject to detention. The MHA'07 introduces a change to this role naming it the RC. An RC can be from one of the five core mental health professions, namely a doctor, clinical psychologist, nurse, occupational therapist and social worker. These individuals will be required to meet with stringent nationally set competencies in order to be approved as an Approved Clinician (AC). An AC approved by a strategic health authority or primary care trust on behalf of the Secretary of State can be appointed by the detaining authority to act as RC for an individual. Several ACs can be involved in the treatment of an individual but only one at any given time can be the RC.

At the point of the initial assessment to decide whether an individual should be detained (or guardianship) under the MHA '07, it will still be only doctors who can give the necessary medical recommendations. ACs of the other named disciplines can be the named RC for the individual from the point of compulsion onwards and will therefore be able (in most cases) to give individuals leave of absence, and to end or renew the compulsion. Renewing detention normally requires the agreement of another professional from a different discipline. With the agreement of an AMHP (see below), RCs will also be able to discharge people from detention onto supervised community treatment – a new form of compulsion in which people are treated in the community, but can be recalled to hospital if necessary.

The second role introduced by the MHA'07 is that of the Approved Mental Health Professional (AMHP). This replaces the Approved Social Worker (ASW) in the MHA'83. This role is open to a range of professions, namely those of nursing, social work, occupational therapy and psychology. It is not possible for a doctor to be an AMHP. The AMHP has the responsibility for providing an independent non-medical assessment of an individual and determining if they meet the criteria for detention and if so making the application for detention under the MHA'07 to the detaining authority. From this flow a number of associated duties such as the production of reports for the Mental Health Review Tribunal (MHRT) and Managers Hearings.

As with the RC, the AMHP will need to meet with stringent nationally agreed competencies as a prerequisite to being nominated for training by their employing organisation. Following completion of training as an AMHP the individual is unable to act in this capacity until they are approved by a Local Authority. Like ASWs, AMHPs act on behalf of local authorities – but unlike ASWs, they do not have to be employees of the local authority.

The MHA'07 has also amended the Mental Capacity Act 2005 (MCA'05), and introduced the Deprivation of Liberty Safeguards (DoLS). The UK was found to be in breach of the European Convention on Human Rights (ECHR) in a ruling from the European Court of Human Rights (ECtHR) in what became known as the Bournemouth gap. The Government has introduced the Safeguards to close that "gap".

In order for a DoLS, assessment to occur there needs to be a minimum of two assessors - a Mental Health Assessor and a Best Interests (BI) assessor. Regulations state that the BI assessor can be drawn from one of the following - social worker, nurse, occupational therapist, psychologist or AMHP.

The BI assessor has to be selected by the supervisory body (LA or PCT) and be appropriate to conduct the assessment in question. One of the functions of the BI assessor is to determine if there is a Deprivation of Liberty occurring. The eligibility assessor, who may be either a S12 Doctor or an AMHP BI assessor, determines if the matter should continue to be assessed under the MCA'05 or the MHA'07 so knowledge of both Acts will be necessary to fulfil this role, for those staff. The Regulations, in relation to assessors and associated Code of Practice to support the DOLS process and safeguards, have completed their parliamentary passage.

A7 Regulation

Continuing professional competence and development

Registration depends on continuing proof of good health, character, and competence. This has two key aspects:

- Firstly keeping up to date with what is expected of a new qualifier as the professional scope of practice changes over time, which may be termed continuing professional competence and
- Secondly keeping up to date with the registrant's individual scope of practice as that develops, termed continuing professional development.

This will often mean that a practitioner no longer covers the whole range of the profession's scope of practice, but will cover the area in which s/he specialises to a greater degree than is expected of a new registrant. In addition, a registrant may extend the individual scope of practice by developing competences that are necessary for a role extended beyond what most in the profession would do. Issues associated with extended roles and regulation are being addressed as part of the Government White Paper¹ as illustrated in a summary of key issues below.

