



**New ways of
working for psychiatrists:
Enhancing effective,
person-centred services
through new ways of working in
multidisciplinary and multi-agency
contexts**


Appendices of the Final Report
'but not the end of the story'

Royal College of Psychiatrists
National Institute for Mental Health in England
Supported by the Changing Workforce Programme

October 2005

A collaborative venture between the following organisations:



Care Services Improvement Partnership 

*National Institute for
Mental Health in England*



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Policy	Estates
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Management	IM&T
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Author	CSIP/NIMHE, CWP, Royal College of Psychiatrists
Publication Date	October 2005
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Description	Final Report from National Steering Group, co-chaired by NIMHE and RCPsych. The Report provides a framework for mental health services to help them develop new ways of working for psychiatrists that supports the delivery of person centred care and provides satisfying and sustainable role making best use of this valuable, finite resource.
Cross Ref	Guidance on New Ways of Working for Psychiatrists in a Multidisciplinary and Multi-agency Context: Interim Report August 2004
Superseded Docs	N/A
Action Required	N/A
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For Recipient's Use	

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Appendix 1

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Appendix 1 (a)

Membership of NSG and Sub Groups

The National Steering Group had representation from all of the following professional bodies. These have endorsed the report and have lent their logos in recognition of this.

- Royal College of Psychiatrists
- British Association of Social Workers
- College of Mental Health Pharmacists
- College of Occupational Therapists
- Nursing and Midwifery Council
- Royal College of Nursing
- Chartered Society of Physiotherapists
- The British Association of Art Therapists
- The British Dietetic Association
- The British Psychological Society
- The Sainsbury Centre for Mental Health
- The Mental Health Nurses Association
- Unison

All of the above, as well as the Royal Pharmaceutical Society, have been a part of the consultation process during the production of this report.

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New Ways of Working for Psychiatrists: Enhancing effective, person-centred services through new ways of working in multidisciplinary and multi-agency context: Appendices

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New Ways of Working for Psychiatrists: Enhancing effective, person-centred services through new ways of working in multidisciplinary and multi-agency context: Appendices

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Appendix 1 (b)

Glossary of abbreviations

A&E	Accident and Emergency
AfC	Agenda for Change
AHPs	Allied Health Professions
AMHP	Approved Mental Health Practitioner
AOT	Assertive Outreach Team
ASW	Approved Social Worker
BAAT	British Association of Art Therapists
BASW	British Association of Social Workers
BDA – MHG	British Dietetic Association Mental Health Group
BMA	British Medical Association
BME	Black and Minority Ethnic
BNF	British National Formulary
BPS	British Psychological Society
CACWI	Centre for Clinical and Academic Workforce Innovation
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCETSW	Central Council for Education and Training in Social Work
CCST	Certificate of Completed Specialist Training
CCTT	Creating Capable Teams Toolkit
CDW	Community Development Worker
CE	Chief Executive
CMHN	Community Mental Health Nurse
CMHT	Community Mental Health Team
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
COT	College of Occupational Therapists
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPF	Capable Practitioner Framework
CPMH	Chartered Physiotherapists in Mental Health
CPN	Community Psychiatric Nurse

CSCI	Commission for Social Care Inspection
CSIP	Care Services Improvement Partnership
CSP	Chartered Society of Physiotherapy
CSW	Carer Support Worker
CWP	Changing Workforce Programme
DDA	Disability Discrimination Act
DH	Department of Health
DLA	Disability Living Allowance
DNA	Did Not Attend
DRC	Disability Rights Commission
DWP	Department for Work and Pensions
ESC	Essential Shared Capabilities
ECT	Electro Convulsive Therapy
FCE	Finished Consultant Episode
GMC	General Medical Council
GMS	General Medical Services
GP	General Practitioner
GPwSI	General Practitioner with Specialist Interest
GSCC	General Social Care Council
HCA	Health Care Assistant
HCC	Health Care Commission
HEIs	Higher Education Institutions
HPC	Health Professions Council
ICD	International Classification of Diseases
IM&T	Information Management and Technology
IT	Information Technology
KSF	Knowledge and Skills Framework
LTMI	Long Term Mental Illness
MD	Medical Director
MDT	Multi Disciplinary Team
MH	Mental Health
MHO	Mental Health Officer
MMC	Modernising Medical Careers
NELMHT	North East London Mental Health Trust

NEYH	North East Yorkshire and Humber [NIMHE Development Centre]
NHS	National Health Service
NHSU	NHS (University)
NICE	National Institute for Clinical Excellence
NIMHE	National Institute for Mental Health (England)
NMC	Nursing and Midwifery Council
NMHPG	National Mental Health Partnership Group
NOS	National Occupational Standards
NSG	National Steering Group
NICE	National Institute for Clinical Excellence
NVQs	National Vocational Qualifications
NWP	National Workforce Programme (of NIMHE)
NWW	New Ways of Working
OT	Occupational Therapist
PA	Programmed Activity
PCGW	Primary Care Graduate Worker
PCLT	Primary Care Liaison Team
PCTs	Primary Care Trusts
PD	Personality Disorder
PGD	Patient Group Directives
PHCT	Primary Health Care Team
PI	Performance Indicator
PMO	Principal Medical Officer
PSI	Psycho Social Interventions
PSYPHER	Psychosis Service for Young People in Hull and East Riding
RCN	Royal College of Nursing
RDC	Regional Development Centre [of NIMHE]
ReFeR	Research Findings Electronic Register
RMO	Responsible Medical Officer
RVQ	Related Vocational Qualification
S4C	Skills for Care
SCMH	Sainsbury Centre for Mental Health
SHO	Senior House Officer
SHAs	Strategic Health Authorities

SMI	Serious Mental Illness
SOAD	Second Opinion Appointed Doctor
SpR	Specialist Registrar
STR	Support, Time and Recovery
SU	Service User
TOPSS	Training Organisation for Personal Social Services
UK	United Kingdom
WAT	Workforce Action Team
WPA	World Psychiatric Association
WTE	Whole Time Equivalent

Appendix 1 (c)

References

National Steering Group Interim Report

Guidance on New Ways of Working for Psychiatrists in a Multi-disciplinary and Multi-agency Context: dh@prolog.uk.com: reference 40379

Mental Health Workforce Strategy

Mental Health Care Group Workforce Team: National Mental Health Workforce Strategy: dh@prolog.uk.com: reference 40276

National Service Frameworks for Mental Health-MH, Older adults, and Children

Department of Health (1999) National Service Framework for Mental Health. Modern Standards and Service Models for Mental Health. London: Department of Health.

Department of Health (2001) National Service Framework for Older People. London: Department of Health.

Department of Health (2004) National Service Framework for children, young people and maternity services. London: Department of Health.

NSF Five years on

The National Service Framework for Mental Health – Five Years On: dh@prolog.uk.com: reference 265907

National Occupational Standards for Mental Health

www.skillsforhealth.org.uk

Ten Essential Shared Capabilities

The Ten Essential Shared Capabilities: A Framework for the Whole of the Mental Health Workforce: dh@prolog.uk.com: reference: 40339

Mental Health and Social Exclusion Report

Social Exclusion Unit (2004) Mental health and social exclusion. London: Office of the Deputy Prime Minister.

Choosing Health – Making healthy choices easier [the Public Health White Paper]

Department of Health (2004) Choosing Health: Making Healthy Choices Easier. London: Department of Health.

The NHS Improvement Plan

Department of Health (2004) The NHS Improvement Plan.: Putting people at the heart of public services. London: Department of Health.

The draft Mental Health Bill

Department of Health (2004) Draft Mental Health Bill. London: Department of Health.

National Standards, Local Action – Health and Social Care Standards and Planning Framework

Department of Health (2004) National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06 – 2007/08. London: Department of Health.

10 High Impact Changes

NHS Modernisation Agency (2004) The 10 High Impact Changes for Service Improvement and Delivery. London: Department of Health.

National Programme for Information and Technology (NpFIT)

www.connectingforhealth.nhs.uk

Independence, Well-being and Choice

Independence, Well-being and Choice – our vision for the future of social care for adults in England: www.dh.gov.uk/publications reference: 268814

WAT Report

www.dh.gov.uk/nsf/mentalhealth.htm

Dogra and Karim 2005

*Training in Diversity for Psychiatrists. *Advances in Psychiatric Treatment* 11: 159-167*

The following items often contain a variety of documents that may be found at www.dh.gov.uk

Agenda for Change

Career Framework

Consultant Contract

European Working Time Directive

Improving Working Lives

Payment by Results

System Reform e.g. Foundation Trusts

Appendix 2

Summary of New Ways of Working pilot development sites for psychiatrists, STR Workers and pharmacy by NIMHE Regional Development Centres

For information on STR workers, please contact Workforce Specialist, Siobhan Chadwick (07717130498) or Alison James (07717130497)

For information on Pharmacy work, please contact Workforce Specialist, Steve Manders (07717130496)

North East Regional Development Centre

Elaine Readhead 07919173948 k.e.readhead@ntlworld.com

Trust	STR Workers	Pharmacy Work	Consultant Work
Doncaster South Humber Healthcare NHS Trust	Yes	Yes	Yes
South West Yorkshire NHS Trust	Yes	Yes	Yes proposed
Leeds Mental Health Teaching NHS Trust	Yes	Yes	Yes proposed
South of Tyne and Wearside Mental Health Trust	–	Yes	–
Sheffield Care Trust	Yes	Yes	Yes proposed
County Durham & Darlington Priority Services NHS Trust	Yes	Yes	–
Tees & North East Yorkshire NHS Trust	Yes	Yes	–
Newcastle, North Tyneside & Northumberland NHS Trust	–	Yes	Yes
Humber Mental Health Teaching NHS Trust		–	–
Leeds North West PCT Mental Health Modernisation Team	Yes	–	–
Gateshead Council/South of Tyne & Wearside Mental Health NHS Trust	Yes	–	–
City of Sunderland Social Services Dept & South of Tyne & Wearside Mental Health NHS Trust	Yes	–	–
Bradford District Care Trust	Withdrawn	–	Yes proposed
Hambleton & Richmondshire Primary Care Trust	Yes	–	Yes
South Tyneside Mental Health National Service Framework LIT	Yes	–	–
Barnsley PCT	Yes		