From Chapter 7, White Paper on regulation, 'Trust, Assurance, Safety'¹

The Government will also consider areas in which regulatory practice and legislative provisions should be harmonised across the regulators so that all have the most up to date and comprehensive powers and duties.

The Government recognises that setting professional practice and conduct standards is at the heart of each regulator's activity, but is also aware that there are substantial areas in which common standards would be desirable. For example, standards of professional conduct and of professional practice relating to areas of practice undertaken by members of many different professions need greater harmonisation.

While it is not the intention that one size should fit all and there needs to be appropriate flexibility to reflect relevant differences between professions. The Government believes that all professionals undertaking the same activity should be subject to the same standards of training and practice so that those who use their services can be assured that there is no difference in quality.

Distributed Regulation

Where a health professional joins a new regulated profession group from within an existing regulated profession, it might be possible for them to remain registered with their existing regulator, in a system of distributed regulation, to avoid costly dual regulation.

Dual registration means that the same person has to be registered with two different regulators to perform one and the same role. This does not apply to any new or emerging profession that will not require regulation by more than one regulator. However, the Government recognises that many professionals feel a degree of loyalty to the profession in which they were first regulated.

¹Department of Health (2007), Trust, Assurance and Safety – The Regulation of health Professionals in the 21st Century, London, TSO.

The Government will therefore explore the practicality of a system of distributed regulation, including its relationship to revalidation, in which a lead regulator will regulate a new profession and register most of its practitioners, including direct entrants.

Entrants from an existing regulated profession:

- who want to retain registration with their original regulator
- and have their new professional registration annotated on their original register along with their existing registration

will need to meet the relevant standards for both their new and their original professions. However, this will be a matter of personal choice.

The Government will consider further the legal and operational practicalities of ensuring that these practitioners meet the same standards as everyone else in the new profession while continuing to meet the requirements of their original regulator.

It should be noted, though, that dual registration is currently necessary for any professional who is qualified in two different professions and wishes to retain the option of practicing in both.

However, the new demands for undertaking continuing professional development and meeting revalidation requirements for two professions may make this, and distributed regulation, a less practical option in future.

Psychological Therapies (see also section 2.4 Improving access to psychological therapies)

Many existing professions, both regulated and unregulated, provide psychological therapies.

These include:

- Doctors (psychotherapy specialist function; other psychiatrists; GPs)
- Nurses
- Social workers
- Occupational therapists
- Arts therapists
- Psychologists
- Psychotherapists
- Counsellors
- New roles in mental health currently under development

For some – such as psychotherapists and counsellors – the practice of psychological therapy may be their entire professional remit. For others psychological therapy will be part of their professional roles alongside the rest of their scope of practice.

This may subdivide into those (such as applied psychologist, music therapist) for whom psychological therapy is an intrinsic part of their training and practice, and those (such as occupational therapist, dietitian) for whom it may be a specialist post-registration addition. Not all may do exactly the same, since some may practise at different levels, working with different levels of complexity and need.

No one profession currently has a monopoly in the delivery of psychological therapies, but it is very desirable that where people from many different backgrounds are doing the same thing they should all do it to the same standard and with similar training.

Existing regulated professions engaged in psychological therapy are subject to different regulators:

- the General Medical Council, with postgraduate standards maintained by the Royal College of Psychiatrists;
- the Nursing and Midwifery Council; and
- the Health Professions Council (HPC).

Regulation by HPC has also been proposed^{2,3}, for psychologists and other psychological therapy practitioners.

Although all these regulatory frameworks are similar, the responsibility for setting standards of competence rests with the individual regulators. There is scope for joint agreement of competences by the regulators, based on a common competence framework, to ensure that standards for the same practice are the same for all practitioners of whatever professional background.