Consultant Development Sites

NIMHE RDC	Site	Regional Lead	Project Lead	Area of work on New and Changing Roles	Others involved
North East	1) Newcastle, Northumberland and North Tyneside NHS Trust	Elaine Readhead Tel: 07919173948	Dr Suresh Joseph Suresh.joseph@nmht.nhs.uk (Sec. Betty Brook) Tel: 0191 2563079 Betty.brook@nmht.nhs.uk	<p>On 13th September 2004, 13 consultant psychiatrists changed their roles following three years of preparation. The role changes are part of a much larger service change- the pathways through care project.</p> <p>The change of roles is from a traditional consultant psychiatrist role to more specialised roles, initially this is in-patient and community. Eventually it is envisaged that specialist roles will develop in primary care liaison, acute integrated treatment and specialist community roles e.g. personality disorder, psychosis, anxiety and depression. From April 2005, further work on caseload management, developing the role of Clinical Administrator, further shadowing, work with CMHTs, and sharing the learning from the development sites is underway.</p>	Judi Egerton, Tel: 07901712554 Judi.egerton@ncumbria.nhs.uk
NIMHE RDC North East	2) Humber Mental Health Team	Elaine Redhead	Nicki Hollingsworth Tel: 01482 389226 nicki.hollingsworth@humber.nhs.uk	<p>The new ways of working programme is focusing on Hull, Adult Mental Health Services. All 8 consultants across the patch have agreed to move from a locality based model to a functional model. A strategic document has been produced and a workshop was held in April, facilitated by NIMHE. The process will be supported by a single path referral system i.e. caseload management process.</p>	Stephen Merson Consultant Psychiatrist Now at: Stephen.Merson@oxmhc-tr.nhs.uk
NIMHE RDC North East					Dr.D.Gee (Consultant Psychiatrist) Peter Kennedy Peter@kennedy89.freeserve.co.uk 07974 14427 Heather Raistrick Heather.raistrick@nimheneyh.nhs.uk 07958973519

NIMHE RDC	Site	Regional Lead	Project Lead	Area of work on New and Changing Roles	Others involved
NIMHE RDC North East	3) Doncaster and South Humber NHS Trust	Elaine Redhead Tel: 07919173948	Graham Higgins Graham.Higgins@dsh.nhs.uk (Sec. Diane Ledain) Tel: 01302 796141 diane.ledain@dsh.nhs.uk	Five potential areas of work identified Development of a nurse consultant role in Learning Disabilities. Increase the focus on nurse lead clinics and pathways and ECT Clinics Increase the number of non-medical prescribers Explore the use of an integrated IT system All of the above are aimed at releasing Consultant time, and dealing with Consultant vacancy issues. Discussions taking place to decide which areas to develop.	Dr Abed (Medical Director) Peter Pratt Tel: 0114 2718631 Peter.pratt@SCT.NHS.UK
	4) Hambleton & Richmond-shire	Elaine Redhead	Dr Chris Simpson Paul Farimond	A whole system approach to MH services and Consultant roles in a PCT.	

North West Regional Development Centre

Paul Greenwood: Paul.greenwood@nimhenorthwest.org.uk

Trust	STR Workers	Pharmacy Work	Consultant Work
Pennine Care NHS Trust	–	Yes	Potential site
Cheshire and Wirral Partnership NHS Trust	–	Yes	–
MerseyCare NHS Trust	–	Yes	–
5 Boroughs Partnership NHS Trust	Yes	Yes	–
North Cumbria Mental Health & Learning Disabilities NHS Trust	Yes	Yes	–
Morecambe Bay Primary Care Trust	–	Yes	Yes
Manchester Mental Health & Social Care Trust	–	Yes	Yes
Bolton, Salford & Trafford Mental Health & Social Care Trust	–	Yes	–
Lancashire Care NHS Trust	–	Yes	–
Blackburn & Darwen Social Services Dept	Yes	–	–
Hyndburn & Ribble Valley Primary Care Trust	Yes	–	–
Lancashire County Council Social Services Dept	Yes	–	–
Cumbria County Council Social Services Dept	Yes	–	–

Consultant Development Sites

NIMHE RDC	Site	Regional Lead	Project Lead	Area of work on New and Changing Roles	Others involved
North West	5) Morecambe PCT	Dr Judy Harrison	Dr Anthony Page Dane Garth Furness General Hospital Barrow In Furness Anthony.Page@mbpct.nhs.uk	<p>Morecambe Bay PCT has agreed to appoint a G-grade CPN to work with both consultants to facilitate the transfer of the routine follow up of stable patients with SMI to primary care, enabling the consultants to take on a more 'consultative' role, in the context of the new multidisciplinary team.</p> <p>The proposal aims to:</p> <ol style="list-style-type: none"> 1) Review QMAS data relating to the general practices in Barrow and Furness to and in the light of it to work with practices to develop consistent criteria and for severe mental illness registers and their use and to offer development support to other practices. 2) To carry out a skills audit in those practices who are developing nurse-led SMI physical health clinics to identify training needs in each general practice. 3) To carry out an audit of any existing practice nurse-led SMI clinics to examine adherence to NICE guidelines on monitoring the physical health of patients on antipsychotic drugs. 4) To pilot in one general practice, a practice nurse-led SMI clinic which includes monitoring mental state and side effects as well as physical health, and includes routine blood tests for patients on mood stabilising drugs. 	
	6) Manchester Health and Social Care Trust	Dr Judy Harrison	Dr Damien Longson SAFIRE, Park House, North Manchester General Hospital, Delauney's Rd, Manchester Mental Health & Social Care Trust dlongson@manchester.ac.uk		

East Midlands Regional Development Centre

Dr Hugh Middleton: Hugh.Middleton@nottingham.ac.uk

Trust	STR Workers	Pharmacy Work	Consultant Work
Leicestershire Partnership NHS Trust	Yes	Yes	Potential site
Northamptonshire Healthcare NHS Trust	–	Yes	–
Sherwood Forest Hospitals NHS Trust	–	Yes	–
Lincolnshire Partnership NHS Trust	Yes	Yes	Yes
Derbyshire Mental Health Services NHS Trust	Yes	–	–
Nottinghamshire County Council Social Services Dept.	Yes	–	–
Daventry & South Northants PCT Mental Health Commissioning Team	Yes	–	–
Nottinghamshire Healthcare NHS Partnership Trust	–	–	Yes

Consultant Development Sites

NIMHE RDC	Site	Regional Lead	Project Lead	Area of work on New and Changing Roles	Others involved
NIMHE RDC East Midlands	8) Nottingham Healthcare NHS Trust	Hugh Middleton Tel: 07719451177 Hugh.middleton@nottingham.ac.uk	Peter Kennedy and Roslyn Hope	<p>A new approach to Leadership- whilst this is not strictly a development site, this is an issue for most sites.</p> <p>This model proposes to identify and address the specific needs of the psychiatrist at four levels:</p> <ol style="list-style-type: none"> 1. For specialist registrars: to learn how mental health services are organised and led, and about the rights and duties of those who are led. 2. For new consultants: to learn about medical leadership in clinical teams and how to work effectively with other leaders and disciplines. 3. For clinical directors: to define the role clearly, and how to realise its full potential in operational management and clinical governance. 4. For the medical director: to play a major part in strategic planning and management of the trust and its medical workforce in partnership with the chief executive and top team. <p>This approach is being explored in Nottingham through a series of planned learning sets.</p> <p>NIMHE East Midlands are also leading on joint work in the area of Acute in-patient care.</p> <p>A working group has been set up to scope and explore role of the consultant psychiatrist in an Acute Care context</p>	
NIMHE East Midlands	9) Lincolnshire Partnership NHS Trust	Hugh Middleton	Paul Barczak Paul.Barczak@LPT.nhs.uk	<p>Exploring the use of guidance from Avon and Wiltshire Partnership, and the role of consultants in CMHTs</p> <p>Questionnaire sent out to sample work/activity</p>	Karen Austin (WF and Service Dev. Lead) Tel 01522 582954 Karen.Austin@lpt.nhs.uk

West Midlands Regional Development Centre

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Trust	STR Workers	Pharmacy Work	Consultant Work
South Birmingham Primary Care Trust	–	Yes	–
Worcs. Mental Health Partnership Trust	Yes	Yes	Potential site
Birmingham & Solihull Mental Health Trust	Yes	Yes	–
City of Stoke on Trent Social Services Mental Health Team	Yes	–	–
Shropshire County Primary Care Trust	Yes	–	–
North Staffs Combined Healthcare NHS Trust	Yes	–	Potential site
Coventry Primary Care Trust	Yes	–	–
MACA Midlands & North	Withdrawn	–	–
Sandwell Mental Health NHS & Social Care Trust	Yes	–	–
South Warwickshire PCT and Warwickshire Social Services	Yes		
North Warwickshire PCT	Yes		
Hereford Primary Care Trust	–	–	Yes
South Staffs Healthcare Trust	Yes	–	Yes
Walsall PCT	Yes	–	–
Wolverhampton PCT	Yes	–	–

Consultant Development Sites

NIMHE RDC	Site	Regional Lead	Project Lead	Area of work on New and Changing Roles	Others involved
NIMHE West Midlands	10) Hereford PCT	Roslyn Hope Tel: 07973438350 roslyn.hope@nims.nhs.uk	Sue Hamilton Sue.hamilton@herefordpct.nhs.uk (Sec. Sally Macintyre) Sally.Macintyre@herefordpct.nhs.uk 01432 262409 Dr Chris Thomas	Development areas are Changing role of consultant psychiatrist Establishing multi-disciplinary assessment clinic Establishing 'prn' clinics Using CPA as standardized assessment tool Establishing clear liaison with GP practices/triage of referrals Work also underway with the Medical Director and consultant group looking changing role of psychiatrists	Rob Cunningham, Mark Hemming, Lisa Barton, Sue Lamerton, Fiona Bird, Martin Foster, Kim Parker.
	11) Worcester MH NHS Trust	Roslyn Hope	Dr S Choong Steve.choong@worcs-mht.nhs.uk (Sec – Elizabeth Frani 01905 681668) Dr. Sally Natynczuk 01905 760364 07771784830 SALLY.NATYNCZUK@worcs-tr.wmids.nhs.uk	Currently exploring ways that one consultant team can work with Hereford. Workshop held on Job Planning and related issues	
	12) South Staffordshire Health Care Trust		Dr. Stuart Vaggers Dr. Abid Kahn	Application received re acute inpatient care	
	13) North Staffs Combined healthcare		Dr Lee	Workshop in September	

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Trust	STR Workers	Pharmacy Work	Consultant Work
Somerset Partnership NHS & Social Care Trust	Yes	Yes	–
North Dorset Primary Care Trust	Yes	Yes	–
Dorset Healthcare NHS Trust	Yes	Yes	–
South West Dorset Primary Care Trust	–	Yes	–
Devon Partnership Trust	Yes	Yes	–
Avon & Wiltshire Mental Health Partnership Trust	–	Yes	Yes
Plymouth Mental Health Partnership Trust	Yes	–	–
Cornwall Partnership Trust	Yes	–	–

Consultant Development Sites

NIMHE RDC	Site	Regional Lead	Project Lead	Area of work on New and Changing Roles	Others involved
NIMHE RDC South West	13) Avon and Wiltshire Partnership Trust	Kate Schneider Tel: 07973 732766 kate.schneider@nimhesw.nhs.uk	Dr Christine Vize Tel: 01380 731336 Christine.Vize@nhs.net (Sec. Jenny Winter) Tel: 01380 731328 jenny.winter@awp.nhs.uk	<p>The Avon and Wiltshire Mental Health Partnership Trust (AWP) has fostered the development of new ways of working (NWW) for consultants by providing a central steer and then supporting local initiatives. One of these, in West Wiltshire, became one of the first pilot sites, and the changes there are now being rolled out more widely.</p> <p>AWP's approach has been to encourage the development of NWW in the following way:</p> <p>Support from the Executive Team and the Board.</p> <p>Defining the boundaries of the role of the consultant. The Trust produced its own 'Trust Guidance on the Role of the Consultant Psychiatrist' in response to requests for more clarity from staff. In this document, it sought to interpret the currently available national guidance, clarify what is law and what is guidance, and define responsibilities of individuals (including consultants) and teams. The guidance supports a model of distributed responsibility, and has led to a number of practical changes which have emphasised the new approach (eg defining episodes of care by team rather than by consultant, PCTs no longer commissioning GP to consultant referrals). Legal advice and the endorsement of CNST (Clinical Negligence Scheme for Trusts) were obtained before the document was approved by the Trust Board. This Guidance is recommended for use by other Trusts developing NWW, and appears as an appendix in the Interim Report of the National Steering Group (2004)</p> <p>Defining the boundaries of the work of the team. A trust wide workshop was held, with commissioners, service users and carers, to produce a 'framework' for the development of entry and exit criteria for services and teams. The framework was then modified according to local/speciality need.</p>	

South East Regional Development Centre

Judi Mallalieu: 07753 821075: Judi.mallalieu@sedc.org.uk

Trust	STR Workers	Pharmacy Work	Consultant Work
East Kent NHS & Social Care Partnership Trust	Yes	Yes	–
Isle of Wight Healthcare NHS Trust	–	Yes	–
Surrey Oaklands NHS Trust	Yes	Yes	–
East Hampshire Primary Care Trust	Yes	Yes	–
Berkshire Healthcare NHS Trust	–	Yes	–
Hampshire Partnership NHS Trust	–	Yes	–
West Kent NHS & Social Care Partnership Trust	–	Yes	–
Oxfordshire Mental Healthcare NHS Trust	–	Yes	–
West Sussex Mental Health & Social Care Trust	–	Yes	–
East Sussex County Healthcare NHS Trust	Yes	–	–
Buckinghamshire Mental Health Trust	Yes	–	–
Portsmouth City Primary Care Trust	Yes	–	–
Surrey County Council	Yes	–	–

Consultant Development Sites

NIMHE RDC	Site	Regional Lead	Project Lead	Area of work on New and Changing Roles	Others involved
NIMHE RDC South East		Martin Hughes Tel: 0781 3613278 martinhughes@blueyonder.co.uk	Judi Mallalieu Judi.mallalieu@sedc.org.uk 07753 821075	Following several events over the last 18 months sharing issues and NWW developments. Workshops have been Recently held for the former three Surrey Trusts and Berkshire MH Trust	

Eastern Regional Development Centre

Paul O'Halloran: 07887723062: paul.o'halloran@nemhpt.nhs.uk

Trust	STR Workers	Pharmacy Work	Consultant Work
Cambridgeshire & Peterborough Mental Health Partnership Trust	Yes	Yes	– New Site
West Norfolk Primary Care Trust	Yes	Yes	–
Suffolk Mental Health Partnership Trust	–	Yes	Yes
Norfolk Primary Care Trust	–	Yes	–
East & North Hertfordshire NHS Trust	–	Yes	–
East Suffolk MIND	Yes	–	–
South Essex Mental Health Partnership NHS Trust	Yes	–	Yes
North Essex Mental Health Partnership NHS Trust	Yes	–	New Site
Norfolk Mental Healthcare NHS Trust	Yes	–	–
Beds & Luton Community NHS Trust	Yes	–	Yes
Hertfordshire Partnership NHS Trust	Yes	–	Yes
Norfolk & Waverley Mental Health Partnership Trust	–	–	Yes
Milton Keynes PCT and Milton Keynes Council Social Services Dept	Yes		

Consultant Development Sites

NIMHE RDC	Site	Regional Lead	Project Lead	Area of work on New and Changing Roles	Others involved
NIMHE RDC Eastern	14) Suffolk Mental Health Partnership NHS Trust	Paul O'Halloran 07887723062 Paul.o'halloran@nemhpt.nhs.uk	Dr Kamal Mohammed kamal.mohammed@smhp.nhs.uk 07855 762536 Dr Albert Caracciolo 07855 773427 albert.caracciolo@smhp.nhs.uk	<p>Improve service delivery within NSF Guidelines</p> <p>Improve patients and carers experience of the service</p> <p>Reduce competing demands on Consultants time with opportunity for professional development and developing special interests</p> <p>Refocus clinical expertise so that consultants provide input to one specified service</p> <p>Dissemination of Expertise and skills to other multidisciplinary team members</p>	(sec. Diane Chapman) 01206 287593 Diane.Chapman@nemhpt.nhs.uk Valerie Lofthouse (Office Manager)
	15) South Essex Partnership NHS Trust		Dr Pauline Roberts 01702 440400 pauline.roberts@southessex-trust.nhs.uk	<p>Aims to look at:-The patient pathway Referrals</p> <p>Integrated system of Care</p> <p>CRHT must gate keep beds</p> <p>Seamless transition</p> <p>Effective liaison with A&E</p> <p>Care co-ordinator maintains role</p> <p>Role of Consultant-needs medical leader/champion</p> <p>Mechanisms for early discharge.</p>	
	16) Norfolk and Waveney Mental Health Partnership NHS Trust		Dr Hadrian Ball 01603 421147 hadrian.ball@nwmhp.nhs.uk	<p>To meet National targets-e.g. fidelity to model in respect of CRHT, further development of AD and EIs.</p> <p>The achievement of these targets will have major implications for the role and job plans of consultants psychiatrists.</p> <p>The purpose of this proposal is to monitor and evaluate the process by which this is brought about and the outcome.</p>	

NIMHE RDC	Site	Regional Lead	Project Lead	Area of work on New and Changing Roles	Others involved
	17) Bedfordshire and Luton Community NHS Trust		Dr Michael O'Rourke 01234 310582 Michael.orourke@blct.nhs.uk	<p>To pilot the Colleges option three for 3 teams in Learning Disabilities in Bedford to give</p> <ul style="list-style-type: none"> Greater anatomy for other clinicians Manageable workloads for consultants Clarity of roles and responsibilities throughout Ability to benchmark services successfully Useful setting for post valuing people Mental Health service models for people with Learning Disability 	
	18) Hertfordshire Partnership NHS Trust		Dr Frances Burnett frances.burnett@hpt.nhs.uk 01727 834330	<p>The project is intended to produce a rapid multidisciplinary response to CMHT referrals. Specifically</p> <ul style="list-style-type: none"> Screen referrals Reduce the waiting time to initial assessment Provide immediate written feedback to referrer and patient Increase the skills of the MDT in assessment of new referrals Reduce follow-up outpatients clinic attendance Reduce administration time 	

London Regional Development Centre

Mike Firn Tel: 020 73072437 Mike.Firn@londondevelopmentcentre.org

Trust	STR Workers	Pharmacy Work	Consultant Work
The Newham Centre for Mental Health	–	Yes	–
Barnet, Enfield & Haringey Mental Health Trust	Yes	Yes	–
North East London Mental Health Trust and Havering Social Services Dept	Yes	Yes	Yes
Epsom & St. Helier University Hospital NHS Trust	–	Yes	–
Oxleas NHS Trust	Yes	Yes	Yes
West London Mental Health NHS Trust – Broadmoor	–	Yes	–
South London & Maudsley NHS Trust	–	Yes	–
East London & City Mental Health NHS Trust	–	Yes	–
Central & North West London Mental Health NHS Trust	–	Yes	–
Camden & Islington Mental Health & Social Care Trust	Yes	–	–
Richmond CAMHS Service	–	–	Yes

Consultant Development Sites

NIMHE RDC	Site	Regional Lead	Project Lead	Area of work on New and Changing Roles
NIMHE RDC London	19) Oxleas NHS Trust	Mike Firn Tel: 020 73072437 Mike.Firn@londondevelopmententre.org	Geraldine Strathdee Clinical Director, Bromley G@strathdee.co.uk Dr.Ifya Okocha Clinical Director Greenwich Directorate ify.Okocha@oxleas.nhs.uk	Forty-six Consultants and middle grade doctors in the Bromley and Greenwich Directorates are developing a methodology and tool kit, to support individual clinicians determine their optimal effectiveness and efficacy. The aim is to facilitate optimal MDT working and ensure best outcomes for service users. The project also has a service and practice development focus to: Re-design outpatient clinics and new models of working with primary care including the development of models of choice in intervention for service users on standard and enhanced CPA. It will develop new models of working with inpatient units including scenario planning for the new mental health legislation, and women only facilities as well as review of ward rounds. The Forty senior doctors have piloted an audit tool of consultant workload, an Audit tool of Outpatient clinic workload, used intelligent information reports, and service user outcomes and satisfaction tool.
	20) Child and Family Consultation Centre, Richmond Surrey		Dr Ann York/Dr Morris Zwi (Consultant Psychiatrist) Tel: 020 8355 1984 Ann.York@swlstg-tr.nhs.uk	First meeting held to discuss area of work, agreed that CWP/NIMHE will work with Richmond, Surrey CAMHS team to develop new ways of working across the team of 17 staff including two consultants. The work be integrated to other developments on South London and St. Georges MH NHS Trust
NIMHE RDC London	21) Waltham Forest PCT	Gemma Hughes	Nick McNulty Nick.McNulty@wf-pct.nhs.uk 07771 685 512	To examine the role of the consultant psychiatrist as part of the change process underway in Waltham Forest. A specific piece of work, which identifies the different possibilities for the consultant psychiatrist workforce within the changing service configuration provides a view of the advantages and disadvantages of changing roles and tests out some new ways of working.