Skills for Health - Competence development for the entire mental health workforce (see also A5 AHP Competency-based Career Framework)

Skills for Health, the sector skills council for health, is leading work to develop a competence framework to cover a range of psychological therapies such as a well-organised psychological therapy service should offer, as described in the Department of Health report *Organising and Delivering Psychological Therapies*⁴. This will cover at least the following models:

- Psychodynamic/psychoanalytical psychotherapy
- Cognitive behavioural therapy
- Family/systemic/interpersonal therapy.

The provision of psychological therapy is not however necessarily so clear cut since many practitioners with a patient assessment role will need to recognise the availability and efficacy of a wide range of therapeutic models to be able to assess patient needs and refer on if necessary.

The competence framework will also need to include generic knowledge, skills and behaviours expected of anyone offering healthcare to users or professional services generally, and generic competences required for all people working in the field of mental health. These should draw on the Ten Essential Shared Capabilities for people working in mental health⁵, and related work such as the National Occupational Standards for Mental Health⁶.

The production of competences spanning the whole mental health workforce will provide the means to identify competences relevant to specific roles at different levels from support and befriending to a range of highly complex psychological intervention and development of new therapeutic techniques and applications. Not all will be relevant to every role but some may be relevant to very different roles that include the same element within different combinations of practice.

² Department of Health (2005) *Applied Psychology: proposals for the statutory regulation of applied psychologists*. Available from www.dh.gov.uk/publications.

³ Department of Health (2006) *The regulation of the non-medical healthcare professions*. Available from www.dh.gov.uk/publications.

⁴ Department of Health (2004) *Organising and Delivering Psychological Therapies*. Available from www.dh.gov.uk/publications.

⁵ Department of Health (2004) *The Ten Essential Shared Capabilities – A Framework for the Whole of the Mental Health Workforce*. Available from www.dh.gov.uk/publications

⁶ Skills for Health (2007) *Mental Health* www.skillsforhealth.org.uk.

A8 Preceptorship

Preceptorship is a training and development strategy designed to assist the transition as practitioners move into new jobs. Although it frequently is used with newly qualified practitioners, and is a requirement for Band 5 staff joining the NHS¹, it has also been used to support 'returners to practice' or staff moving into new clinical fields. In the context of rapidly changing practice, preceptorship potentially provides a powerful tool to support the recruitment and retention of allied health professionals.

The NHS preceptorship model requires managers and professional leads to set local competency standards against which practitioners are assessed using the Knowledge and Skills Framework². Practitioners therefore collect written evidence of their learning and this can be used as part of their portfolio for re-registration purposes. Learning is facilitated by an assigned preceptor, often the clinical supervisor, who offers structured development opportunities such as observed practice and reflective feedback, role modelling and teaching. These activities are vital to consolidate the individual's role identity and build on the entry-level competence and confidence of new practitioners. This is particularly important for allied health professionals working in mental health who may have had limited exposure to some clinical fields at under-graduate level.

Since the formal introduction of preceptorship, several models of implementation have been developed within and across trusts and on a uni-professional^{3,4,5} or inter-professional level and there is emerging good practice guidance.

The evaluation⁶ of a preceptorship programme for new occupational therapists working within the London Mental Health Trusts and partner organisations highlighted that supervisors found the programme more effective than previous supervisory practice; in relation to supporting practitioners in the transitional period, facilitating clinical skills and behaviours and preparing practitioners for their development review⁷. The two factors for which preceptorship was rated as particularly effective related to promoting reflective practice and providing competences for performance review. New practitioners identified benefits such as regular supervision and constructive feedback as well as a structured approach to CPD.

Successful implementation requires commitment from senior managers to develop a preceptorship policy that is consistent across staff groups, particularly if there is a link to pay progression.

¹ Department of Health (2005), *Agenda for Change Terms and Conditions Handbook 2005* Department of Health.

² Department of Health (2004), *The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process, Final Version* London, Department of Health.