STR Workers "A typical Support, Time and Recovery worker Accelerated Development Site is a partnership of local statutory and non-statutory agencies. Generally, one of these agencies – in most cases a NHS Trust or Social Services Department – assumes lead responsibility. A range of non-statutory agencies are involved within most sites; these can include those that are unique to that locality or region, and local branches of national agencies such as Mind, Rethink, Richmond Fellowship and Maca". Some 66 sites and 110 organisations are currently engaged. The are 44 sites engaged in the Pharmacy Programme.

Appendix 3

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Appendix 3 (a)

Summary of the Traditional Expectations and Modern Aspirations and Distinctive Contributions of staff, service users, carers, and the voluntary sector

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Summary of the Traditional Expectations and Modern Aspirations

Role	Traditional	Future
Art Therapist	<p>Art Therapy is a form of psychotherapy using art as its primary medium. Art therapists work 'side-by-side' with clients, and do not impose interpretations onto the artwork. They hold a non-judgemental stance towards client and artwork, as this is not about 'good or bad' art, but about uncovering meaning.</p> <p>Art therapy is a psychological therapy and not a 'therapeutic activity'. Traditionally, it has often been confused with therapeutic occupation. However, art therapy clients may rediscover their creativity and reconnect with a neglected part of them, and enjoy making art again. This sometimes gets pursued outside of art therapy.</p> <p>Art therapists often work as lone practitioners and lack time needed to network with colleagues; consequently, some confusion may persist on what they do. When they contribute to the team, they often bring a different perspective on the clients' process, since the artwork helps when they cannot find 'the words to say it'.</p>	<p>Art therapists need to continue developing practice in a way congruent to our changing social-cultural context: Art therapists do focus on issues of equality of access to treatment and anti-discriminatory approaches. They make essential contributions to service-users involvement where there are barriers to verbal communication (e.g. English as a second language)</p> <p>Art Therapists are now aware that there is a pressing need for evidence about their practice. Their clinical role has to extend to audit and research skills. The BAAT has a thriving Art Therapy Practice Research Network, where clinicians develop audit and research skills and collaborate on projects.</p> <p>Art therapists are aware of a need for openness to share skills and knowledge. There is a demand for flexibility in extending clinical roles to meet the 'Ten Key Roles' and work across boundaries with other professionals. They also need to develop management and leadership roles within their organisations.</p>
Carer	<p>Not recognised for the contribution they have made to supporting people with mental health problems on a 24/7 basis</p> <p>Not fully involved in the assessment and care planning process</p> <p>Expect the consultant psychiatrist to be in charge and to be seen regularly</p> <p>Passive recipients of services</p>	<p>Seen as having their own needs that should legitimately be met to fulfil not only their caring role but also their own lives.</p> <p>Recognised as major partners in the assessment and care planning process.</p> <p>Participating in the recruitment and training and evaluation of staff.</p> <p>Demanding a co-ordinated approach to care, addressing the wide range of physical, mental and social needs of their loved ones.</p> <p>Supporting the development of new roles in the workforce which give time to the service user</p>

Role	Traditional	Future
Dietitian	<p>To improve the physical health of service users by reducing the risk of CHD, diabetes, obesity, cancer, gastrointestinal side effects of medication, malnutrition, disordered eating by:</p> <p>Working with medical, nursing, pharmacy and AHP staff to identify needs of those at risk.</p> <p>Working with inpatient and community teams implementing appropriate care plans to address these needs, implementing lifestyle changes such as health promotion and working with weight loss groups.</p> <p>Working with hotel service providers ensuring that all nutritional requirements are met within the inpatient and community locations.</p>	<p>Service users need to access to care, which is appropriate to the individual, timely and supported.</p> <p>Service users suffer more physical ill health, related to lifestyle and have needs, which have not been met from the primary care services.</p> <p>There is a recognition that there are insufficient specialists dietetic posts within the mental health services and action taken to address this.</p>
General Practitioner	<p>An individual acting as patients advocate, on a pedestal, providing 24-hour personal care.</p> <p>Providing continuity of care using minimal recording in medical records.</p> <p>Self employed providing isolated medical services with an open ended contract with considerable variance of service provision between practices, gate keeping specialist services.</p>	<p>Team member acting as patients' advocate who can be challenged, providing accessible shared care with a practice team between 8.00 am to 6.30 pm Monday to Friday.</p> <p>Providing evidence based continuity of quality care using detailed recording in computerized medical records that can be audited.</p> <p>Self employed providing expanding range of services in primary care with interagency working meeting external targets.</p>
Non-Professional Workforce	<p>Engaged in tasks that release professionally qualified staff from routine</p> <p>Generic duties to undertake professionally specific, interventions with patients.</p> <p>'Unqualified', but much appreciated by patients</p>	<p>Development of the role, with further training, to be able to participate in more skilful interventions with individuals with mental ill health.</p> <p>Improved career structure that values practical, face to face work with service users.</p>

Role	Traditional	Future
Not-for-Profit, Non-Governmental Organisation	<p>Service users and carers have traditionally valued the voluntary sector for its independence from statutory services, its non-judgemental emphasis, commitment to rights, campaigning and care: an effective, and often the only, voice for service users, their families and friends.</p> <p>Commissioners and referrers have respected its specialist expertise and focus, probably also considering it to be lower cost with the added value of endless goodwill and commitment. They may have considered it as lacking a professionalism traditionally assumed to accompany statutory responsibility.</p> <p>Society's traditional expectations of the voluntary sector involve charity, commitment and campaigning, and tireless fundraising.</p>	<p>Maintain our independence whilst maximising our influence in service provision and policy development, advancing the critical factors for recovery, well-being and hope, such as: inclusion, anti-stigma, early intervention, alternatives to hospital, flexibility, advocacy, carer support, service-user leadership and self-management, training and employment.</p> <p>Sustain our fertile mix of the skills of a professional workforce and efficient business management on the one hand, and the passion and commitment of the experts by experience on the other, and a vital engagement between the two.</p> <p>Uniquely, service users and carers, the public and the statutory sector, continue to look to the voluntary sector to campaign for rights and services, to research need, lobby decision-makers, and promote collective aspirations in order to achieve advances, solutions and, occasionally, small revolutions (eg the carers' movement and the Alliance against the Mental Health Bill).</p> <p>The sector's own workforce expects improved working conditions, personal development and career opportunities – in addition to organisational flare and vision, and a distinctive public profile.</p>
Nurse	<p>A self-sacrificing profession, whose role it is to support medicine.</p> <p>Providing basic and non-technical care, but often closely allied to service users.</p> <p>Focusing on containment and treatment</p>	<p>Deliverers of truly holistic care, focusing on service users desired outcomes.</p> <p>Increasingly evidence based.</p> <p>Developing a range of new roles and skills to meet needs, e.g. nurse prescribing, psycho- social interventions.</p>
Occupational Therapist	<p>More frequently based within an OT department, or working in isolation as part of a team.</p> <p>Group and individual interventions offered to service users, the majority of which are activity based and perceived as diversion.</p> <p>Service is offered during the hours of 9-5, Monday to Friday.</p>	<p>Develop an individualised occupational therapy response according to service users' needs and aspirations as part of a multi- disciplinary team.</p> <p>Wide range of interventions concerned with developing roles and skills of service users to promote their participation in all areas of life.</p> <p>Flexibility working, including weekend and shift work.</p> <p>Extended roles in relation to medication, mental health legislation and leadership.</p>

Role	Traditional	Future
Pharmacist	<p>To dispense and provide advice to patients in a professional manner.</p> <p>To provide unbiased advice to other healthcare professionals when requested.</p> <p>To be the experts regarding drug usage, side effect, interactions, pharmacokinetics etc.</p>	<p>More pharmacists recruited to mental health specialist field to provide proactive, patient centred, holistic pharmaceutical care to patients with mental health needs in all settings (inpatients, outpatients, home treatment)</p> <p>Specialist mental health pharmacists taking on prescribing or mentoring responsibility for service users medicines management.</p> <p>Pharmacists taking on leadership roles for medicines management within teams</p>
Physiotherapist	<p>Physical health focus</p> <p>Not member of multi-disciplinary team</p> <p>More likely to work with older people</p>	<p>Care co-ordinator</p> <p>Using physical activity to enhance mental well being</p> <p>Whole person approach</p>
Psychiatrist	<p>Exercise authority and responsibility as one holding power in an organisational hierarchy.</p> <p>Hold relevant expert knowledge, and act as a leader of others using that knowledge and related skills.</p>	<p>Provide expert medical input to multi-disciplinary assessments and therapeutic endeavours.</p> <p>Make broader contributions, as one of a range of senior practitioners, to the care of individual patients, corporate clinical governance, and health services management.</p>
Psychologist	<p>Predominantly one-to-one out-patient CBT or psychotherapy, largely with non-SMI clients.</p> <p>Referrals from colleagues of complex cases and personality disorder.</p> <p>Absent from CPA co-ordination, statutory responsibilities, on-call duties and in-patient work.</p> <p>Although extensively trained in research, audit and organisational intervention, not commonly asked to undertake such tasks, and rarely recognised as a routine aspect of role.</p> <p>Covert supervision of other MDT members.</p>	<p>Greater contribution to the management of people with SMI including psychosis.</p> <p>Clinical Supervisor role in new MH legislation.</p> <p>Greater involvement in the determination of capacity.</p> <p>Recognition of non-face-to-face work by managers, such as supporting and enhancing team working and overt supervision of others involved in providing psychological intervention including PSI.</p> <p>Greater influence on trust strategic decision-making, along with more clinical leadership.</p> <p>Engender wider access to, and choice in, psychological therapies in primary, secondary and tertiary care.</p>

Role	Traditional	Future
Service User	<p>The service user is seen as an “add on” in the delivery of their own care and the last person with whom the team consults about their treatment.</p> <p>The “them and us” barrier creates an artificial divide which allows poor practice and prevents a common goal of enabling the patient to achieve a quality of life that is self defined and reflects their own hopes and ambitions.</p>	<p>Modern practice is about having the service user at the heart of every aspect of their care as an equal partner.</p>
Social Worker	<p>Traditionally work with people who have become dislocated in some way from civil society.</p> <p>For some, social workers are seen as non-conforming, interfering politically correct risk-takers.</p> <p>Intervention is necessarily eclectic to respond to a wide range of psycho-social need. Apart from high-profile child protection work, eclecticism has traditionally become synonymous with ‘everything that nobody else is doing’.</p>	<p>That social work knowledge, skills, values and experience are acknowledged as critical to promoting and delivering the social inclusion agenda.</p> <p>That social care has a greater leadership profile in mental health services.</p> <p>That social workers have a fundamental influence on the training, development and delivery of the AMHP role in the new Mental Health Bill.</p>

Distinctive contributions of staff, users, carers, and the voluntary sector to multi-disciplinary and multi-agency team/s

It was considered essential that the current professional and support roles were understood in order that progress could be made in ensuring that the best use of their individual distinctive contributions could be made to the work of multi-disciplinary and multi-agency teams.

A presentation format was agreed for this process to help identify the distinctive contribution each profession/role; once this was clear it then allowed discussion on shared work areas and potential for new and changed ways of working.

For each profession/role the Distinctive Contribution has an Introduction, Education and Training, Traditional Expectations, Future Aspirations and, where possible, a worked example section to explain current thinking.

1.0 Contribution of Art Therapy

1.1 Introduction

Art Therapy is a form of psychotherapy that uses art as its primary medium. It enables clients to address or explore what may often be severe emotional and behavioural problems. It may be particularly helpful for people who find verbal communication difficult. Clients do not need to have any previous experience or expertise in art.

Art Therapists are not the only professionals to use art in their work with clients. However, as artists themselves, they have a unique grasp of the relationship between the creative process and communication.

As a profession, Art Therapy is strongly anchored within public services. Since 1997, it has been a State Registered profession and is regulated by the Health Professions Council (both Art Therapy and Art Psychotherapy are protected titles and here the title Art Therapy will be used to include both). The professional body is the British Association of Art Therapists (BAAT).

1.2 Education, Training and Career Routes

Pre-Qualifying Training Requirements

Art Therapy training is at Masters level. All applicants should have a primary degree or equivalent. This will normally be in arts-related subjects. However, special entry candidates will be considered if they have professional qualifications in e.g. medicine, psychology, occupational therapy, nursing, social work and special needs teaching. All applicants are required to have fulfilled a minimum of one-year full time employment (or part-time equivalent) in the care sector, where their primary role is care delivery.

Consequently Art Therapy trainees are mature students who come to the course with considerable work and life experience. Many have also had successful first careers and the attrition rate is low (2 to 3 per 25 students)

Equal Opportunities in Training

The Art Therapy trainings' profile is as (approximately) follows:

- 15% of students from ethnic minorities.
- 5.5% disabled
- 15% dyslexic

There is no data available that shows how many Art Therapy Trainees have themselves been mental health service users; however, anecdotal evidence suggests that many have come to train after such experiences. Despite the fact that most trainees mostly self-fund, all courses are oversubscribed.

Qualifying Training

Art Therapy training institutions must meet the Standards of Education Training, as set out by the HPC in consultation with the BAAT. Trainees are taught theories of child development, the main tenets of psychoanalysis and psychotherapy, individual and group approaches, and focus on work within mental health, learning disability, etc. Art Therapy experiential learning is also a major part of the training. Basic research skills are also taught. Trainees must be in personal therapy for the duration of the training.

Career Routes

Since it can sometimes be difficult to find full-time paid employment on leaving college, many Art Therapists begin their careers by working part-time and sessionally. Frequently, newly qualified Art Therapists gain employment by using high levels of initiative to set-up posts in settings where art therapy has not previously been available. Furthermore, even though they will be recruited for their Art Therapy skills, they may often be employed under different titles such as 'day centre workers'.

Newly qualified art therapists need the most support in the period between finishing training and finding employment. The BAAT is now actively targeting support towards newly qualified art therapists to help them find employment by running workshops and publishing advice packs.

The retention rate for Art Therapists is high and they often stay in posts for long periods of time, providing excellent value for money for their employers and much needed stability for their clients and their teams who benefit from continuity in therapeutic care.

After this initial post-training period approximately 70% of Art Therapy will work in the health service (predominantly CAHMS, adult mental health and learning disabilities). However the application of Art Therapy/Psychotherapy is very broad and Art Therapy will work all areas of care including schools, hospices, head injuries, drug and alcohol, refugee and trauma clinics etc.

The new pay structure being implemented in the NHS under Agenda for Change is likely to enhance career prospects for members of the profession and to ensure a more appropriate remuneration that has been provided to date under the Whitley pay scale.

1.3 Traditional expectations of the profession

From the profession

- **As a clinician**, the Art Therapist is expected to foster a safe and facilitating environment in which clients may develop an emotional language through the use of art. The Art Therapist should adopt a non-judgemental stance towards the client and the artwork, stressing that the process is not about making 'good or bad' art, but is about using a valued form of expression to explore their difficulties. The Art Therapist should hold a 'side-by-side' view of the therapy with the client, and not impose meaning or interpretations onto the client's artwork.
- **As a team member**, the Art Therapist can often contribute to the team's thinking from a different perspective on the client's views and process, since the artwork may symbolise previously unarticulated confusion or conflicts.
- **Art Therapists** have been under-represented at strategic levels: this has been partly as a consequence of working as lone practitioners, but also as a result of a lack of professional culture of management skills and leadership.

From service users and carers

- **'I am no good at art...'**: some confusion that one has to be an artist to take part, although this is addressed early on with the art therapist.
- **'Not finding the words to say it'**: relief at being offered a non-verbal treatment, especially when feeling stressed and unwell. Also, for parents and carers of children, or for people with English as a second language, relief at accessing a treatment where language is not a barrier

- **‘Discovering creativity’:** clients feel they can reconnect with a neglected part of themselves, and enjoy making art again. This sometimes gets pursued outside of Art Therapy.

From referrers and members of other mental health professions

- **Art Therapists as lone practitioners** often lack the time needed to network with colleagues, consequently, some confusion exists on what it is they do.
- **Confusion between Art as psychological therapy and Art as a ‘therapeutic activity’:** Art Therapy is a psychological therapy, but many colleagues think that it works in providing a therapeutic occupation.
- **Confusion as to whom to refer:** again, it is often believed that clients need to be ‘good at art’ to be referred, although this is not the case

From society

- **‘What’s Art Therapy?’** Existence of the profession poorly known until recently, apart from within specialist health care settings.

1.4 Future aspirations

From the Profession

- **Evidencing the efficacy of Art Therapy:** Art Therapists are now aware that their clinical role has to extend to audit and research skills and that there is a pressing need for evidence about their practice. The BAAT has a thriving Art Therapy Practice Research Network, where clinicians develop audit and research skills and collaborate on projects.
- **Taking on management and leadership roles:** Art Therapists are also aware that these roles need to be developed and that Agenda for Change has opened possibilities that need to be met.
- **Developing practice in a way that is congruent to our changing social-cultural context:** Art Therapists do focus on issue of equality of access to treatment and on providing this in anti-discriminatory approaches.
- **Being part of State Registered Allied Health Professions,** Art Therapists are expected to work more proactively in collaboration with colleagues: they share with them the Ten Key Roles agreed by AHPs and DOH (2004) and need to extend their traditional views of themselves as being ‘clinicians only’.

From Service Users/Carers

- **Need for culturally sensitive approaches:** as in point above
- **Expectations of good and open communication** with clients or carers, about the treatment, and about choices when applicable.

From Referrers and other mental health professions:

- **Improved communication** on what Art Therapy is, and provision of evidence
- **Flexibility in extending clinical role** to meeting the ‘Ten Key Roles’
- **Openness to share** skills and knowledge

From Society

- **Increased awareness of Art Therapy:** frequent press articles and on radio and TV. Also, the AHPs network has enabled a higher profile within career services, etc.
- **Our clients are our best advocates:** Really positive feedback on the value of Art Therapy, from both clients and carers.

Extended roles and responsibilities

Art Therapists

- Lead on management, research, development and workforce planning within NHS Trusts. They develop trust wide supervision policies and trainings.
- Lead clinical teams in such areas as learning disabilities and therapy based treatment programmes in drug and alcohol services.
- Provide expert clinical consultation for complex cases for Multi-disciplinary teams.
- Lead clinical governance forums and sit on ethical committees.
- Make essential contribution to public and service-users involvement where there are barriers to communication by impairments in cognitive (e.g. in learning disability) or physical/mental (working with speech and language therapists in traumatised acquired head injuries or mute children) functioning.
- Art therapists act as 'Expert Witness' provide court reports and represent 'looked after children' on matching panels.
- Represent their trust in many of these areas to other organisations and at national level forums.

All Art Therapy trainings are over-subscribed and Art Therapists could perform essential roles where there are staff shortages.

2.0 Contribution of Carers

2.1 Present

Carers are usually thought of as carers of their adult children; but today, many are also users of services and partners of service users with children. It is even more important that statutory services and other agencies remember the whole family; in particular the children who are young carers. Services must be provided for developing children and their parents. The cost to society and the harm done to the individual when they are ignored is great. In the near future, the country will be faced with an ageing group of people who have mental illness and have coped in the community only through the support of family and friends.

As family carers age, become unable to provide support, and as the health of the service user both physical and mental deteriorates (and there is plenty of evidence for this), they will require more care. Many may not be able to live alone in the community any longer.

The changing role of all professionals must address this now, before services are hit by an unexpected demand for care from people who have in the past required little of the statutory services. Presently we are trying, rightly, to improve early intervention for young people – we should. But, at the same time, we need to look ahead. We may need to provide much more supported accommodation or intensive community support of both domestic and social kind whilst caring for their physical and mental health. Liaison of professional workers in mental health with primary care and with hospital services is essential for the needs of the mentally ill. Poor physical health certainly affects mental capacity.

2.2 What Carers would like to see:-

In simple terms, we want new models of care and new ways of working that take account of and enhance the mental and physical health needs of the person, their families and relationships.

We also want to ensure that staff work to support the person in the community with minimal use of hospital admission.

2.3 Clinical and team responsibility

The move for psychiatrists being responsible for only those they are seeing and responsible only for the advice given to other members of the team is the model for the future. I believe it can work.

The public will need reassurance, however, about who is responsible for their care. They are used to believing it to be always the doctor. Changes in accountability must be made clear for carers as well as service users and other staff and management. Continuity of care can appropriately be provided by the care co-ordinator, as long as they are developed to undertake the role. Teams can and do, share expertise and cover in emergencies such as staff absence. Carers are reassured by having contact with a team member when the designated member of staff for their relative is absent.

We are concerned that the service user receives care/therapy from the most appropriate worker and that the worker is selected for their skills, knowledge and ability to work with the individual. Where the two do not make a therapeutic relationship, opportunity to change to another worker should not be a problem. Carers wish to have access to the worker when they feel it is necessary for progress.

In emergencies, communications and patient information must be available to all members of a team. It is hoped the recent introduction of specialist teams such as early intervention and home treatment will remain.

Access to any discipline must be available if the service user is to have choice.