³ Harbottle, M. (2006), "An investigation into the perceived usefulness of preceptorship: an exploratory study between two radiotherapy centres", *Journal of Radiotherapy in Practice*, vol. 5, no. 1, pp. 43-54.

⁴ Morley, M. (2006), *Preceptorship Handbook for Occupational Therapists* College of Occupational Therapists, London.

⁵ Royal College of Speech and Language Therapists (2007) *Speech and Language Therapy Competency Framework to Guide Transition to Full RCSLT Membership* London.

⁶ Morley, M. (2007), *Preceptorship Training Manual* College of Occupational Therapists, London

⁷ Morley, M. (2006) Supporting newly qualified OTs with preceptors. *Employing Allied Health Professionals* 18, 14-16. 2006.

The following checklists⁸ were compiled by managers within the London mental Health Trusts involved in the implementation of preceptorship over the last two years.

Senior Managers should:

- Secure commitment to the preceptorship programme if possible on an inter-professional basis.
- Build on existing positive practice, such as induction, development review and supervision
- Reach agreement with partner organisations on the implementation plan for preceptorship particularly in relation to rotational posts.
- Work with Human Resources and staff organisations to develop processes to support implementation
- Ensure that preceptors and preceptees have training and access to ongoing support
- Monitor the implementation of the program

At departmental/ team level, managers should:

- Be aware of the transitional issues that face newly qualified staff.
- Have clear expectations about what is expected of newly qualified staff.
- Update induction process to incorporate preceptorship
- Provide preceptor/ supervisor and preceptees with support and preparation time to undertake joint working, role modelling, reflection and feedback.
- Sustain the implementation of the program.

⁸ Morley, M. (2007) Helping newly qualified staff through the first year. *Employing Allied Health Professionals* 22, 3. 2007.

A9 Complexity¹

The problems faced by service users and their carers in mental health are rarely straightforward ones. It is therefore important, that health care services are able to draw on a wide range of skills to deal with this complexity - amongst them, those of AHPs.

AHPs working in specialist mental health roles have the ability to analyse the multi faceted aspects arising in mental health, including additional physical aspects and thus shed light on the issues. This is through offering fresh approaches, new thinking, techniques and interventions.

For these reasons, AHPs can work together with the service user, carer, other mental health professionals and support staff, to problem solve and help 'smooth the way', even in seemingly intractable situations.

Summary of contribution from NWW Working Party on Complexity to main NWW report

Complexity is a widely-used concept in both government policy documents on mental health provision, such as "stepped care model" and "our health, our care, our say" and in general NHS use.

The NWW Working Party on Complexity reached the following main conclusions:

1. Terms such as "complex" should only be used with careful consideration of the implications and consequences. It brings with it a legacy of unacceptable concepts and discriminatory and pejorative language. Furthermore, there is no clear, widely accepted definition of what complexity means; nor is there an agreed approach for working with it. It needs to be defined for mental health for planning individual care and services, and in a way that is seen as helpful to the individual.
2. Links between use of the term complexity, enhanced CPA, chronicity of a condition, and the requirements for different levels of stepped care, need to be made explicit and might make the concept seem more relevant to service users.
3. Key variables that appear associated with complexity include:
 - a. duration, severity and number of problems
 - b. level of functioning
 - c. level of risk/vulnerability
 - d. contextual factors (that may affect an individual's ability to make use of traditionally delivered services), e.g., language difficulty, living in a rural area with no transport, race and culture
 - e. the ability of the service and individual clinician to respond appropriately and effectively to the patient's needs, in terms of knowledge, skills, and emotional and physical resources.

It is the combination of these variables, rather than each in isolation, that seems to create complexity.