2.4 Training for the Future

Carers would like to see

- More occupational therapists and assistants.
- More psychologists and junior psychologists.
- A wide diversity of support staff working alongside professional staff. However, unless these support staff have in-service training, defined job descriptions, supervision and opportunities to progress, they will always be an unstable workforce.
- More initiatives to attract mature people to shorter training for various professions would be worthwhile. Most carers feel that professional training is too long and too academic when they consider how they learn and cope for long periods of time with difficult behaviour, without training.
- Carers have been pleased to hear about the new grades of workers such as graduate primary care workers attached to primary care. So far, we have little experience as they are few in number. However, a career structure and ongoing training in their specialty are vital to retain them and benefit from their developing skills and experience.
- Carers would like to see the training (of all disciplines) include more time on the skills of communication, motivation and family help such as family behavior therapy. These subjects could be shared basic training for all, as captured in the '10 Essential Shared Capabilities' Above all, the workforce must be practically orientated, have common sense and be proactive on behalf of the service user.
- Care Co-ordinators are vital in communicating and in liaising with social, housing, education and work placements – whilst not being expected to know everything. The role is one that would be enhanced by having some training and not just one 'to grow into'. The role is a vital lynchpin if the whole needs of an individual are to come together. The needs of the family carer or friend should be part of the package of care for the individual service user.
- The experience of carers can be put to use more effectively in the future by promoting their development to recruit staff, deliver training and evaluate effectiveness. This will take time and resources, but could bring great benefit for all.

2.5 Crossing Boundaries

- Carers hope that the increase in support staff attached to professional workers and an increase in the numbers of professional workers will see some 'blurring' of professional boundaries.
- The boundaries between services for 'age groups' leave many service users without the support they are used to and young people with difficulty in accessing suitable services. Presently, sixteen to eighteen year olds have an inadequately staffed CAMHS service – unless psychosis gets them referred to early intervention services.

- Sixty-plus year old service users with psychosis are deprived of services they have used over many years and often have nowhere else to go. Services for those with organic disorders do not fulfill the needs for those who have long term psychotic disorders.
- Services for those with organic disorders may find they need to treat a much younger age group in the future. Flexible management of services must be a workforce priority.

2.6 New ways of working in the future

I feel the good will and hard work of all engaged in this programme of work bodes well for the future; but carers will only feel it when it impacts on everyday practice.

Pauline Arksey MBE

3.0 Contribution of Dietitians

3.1 Introduction

Dietitians apply sound, scientific, evidence-based knowledge of nutrition and diet to promote and protect health; to prevent, treat and manage illness; and to deliver good nutrition safely for those unable to eat normally.

The title 'dietitian' is protected under the regulations of the Health Professions Council, so can only be used by graduates whose qualification meets the requirements for registration with the Health Professions Council which sets and regulates standards for pre-registration training and continuing professional development. The Standards of Conduct, Performance and Ethics, and Standards of Proficiency are supplemented by the Code of Professional Conduct of The British Dietetic Association. There are approximately 5,000 dietitians registered with the Health Professionals Council, most of whom are working in the NHS. Many are specialists in specific branches of health care, though fewer than 5% are specialists in mental illness.

People with a mental illness have high rates of physical illness and are at an increased risk of developing and dying prematurely from coronary heart disease, cancer and obesity, all of which are critically affected by diet (1) and malnutrition is a consequence of self neglect. Medication used in treating mental illness has side effects including weight gain, hyperglycaemia, diabetes, and gastrointestinal problems which need long term dietary management. Dietitians can help reduce this additional burden both by direct intervention with service users who have complex therapeutic dietary requirements, and by training and supporting other mental health care professionals to deliver evidenced based nutrition education. In the specific area of eating disorders, skilled nutritional management is necessary for safe and effective treatment and risk management (2). A Mental Health Policy Report (3) identified a need for greater access to dietitians and everyone with diabetes **should** receive dietary information and support (4)

There is evidence that people with mental illnesses suffer discrimination and inequalities in health care (5) The Disability Rights Commission has launched an investigation because of the overwhelming weight of evidence pointing to disparities in health outcomes experienced by people with long term mental illness and people with learning disabilities.

Due to the small number of dietetic posts within the mental health services it is difficult for dietitians to meet the needs of service users, although these needs may be great. Most people with a mental illness who need dietetic treatment are referred to dietitians in primary or acute hospital care, who may not have the specific skills and professional support to provide the most appropriate care.

3.2 Education, training and career routes

There are two ways to qualify as a Registered Dietitian:

- Completion of a four year full time degree in nutrition and dietetics
- Completion of a two year full time post-graduate qualification (often a masters' degree), following a first degree in a related area.

Entry for the undergraduate degree requires 'A' level passes in 2 or 3 science subjects including chemistry, or an equivalent. All courses include a period of practical training in hospital and community settings. These placements must meet the standards set by the HPC.

Career routes and progression

- Entry level 5 on the career map as a newly qualified practitioner, most usually to a post in an acute hospital setting, which provides a breadth of experience, often by means of rotation in different areas of care.
- After 2-3 years of clinical experience and continuing professional development, a dietitian may apply for a level 6 post, specialising in one area. This would be the minimum entry point for dietitians in the mental health services.
- After adequate training and experience the dietitian can apply for a level 7 post, as an advanced practitioner or research dietitian in a specialist field, or as a team leader managing and supporting an area of service.

Continuing competence to practise is regulated by the HPC and supported by the BDA award of the Advanced Dietetic Practitioner I & II.

3.3 Traditional expectations

From the profession

Dietetics has traditionally been viewed primarily as part of physical health care, and dietitians seen as peripheral to mental health services. They have often been lone practitioners with a high caseload responding to referrals for individuals requiring therapeutic diets.

From users and carers

Individuals referred have usually expected a directive approach from dietitians. They anticipate a “medical model” of care, and a dietary “prescription”..

From other members of the mental health professions

Mental health care professionals traditionally have had limited training and practice in physical health care and have referred all nutritional issues to the dietitian. This distancing from nutritional care has been exacerbated by the separation of nurses from the task of feeding hospital in-patients by the contracting-out of catering services.

From society

Physical and nutritional care have not been given priority in the treatment and care of people with mental illness. This neglect has allowed physical health problems to develop, creating an increased burden for the individuals, their carers and health care professionals.

3.4 Future aspirations

In the past few years, there has been an increasing recognition within the NHS of the importance of food and nutrition in promoting health and recovery from illness (6). This has been the case in mental as well as physical health care. The incidence of the Metabolic Syndrome is higher in people treated with the atypical and typical neuroleptics (7) and the NICE Guidelines for schizophrenia recommend monitoring for weight gain and hyperglycaemia and more research on effective interventions for managing physical health. There is an increasing interest by professionals and the public that diet can influence mental as well as physical health and well-being (8). These emerging concerns and priorities have created an increasing demand for the services that dietitians can provide in the mental health services.

From the profession

- To ensure that all service users have access to nutritional advice and support from specialist dietitians working in the mental health services. Improving physical health will benefit the service user's response to treatment.
- To implement initiatives in nutritional care within the NHS i.e., nutrition screening requirements (9) and the development and implementation of hospital nutrition policies as required by the NHS Plan (10) which will include devising and delivering training to other professionals involved.
- To demonstrate commitment through CPD to evidence-based practice, providing information, training and opinion at all levels.
- To be consulted as appropriate in service planning.

From referring agencies

- To provide a dietetic service which is appropriate, timely and supportive to service users.
- To take a holistic and motivational approach to clinical work with patients to promote their empowerment in their care
- To function as fully-integrated members of multi-disciplinary teams.
- To provide a high level of expertise in the area of nutrition and dietetics as applied to all areas of mental health care

From service users and carers

- To provide a service which offers choice, convenience and support.
- To work within the team caring for them, in hospital, community, or primary care
- To apply a high level of knowledge and skill in engaging and motivating service users to facilitate and sustain change in eating behaviour

From other mental health professionals

- To provide a dietetic service for users in every area of mental health care
- To act as an information resource on all nutritional issues
- To work as a member of a multi-disciplinary team. Colleagues expect to have timely and easy access to the expertise (11) from specialist dietitians.
- To promote improvement in food provision for all inpatient and community settings ensuring that service users are enabled to choose an appropriate diet to promote physical health.
- To provide evidence-based information and training on nutrition, dietetics and changing eating behaviour for them to use appropriately e.g. Lifestyle and weight loss groups.

From society

- To minimise nutritional risk for the people in their care
- To offer easily-accessible, evidenced based nutritional information and advice to improve mental health and well-being.

- To respond actively to relevant reports from research, government and voluntary organisations to support continuing improvement in all areas of nutrition and health

New ways of working would involve dietitians working in multi-disciplinary teams training and supporting others to give consistent, appropriate and evidenced based advice which links to the NOS, The Health & Wellbeing Dimensions of the Knowledge & Skills Framework and the Ten ESC (11).

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4.0 Contribution of General Practitioners

4.1 Introduction

Primary Care services are the major provider of Mental Health Services. This was acknowledged in the National Strategic Framework for Mental Health 1999 by the statement that 90% of mental health care contacts occur in a primary care setting. Since then there has been an increased focus on primary care delivery of patient care. This provision for mental health is poorly understood with little research or mapping of service provision.

Multi professional teams of general practitioners, practice nurses, and administrative staff provide primary care services with close working relationships with health visitors and district nurses. The majority of practices also have an attached counsellor (often employed directly by practice). Nurses increasingly provide first point of contact including NHS Direct and out of hour's services.

The NHS plan provided new ways of working with additional 1000 graduate workers and 500 gateway workers. These are increasingly being configured into multi professional teams that are developing innovative ways of liaison with primary health care teams.

The scope of this paper is general practitioner centric, however there needs to be recognition of the valuable contribution made by other colleagues in primary care setting. The understanding of multi-professional working in primary care needs to be improved with research and service mapping so as to meet patient needs and improve seamless care with specialist services.

4.2 General Practitioners

Qualifying and training – Education Training and career routes

Entry qualifications are usually three grade A A/levels followed by 5 years undergraduate study. There are some new fast-track courses of 4 years undergraduate study for students with a previous degree. In both cases, there is then a minimum of 4 years postgraduate study to become a General Practitioner (GP). Following qualification, GPs can join a partnership or become a salaried partner. Once a partner there is little career progression with few partnerships maintaining previous traditional hierarchical structures. Some GPs undergo further training to have a particular special interest and this is now recognised as a particular role often working in intermediate care between Primary and Specialist services (“GP with special interest”).

4.3 Traditional expectations of the discipline and specialty of general practice/family medicine

The traditional role of general practice can best be understood with reference to the European Definition of General Practice/Family Medicine 2002 this is as follows:

“General practice/family medicine is an academic and scientific discipline, with its own educational content, research, evidence base and clinical activity, and a clinical speciality orientated to primary care.”

i. The characteristics of general practice/family medicine are that it:

- a) Is normally the point of first medical contact within the health care system, providing open and unlimited access to its service users, dealing with all health problems regardless of the age, sex, or any other characteristic of the person concerned.

- b) Makes efficient use of health care resources through co-ordinating care, working with other professionals in the primary care setting, and by managing the interface with other specialities taking an advocacy role for the patient when needed.
- c) Develops a person-centred approach, orientated to the individual, his/her family, and their community.
- d) Has a unique consultation process, which establishes a relationship over time, through effective communication between doctor and patient
- e) Is responsible for the provision of longitudinal continuity of care as determined by the needs of the patient.
- f) Has a specific decision making process determined by the prevalence and incidence of illness in the community.
- g) Manages simultaneously both acute and chronic health problems of individual patients.
- h) Manages illness, which presents in an undifferentiated way at an early stage in its development, which may require urgent intervention.
- i) Promotes health and well being both by appropriate and effective intervention.
- j) Has a specific responsibility for the health of the community.
- k) Deals with health problems in their physical, psychological, social, cultural and existential dimensions.

ii. The Speciality of General Practice / Family Medicine

General practitioners/family doctors are specialist physicians trained in the principles of the discipline. They are personal doctors, primarily responsible for the provision of comprehensive and continuing care to every individual seeking medical care irrespective of age, sex and illness. They care for individuals in the context of their family, their community, and their culture, always respecting the autonomy of their patients. They recognise they will also have a professional responsibility to their community. In negotiating management plans with their patients they integrate physical, psychological, social, cultural and existential factors, utilising the knowledge and trust engendered by repeated contacts. General practitioners/family physicians exercise their professional role by promoting health, preventing disease and providing cure, care, or palliation. This is done either directly or through the services of others according to health needs and the resources available within the community they serve, assisting patients where necessary in accessing these services. They must take the responsibility for developing and maintaining their skills, personal balance and values as a basis for effective and safe patient care.”

The above can be accessed via Royal college of General Practitioners website in the section College Viewpoint or via [http:// www.euract.org/html/pap04102.shtml](http://www.euract.org/html/pap04102.shtml) (accessed 10.05.2005).

4.4 Future Aspirations

General Practitioners have had to manage an increasing population focus of service delivery as well as the expectation that most conditions can be managed in a community setting. The predictions are that this will increase with a focus on management of patients with long-term conditions and public health agendas. The new General Medical Services Contract was an attempt to manage the increasing workload and to improve working conditions so as to aid recruitment to General Practice as a career choice for postgraduates. Currently the case for common mental health conditions has not been made clearly enough for these to be accepted within the quality and outcome framework for the new contract causing a focus to more of bio- physical rather than psychosocial aspects of care.

Patient choice and the General Practitioner acting as the patient's advocate balances the population view. Maintaining this balance is part of the core role of being a General Practitioner. Access, information and choice in treatment or where to be treated are declared political patient desires of modern General Practice. Patients with long term conditions still desire a relationship with "their doctor" and most GPs reciprocate this desire to relate to "their patient".

4.5 Worked Example

Access to GP consultation

Access to GP's has been a recent focus of Primary Care developments. Out of hours, someone other than the patients GP now usually provides care. Patients with mental illness may have difficulty persuading receptionists of the need for a same day appointment, particularly with "their" doctor. Home visits are normally reserved for housebound or terminally ill patients so most people would be expected to attend the primary care centre. In walk in or acute illness clinics the first clinical point of contact is with a nurse however, few nurses have any mental health training. Increasingly nursing team members may alert the GP of their concerns over a patient and ask them to see their GP.

In describing their symptoms, most patients with psychological distress do not present with psychological symptoms but rather physical expression of their psychological distress. Thus, a typical presentation would be "not feeling right", "tired all the time", "no energy", "can't sleep": psychological presentations might be "I can't cope anymore". Sometimes it is a carer who contacts the GP expressing their concern over abnormal behaviour of the person they are caring for. The carer is likely to be registered with the same practice. The GP has a duty of care to both patient and carer and has to balance this with acting in a way that maintains ongoing relationships with both.

GP Consultation

The average consultation time remains less than 10 minutes. One of the first priorities is to exclude serious physical disease as a cause of mental disease; this includes drug and alcohol misuse.

Using consultation skills and pattern recognition the GP will develop a formulation of problem identification and possible diagnosis. The formulation will be framed by the previous knowledge available to the GP (both personal and from the medical record) and the current psychological symptoms and signs shared and recognised. The GP will carry out a risk assessment that will define whether the patient needs further assessment or management by specialist services and the urgency of that assessment. The GP will then share this formulation with the patient and develop an agreed shared management plan. If the symptoms warrant referral to specialist services the GP will complete a referral form as detailed by local policy.

Often time is used as a diagnostic tool and the patient asked to return for a further appointment, this may also allow for other investigations to be carried out including blood tests.

This bio-psycho-social assessment within the context of a continuing relationship and continuous medical record is unique to a GP consultation. Other members of the primary care team may carry out some aspects such as a mental health assessment, as part of a time-limited interaction with the patient.

Shared Care

The possible variations of shared care between primary and specialist services form a continuum from telephone consultation without seeing the patient through to inpatient care. Arrangements vary between PCTs, few areas have any primary care mental health services and the majority of recent investment has been in specialist services. Access to specialist assessments is variable.

The focus on services for people with severe mental illness has meant exclusion criteria for people who do not have severe problems giving rise to unmet need – this is a source of conflict between primary and specialist services in many areas.

For all patients the Primary Care retains care of the patients carer (usually the same practice). Physical health care also remains the role of the GP/ primary care for patients and carers. As part of the new General Medical Services Contract, GPs are encouraged to ensure patients who have agreed and have a severe mental illness, have an annual review.

Following assessment by specialist services medication prescribing and management is usually transferred to the GP.

Depending on the Care Plan after a period of time the patient is then transferred back to GP care for ongoing management, this includes an awareness of the possible relapse of severe mental illness and ongoing medicine management.

Dr. David Smart.
General Practitioner

5.0 The contributions of Non-Professionally Affiliated Staff

5.1 Introduction

The non-professional affiliate staff are becoming relevant to every professional in mental health services because of shortages and the evolving new roles for professionals across the board. In the NHS, those non-professionally affiliated staff, who are engaged under the watch of professionals, can generally be referred to as Health Care Assistants (HCAs) but have also been known in the past as nursing auxiliaries, care assistants and health support workers. Various professionals have adopted different titles to reflect their professions e.g. OT Helper. In Social Services, community support workers have been a major staff group working with social workers and then multidisciplinary teams.

There are other non-professionally affiliated staff in mental health who do not necessarily have direct contact with patient but the role they play in service delivery are very relevant to the quality of service provided. These will include the secretaries, receptionists, and other administrative staff.

Generally speaking these groups of workers have no regulatory/professional bodies.

United Kingdom (UK) literature appears to support the introduction of non-professional affiliated role (Needham, 1996; Poole, 1998; Abbott, Johnson & Lewis, 2001). These may or may not have contact with the patient; nevertheless the essential role they play in care frees the professionals to focus on more patient specific engagement. The importance of HCAs in mental health is demonstrated by the fact that they constitute the largest number after professionally qualified nurses: 31,000 in 2003 working in mental health. It is therefore no coincidence that the focus of discussion of the role of non-professional affiliates in mental health will be significantly related to HCAs.

HCAs are health care staff who are not nurses but who are employed to perform tasks that were previously performed by nurses. Their primary role is to support nurses with the day-to-day tasks of patient care. Generally speaking, nurses in NHS have enjoyed high satisfaction with the ability of HCAs to perform tasks, communicate pertinent information and the time they release to undertake professional activities (McLaughlin et al., 2000). Notwithstanding this, there is still some considerable resistance in nursing to increasing HCA numbers and roles. Although, there has not been a specialty specific survey of mental health nurses on their perceptions of HCA performance, anecdotal evidence suggests that while some may have concerns regarding the competence of HCAs to perform certain tasks, others value their involvement in mental health care. Spilbury and Meyer (2001) note that NVQ level-3 trained HCAs may even give better care than junior nurses. Their introduction into services is sometime viewed with suspicion, as a way of diluting the workforce with a less expensive alternative (Meek, 1998). But more importantly, the service users' evaluation of the role of the HCAs within a community mental health intensive care team demonstrated that a patient – centred approach related to the personal qualities of the non-professionally affiliated staff (Meek, 1998). HCA's have got roles to play both in acute inpatient and community mental health settings.

5.2 Qualifications and Training

HCA's are initially unqualified, implying not registerable by the professional body – Nursing and Midwifery Council (NMC). However, to be recruited as an HCA, one must be literate, empathic and able to communicate effectively. Most recruits have other qualifications, which are not directly relevant to their roles in mental health care. The average age and maturity of HCA's is higher than

that of mental health nurses suggesting greater life experience. Their background qualifications and life experiences can be a great asset to services in terms of skill-mix and flexibility of role.

HCA's usually undertake in-service training leading to a vocational qualification. Most training is work-based with day release courses. *Induction training* is provided by all employers in the first few weeks of employment and is based on National Occupational Standards (NOS). New entrants learn skills like hygiene, health and safety, manual handling techniques and personal care skills together with recording blood pressure, temperature, pulse, and respirations. There are also interpersonal skills for dealing with patients and their relatives. *Foundation training* may lead to NVQ Level 2 and 3 in Care. Assessment is based on observation in the workplace and written coursework. There are no formal exams. An NVQ 3 in Care certificate can lead to entry to the pre-registration nurse training in the UK. With the right will and aptitude, HCA's can progress through the skill escalator approach (DoH, 2001) to professional roles.

Attaining NVQ level 3 now qualifies HCA's to be registered members of the Royal College of Nursing, but registration with the NMC is still a subject for debate. However it was agreed in 2004 that there should be a joint approach to future regulation of HCA's and other hitherto unregulated health professionals with the Health Professions Council (NMC, 2004).

5.3 Traditional Expectations

HCA's work in all mental health care settings alongside nurses and the role varies according to the area the person is deployed. The mental health nurse is responsible both for delegating and supervising the HCA's roles. Duties can include helping with a patient's personal hygiene; helping them to dress and to eat, appropriate orientation of the patient to the environment, observations to ensure safety of patients and others, making beds, taking, measuring and testing samples of bodily fluids, talking to patients on a one to one basis and supporting patients with mobility problems. HCA's who work with mental health patients may help them with activities to increase their self-confidence, including shopping trips or outings to leisure facilities. Their occasional involvement in control and restraint can militate against the good rapport developed with the patient. Often there is role confusion between HCA's and nurses (Baldwin et al., 2003).