4. Judgements of degree of complexity, and the perceived need to make such judgements differ, not just according to the beholder (service provider, user, carer, etc), but also according to the time, place and context.
5. Poor outcome should not necessarily be viewed as a defining feature of complexity, as it could merely reflect the clinician's sense of 'stuckness' or the inappropriateness of the service offered

6. Stakeholders (particularly service users and carers) should reach a consensus on what outcomes should be aimed for, since expectations will influence perceptions of complexity
7. For those service users within primary care who have high level or complex needs, it is important to adopt, where appropriate, case management/care coordination, or simply a more intensive approach.
8. Where there is a complex overall picture, a holistic approach should be adopted to take into account of the wider context. This may necessitate specialist intervention. Equally, simple interventions for circumscribed issues can sometimes be beneficial, even when there is a complex overall picture.
9. Service planning and commissioning, needs to take account of greater complexity bringing the likely need for greater amounts of resource, including time, knowledge, skills, and energy.
10. All service users have equal rights of access to mental health services regardless of complexity. It is important that services for people with needs at both ends of the complexity spectrum are not marginalised for being either too highly or not sufficiently complex.
11. Ultimately, service users and their carers are the ones that live with complex needs. They have the wealth of experience to draw upon to help distinguish helpful from unhelpful strategies, sometimes before clinicians reach the same conclusions. Therefore, service users and their carers should be involved in a routine and fully integrated manner, in planning, designing, delivering and evaluating services that respond effectively to complexity within mental health care.

¹NWW Working Party on Complexity Interim Progress Report, Section 4 NWW for Everyone report

A10 Creating Capable Teams Approach (CCTA)

The CCTA was launched at the national New Ways of Working (NWW) conference on the 25th April 2007 and consists of an executive summary, a facilitator's handbook, a participant's handbook, a CCTA leaflet and a CD Rom.

A limited number of CCTA packs have been distributed to organisations via the CSIP Regional Development Centres (RDC) however, the main method of distribution is via the CD Rom (also available from the RDCs and via the website www.newwaysofworking.org.uk)

The CCTA:

- Was designed to be used with teams, with participation from their service users and carers.
- Requires ownership and commitment from the Senior Management Team
- Was developed to help integrate new roles and new ways of working into MDT's
- Focuses on the capabilities required to meet the needs of services users and carers
- Supports the production of a Team Workforce Plan
- Is being developed with involvement from service users & carers
- Is relevant to all service areas

CCTA is delivered in five steps including three workshops

	STEP	TITLE	FORMAT	DURATION	WHOS INVOLVED
PREP	1	PREPARATION & OWNERSHIP	A series of Meetings & individual work	AS REQUIRED	Facilitator Senior sponsor SMT Team Team Leader
	2	TEAM FUNCTION & LOCAL POPULATION	Workshop 1	1 DAY	Team Facilitator
WORKSHOPS	3	SERVICE USER & CARER NEEDS	Workshop 2	1 DAY	Team Facilitator
	4	CREATING A NEEDS LED WORKFORCE	Workshop 3	1 DAY	Team Facilitator
POST	5	IMPLEMENTATION & REVIEW	Meetings	AS REQUIRED	Senior Sponsor Team Leader Facilitator SMT

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A11 Meeting physical health needs

AHPs have important contributions to play in health promotion and disease prevention, including nutrition, exercise and falls prevention; in providing appropriate interventions for physical illnesses, including swallowing and communication problems, rehabilitation following stroke or musculoskeletal problems; and improving confidence in everyday living skills, including the provision of assistive technology. Additionally AHPs can have a positive impact for service users where their illness has intrinsically linked physical and mental health aspects for example eating disorders or self-harming behaviour. Many of the examples in this report demonstrate the specialist contribution different AHPs can bring to service users and carers to address both their physical and mental health problems using a person-centred approach.

*Choosing Health; making health choices easier*¹ and *Choosing Health; supporting the physical health needs of people with severe mental health illness*² both identified people with mental health problems as being more likely to suffer a range of physical illnesses and conditions, and highlighted them as a priority group. There is also recognition that supporting this group to lead healthier lifestyles would enhance their mental and psychological well-being as well as their physical health. Additionally *Saving Lives*³ states that people with a mental illness are at an increased risk of developing and die prematurely from coronary heart disease, cancer and respiratory disease.

*Everybody's Business*⁴ identifies the physical and emotional effects of caring for older people with mental health problems, and the intrinsic link between mental and physical health needs amongst older people. People with dementia are at a higher risk of falls and malnutrition than the general population, and people with a physical health problem are more likely to suffer from depression.

*The Chief Nursing Officer's review of mental health nursing, From Values to Action*⁵ has recommended that mental health nurses attain the necessary physical healthcare skills to address these needs, and be able to refer on to other staff as appropriate. This is a positive development for the holistic care of people cared for by mental health services. However we shouldn't lose sight of the fact that many allied health professionals already possess many of these skills, as their training encompasses both physical and mental health, and are therefore ideally placed to address this gap in current mental healthcare provision, and to lead, train and mentor mental health nurses delivering lifestyle interventions.

'Tone up, feel good' health and exercise for people with depression: Elderly Mental Health Service in Liverpool is a weekly group held for 1.5 hours over 8-12 weeks with 6-8 clients. Mood levels on a Visual Analogue Scale (VAS) chart recorded at intervals during programme .i.e. on arrival, after breathing exercises, after mini circuit and at end of session. All exercises are completed in house with no special equipment. Once completed, clients can progress to monitored, graded use of pedometer to increase outdoor activity. Hospital Anxiety and Depression scale (HAD) and subjective comments are also used.

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¹ Department of Health (2004), *Choosing Health: making health choices easier*, London, DH

² Department of Health (2006), *Choosing Health; supporting the physical health needs of people with severe mental health illness*, London, DH

³ Department of Health (1999), *Saving Lives: our healthier nation*, London, DH

⁴ Care Services improvement Programme (2005), *Everybody's business: Integrating mental health services for older people*, London, DH

⁵ Department of Health (2006), *The Chief Nursing Officer's review of mental health nursing: From Values to Action*, London, DH

A12 Developing the evidence base

The foundation of an evidenced based practice approach to the care of individuals is the judicious use of the current best available knowledge to guide a practitioner's decision making¹. Arguably, this definition also includes practice-based evidence. Adopting evidence based practice, as part of any mental health care intervention is important in a number of ways including:

- Enhancing health care gain for service users
- Supporting effective commissioning based on clinical outcomes
- Enhancing capacity for accurate clinical decision making
- Improving equity in terms of access and choice
- Maximising value for money
- Supporting clinical governance
- Developing effective and efficient framework for postgraduate education

AHPs have expressed great motivation to underpin their interventions with evidence and at the same time have acknowledged the challenges to this goal². Gerrish and Clayton³ describe the best practice as an approach that considers the research evidence in addition to the service users' narrative, the environmental context, the complexity of need and the expertise and tacit knowledge of the clinician.

With regard to the generation of evidence for practice, the positive testing of a hypothesis by gathering data using techniques such as randomised control trials is often put forward as the ideal form of evidence based practice. This works well for testing the benefit of a pharmaceutical or similar single element intervention. The "positivist" approach is not always well suited to measuring the work of AHPs, who generally undertake interventions in a holistic manner, in circumstances where it is difficult/ impossible to hold other parameters constant.

Pope and Mays⁴ (1995) argue that naturalistic research makes an important contribution to health care because it enables access to areas which are not amenable to the positivistic approach. This allows the gathering of data/evidence as it naturally occurs in real settings and then to retrospectively examine the evidence for correlations. AHPs might use this approach to gather and examine a variety of data/evidence on the effectiveness of their interventions. For example discussing and recording service user perceptions and preferences and/or recording more concrete data such as discharge/relapse rates, from which to draw conclusions. Further reading is available about the differences between the positivistic and naturalistic approaches to gathering evidence is presented by the NHS executive⁵

The Knowledge and Skills Framework (KSF) defines and describes the knowledge and skills that staff need to put into practice in order to deliver quality services to users and carers. Within KSF, there is ample scope to incorporate NWW and innovative practice through

¹ Sackett, D.L.; Rosenberg, W.M.C.; Muir Gray J.A. et al (1996) Evidence based medicine: what it is and what it isn't. *British Medical Journal* 312:71-72

² Metcalf C., Lewin R., Wisher S. et al. (2001) "Barriers to Implementing the Evidence Base in Four NHS Therapies – Dieticians, occupational therapists, physiotherapists, speech and language therapists" *Physiotherapy* 87 (8) 433-441

³ Gerrish K., and Clayton J. (2004) "Promoting evidence-based practice: an organizational approach" *Journal of Nursing Management*. 12, 114-123

⁴ Pope, C. and Mays, N. (1995) Reaching the parts that other methods cannot reach: an introduction to qualitative methods in health and health services research. *British Medical Journal* 311, pp42-45.

⁵ NHS Executive, Anglia and Oxford, edited by RCN Institute and Jill Rogers Associates. (1999) Evidence-based Health Care. Unit 2. Asking the Questions: Finding the evidence. pp 21-3. Critical Appraisal Skills Programme (CASP) and Health Care Libraries Unit (HCLU)

developing and utilising evidence based practice. For a full list of KSF evidence based practice areas and where to locate them, see Page 231 *The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process*⁶.

The regular use of best-researched evidence for practice decisions remains an aspiration for practitioners in many AHP disciplines - NHS Centre for Reviews and Dissemination⁷. A cultural shift needs to occur in the UK to ensure that the evaluation of AHP interventions through research becomes a priority for mental health practice.

This can be achieved by:

- Making use of research funding (National Institute for Health Research www.nihr.ac.uk) in appropriately designed research studies to generate a greater evidence base of AHP practice in both specialist skills and extended scope practice.
- Partnership working between academic institutions and clinical services.
- Realistic evaluation of AHP practice using a Naturalistic approach based on qualitative research methods would generate further knowledge about aspects of practice that are difficult to evaluate using traditional quantitative methods.
- Developing new working practices which enhance the knowledge, skill and confidence of AHPs' to use the available evidence in practice for and with service users.
- Inclusion of evidenced based mental health AHP interventions within the NICE national guidelines.
- Inclusion of evidenced based mental health AHP interventions within the NICE national guidelines.

Research and Development Specialist – Arts Psychotherapies (AsPs)

The post holder aims to facilitate research and promote a research culture in the arts psychotherapies in order to establish an evidence base for best practice in line with the NSF:

- *to engage with national researchers with a view to the Trust's AsPs being part of larger research projects and to build an archive that would be available to the AsPs and the wider Trust and others from outside the Trust.*
- *to keep up to date with current research and cascade this information to the AsPs across the Trust to ensure best and most up to date practice and a high quality service .*

This post was established in 2000 and the benefits of the post have been:

- *the development of a workforce that is very research aware and an increase in research activity.*
- *engagement in a national research project, the largest of its kind in the world, looking at the efficacy and cost effectiveness of art therapy for people with schizophrenia.*
- *therapists are more willing to engage in research as they know they will have advice and full support throughout their project*

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⁶NHS Employers (2004), *The NHS Knowledge and Skills Framework (NHS KSF) and the development review process*,

⁷NHS Centre for Reviews and Dissemination (1999) "Effective Health Care – Getting Evidence into Practice" 5 (1) 1-16, University of York, The Royal Society of Medicine Press Ltd.

A13 Further sources of information

- **Health reform in England: update and next steps** – identifies four inter related and mutually reinforcing streams of work - more choice, more diverse providers, money following the patient, system management and decision making
<http://www.dh.gov.uk/assetRoot/04/13/72/27/04137227.pdf>
- **Our health, our care, our say: new direction for community services** – has four main goals, better prevention services with earlier intervention, more choice and a louder voice, do more on tackling inequalities and improving access to community services, more support for people with long-term needs.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127453
- **Choosing Health: Supporting the physical health needs of people with severe mental illness** – a best practice document to help PCTs plan for, design, commission and monitor services that will deliver improved physical health and well-being for people living with severe mental illness.
<http://www.dh.gov.uk/assetRoot/04/13/82/90/04138290.pdf>
- **10 High Impact Changes for Mental Health Services** – aim to improve quality of care and also improve efficiency of services providing a more streamlined and effective service tailored to individual needs
http://kc.nimhe.org.uk/upload/CSIP_NIMHE_10HICs1.pdf
- **10 Essential Shared Capabilities** – provide the mental health specific and achievements for education, training and CPD at pre-registration/qualification stage and are complementary to other frameworks such as National Occupational Standards (NOS) and the Knowledge and Skills Framework (KSF)
<http://www.lincoln.ac.uk/ccawi/publications/Ten%20Shared%20Capabilities.pdf>
- **Creating Capable teams Approach** – was developed with involvement of service users and carers to help integrate new roles and NWW into multidisciplinary teams (MDTs). It is delivered in five steps which incorporate three workshops. For further information about the CCTA please contact: Nicki Hollingsworth, CCTA National Lead, 07818046431 or nicki.hollingsworth@humber.nhs.uk
- **New ways of working for psychiatrists: Enhancing effective person-centred services through new ways of working in multidisciplinary and multi-agency contexts. Final report 'but not the end of the story'** – identifies new and changing roles for psychiatrists and while the primary focus was on consultant psychiatrists the multidisciplinary teams with whom they work are recognised as being of equal importance and that changing the role and focus of one profession affects the team as a whole. The appendices contain statements of the contribution of stakeholders including AHPs. <http://www.lincoln.ac.uk/ccawi/publications/NWW%20Psychiatrists.pdf>

Further Reading

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Other useful websites

www.nhscareers.nhs.uk

www.nhsemployers.org

www.newgenerations.org.uk

A14 Glossary

10 ESC	Ten Essential Shared Capabilities
AC	Approved Clinician
AHP	Allied Health Professional
AMHP	Approved Mental Health Practitioner
APMT	Association of Professional Music Therapists
ASW	Approved Social Worker
BAAT	British Association of Art Therapists
BADth	British Association of Dramatherapists
BDA	British Dietetic Association
CCTA	Creating Capable Teams Approach
CHRE	Council for Health Regulation Excellence
COT	College of Occupational Therapists
CPD	Continuing Professional Development
CSIP	Care Services Improvement Partnership
CSP	Chartered Society of Physiotherapy
DH	Department of Health
DNA	Did Not Attend
DoL	Deprivation of Liberty
ECtHR	European Court of Human Rights
KSF	Knowledge and Skills Framework
HEI	Higher Education Institute
HPC	Health Professions Council
MCA	Mental Capacity Act
MDT	Multidisciplinary Team
MHA	Mental Health Act
MHAHPAG	Mental Health Allied Health Professionals Advisory Group
MHRT	Mental health Review Tribunal
MPET	Multi-Professional Education and Training
NICE	National Institute for Clinical Excellence
NIMHE	National Institute for Mental Health England
NMET	Non-Medical Education and Training
NOS	National Occupational Standards
NWW	New Ways of Working
PEC	Professional Executive Committee
PCT	Primary Care Trust
RC	Responsible Clinician
RCSLT	Royal College of Speech and Language Therapists

REC	Research and Ethics Committee
RMO	Responsible Medical Officer
SfH	Skills for Health
SHA	Strategic Health Authority
SIFT	Service Increment For Training

Collaborative work between the following organisations:



Care Services Improvement Partnership **CSIP**

***National Institute for
Mental Health in England***



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