5.4 Future aspirations

Along with some elements of traditional roles the HCA's would be expected to work with some level of responsibility, autonomy and skill rarely found at present. The knowledge and skill base would include:

- Monitoring the patient's condition by skilled observation and reporting to the nurse.
- Risk assessment and risk management
- Implementing investigations and actions within given parameters
- Advising and supporting daily living
- Personal hygiene
- Education of patient and carer
- Health education and promotion
- Competence in the use of IT in care delivery setting
- Assistance with formal documentation (eg benefit claims)

- Liaison with other agencies and services
- Activity coordination
- Housekeeping role
- Engagement in psychosocial interventions after appropriate training.
- Becoming key worker eventually.

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6.0 The Nursing contribution

6.1 Introduction

Up to 80% of direct NHS care is provided by nurses, working in all settings, and across all age ranges. In mental health, nurses are the largest occupational group both in relatively new services, such as assertive outreach, community forensic, criminal justice and crisis teams, as well as in established services such as inpatient units, community mental health teams, specialised drug and alcohol services and child and adolescent mental health. Nurses work across the plurality of service provision and hence provide professional continuity throughout the entire patient pathway. Nurses frequently play key roles in the non-statutory and independent sectors as well as within the NHS.

In inpatient, and increasingly in community settings nursing is provided 24 hours a day, 365 days of the year. For the vast majority of such “out of hours” services; nurses are the major direct care providers. Such extended and close contact with service users leads to an intimate knowledge of the individual and their significant others.

95,000 nurses are able to practice as registered nurses in mental health across the UK (NMC March 2003), however many do not currently work in mental health settings or within the NHS. In England, there are now 47,000 registered nurses within the speciality in the NHS. The ratio of women to men is nearly 2:1.

The title “nurse” is legally protected, however, definitions of nursing tend to be broad and do not clearly distinguish a unique role as compared to other professions:

The personal concept of what nursing is, what it is for and how do we do it is rarely put into words, and cannot therefore be easily communicated... Nursing is the use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death. (RCN 2003).

Mental health nursing can potentially provide truly holistic care, with a range of interventions, from intimate physical care to formal psychological approaches, and from directly applying constraints under the Mental Health Act to spending extended periods of unstructured time with service users. Additionally, the two-thirds of qualified nurses who work in inpatient care areas also have direct health and safety responsibilities and responsibility for managing the environment.

6.2 Education, Training and Career Routes

Entry qualifications

Initial entry requirements are 5 GCSE passes or a suitable vocational qualification, e.g. NVQ Level III or RVQ Certificate in Community Mental Health. Formal academic requirements will become locally determined in the future.

Length and type of training

Initial training is typically a three-year university based course to diploma or degree level. Registration requires evidence that generic nursing competencies as laid down by the Nursing and Midwifery Council have been achieved. The first year is a core syllabus shared with all nursing specialities. 50% of time is spent in practice settings. Registered nurses must be able to:

- Assess needs

- Plan care
- Implement care
- Evaluate outcomes

Upon qualification a period of 6 months preceptorship is required for newly qualified staff. The qualification of Registered Nurse is the basic qualification. Many nurses continue to progress to higher degree level.

Nursing is uniquely flexible, in terms of taking on new roles and working across the entire range of health (and social) care settings. On registration, Mental Health nurses have training and a wide range of skills, including in:

- Psychological care
- Physical care
- Social care
- Management

Following qualification, additional skills in these and other areas are developed dependent on area of work and additional training.

Career routes/progression

Typically, nurses can progress along clinical, educational or management career pathways, sometimes moving between the three areas, and commonly receiving specific training to support their role. The introduction of Nurse Consultants has provided a developed clinical career pathway, requiring high level clinical expertise and a post graduate qualification. On average Nurse Consultants have 17 years of nursing experience (Association of Nurse Consultants 2004).

Developing skills sets

Increasingly Mental Health nurses are moving towards developing specific skills in cognitive behavioural therapy, psychosocial interventions and supplementary prescribing. Current proposals suggest a new structure for nursing in the future, with Advanced Practitioner status being linked to a Master's Level clinically based qualification (NMC 2005).

Professional accountability

The professional behaviour and conduct of nurses is governed by the Nursing and Midwifery Council Code of Professional Conduct. This is currently being supplemented by the development of Standards for Mental Health Nursing practice.

6.3 Traditional expectations of the profession

The public

Traditionally nursing has been seen in the public eye as a self-sacrificing profession, whose role it is to support medicine. Service users typically highly value relationships with nurses (National Patient Survey 2004). These tend to be more informal and holistic in nature than those with many other healthcare professions. Users are generally positive about nurses developing new roles, e.g. prescribing, although seek reassurance that educational preparation is sufficient (Harrison 2003). Most service users expect more informal and lengthier contact with nurses than with doctors.

Recently nursing has publicly been identified as having a revitalised role in providing an authoritative figure (Modern Matrons) to service users and carers, one who is responsible for maintaining health care standards generally, and specifically in term of improving inpatient environments.

Other professions

Nursing has often been seen as in a hierarchical relationship with medicine, an attitude that needs to be constantly challenged. Currently there is an increased emphasis on nurses gaining specific therapeutic skills, such as in psychosocial interventions, however many of the nurse's skills are "invisible" and can often be undervalued as a result (Michael 1994).

6.4 Future aspirations

Nursing expects its activities to be delivered in a holistic framework, underpinned by bio psychosocial perspectives. Mental health nursing values people centeredness, seeks to empower, to work with and alongside, to form partnerships and therapeutic alliances, with a primary focus on service users and their desired outcomes. Mental Health nursing activities are diverse.

Nursing will continue to become increasingly professionalized, with higher academic requirements and a growing evidence base to support practice.

Mental Health nurses at all levels are expected to deliver personal, psychological, physical, social and spiritual aspects of care and treatment. In addition, they may potentially operate as consultants, cognitive or analytical therapists, advisors and advocates, as well as providing basic physical care. Nurses are expected to be particularly adept when acting as "conduits", sharing and communicating various types of information with others. The development of broad based generic skills and specialisation are neither mutually exclusive, nor is one superior to the other.

Nursing expects itself to be an independent profession equal to others, with every registered nurse fully accountable for their own practice. Increasingly there is an expectation that practice shall be evidence-based. Increasingly policy encourages the development of *Nurse led services*. They are envisaged as utilising the flexibility of nursing to provide responsive and, often, new services, particularly in "chronic disease management" settings. Examples are most commonly provided by Nurse Consultants in new mental health practice areas.

Nursing roles will continue to change and develop. There is a recognition that the capacity of the workforce must be developed, and that the creation of new roles and workers will allow nurses to focus on what they do best. This also requires the identification and availability of the necessary education and training to support this. Changes are already evident, such the embracing of new skills, such as nurse prescribing, and new roles, such as that of nurse consultant. Other future challenges will include: new roles under mental health legislation, more changes in clinical practice, greater attention to health promotion and increasing service user autonomy.

In common with other disciplines, diversion to administrative, bureaucratic and managerial tasks detracts from nurses core function, *when these do not contribute directly to improving the patient experience*. The booking of agency & bank staff, and managerial "acting up" arrangements, for example, detract from clinical contact time.

The sheer numbers, contribution, and diversity of mental health nursing within the workforce means the NSF and NHS Plan cannot be achieved without nurses, even before their unique individual contributions are taken into account.

Authored by Nurses within the New Ways of Working Steering Group and sub-groups

7.0 Contribution of Occupational Therapy

7.1 Introduction

The number of occupational therapists registered to work across the health and social care sectors in the UK totals over 26,000. It is estimated that about 30% of these work in mental health. Occupational therapy is provided by both qualified and support staff. Within mental health, occupational therapy is provided in a wide range of services including the more traditional places, such as acute inpatient wards and rehabilitation, and also the new developing services such as home treatment and assertive outreach. These new types of services have brought with them opportunities and acknowledgement that occupational therapy has a role to play in evenings, at weekends and even on call.

Occupational therapy is concerned with the nature, balance, pattern and context of occupations and activities in the lives of individuals, family groups and communities. The desired outcome of occupational therapy is that the client achieves a satisfying performance and balance of occupations that will support recovery, health, well-being and social participation.

The core skills of occupational therapy are built around occupation and activity.

These include:

- Collaboration with the service user: building a collaborative relationship with the client that will promote reflection, autonomy and engagement in the therapeutic process.
- Assessment: assessing and observing functional potential, limitations and needs including the effects of physical and psychosocial environments.
- Enablement: enabling people to explore, achieve and maintain balance in the activities of daily living in the areas of personal care, domestic, leisure and productive activities.
- Problem-solving: identifying and solving occupational performance problems.
- Using activity as a therapeutic tool: using activities to promote health, well being and function by analysing, synthesising, adapting, grading and applying activities for specific therapeutic purposes.
- Group work: planning, organising and leading activity groups.
- Environmental adaptation: analysing and adapting environments to increase function and social participation.(Creek J 2003, p36)

Occupational therapy education is broad based, covering mental and physical health, development, learning and the influence of context and culture in fulfilling occupations.

The profession of occupational therapy originates from within mental health in the early years of the 20th century. It was noted that people's mental health improved when structure, purpose and fulfilment were introduced into the large psychiatric institutions through programmes of activity.

'Occupational Therapist' is a protected title under the regulations of the Health Professions Council (HPC). Pre-registration education and Continuing Professional Development requirements are regulated by the HPC for occupational therapists and are necessary to gain and maintain registration.

The HPC publishes the standards of proficiency for safe and effective practice for occupational therapists (HPC 2004). The Code of Ethics and Professional Conduct is published by the professional body, the College of Occupational Therapists (COT 2000) and is a public statement of the values and principles in promoting and maintaining high standards of professional behaviour in occupational therapy.

Both these documents provide guidance on the limitations of the professional role of occupational therapy.

7.2 Education, Training and Career Routes

Entry qualifications vary depending on the level of academic award associated with registration.

- For full time undergraduate pre-registration programmes, this will be 5 GCSEs at C Grade or above, plus 2 A levels or equivalents.
- Full time post-graduate Diploma or Master's programmes require first level degrees and relevant experience.
- The requirements for part-time in-service training are the same as for full time under graduate programmes or by portfolio and employer sponsorship.

Length and type of training

- Three and four year full-time BSc (Hons) in Occupational Therapy
- Two year accelerated Post-Graduate Diploma in Occupational Therapy
- Two year MSc in Health Through Occupation
- Four-year part time in-service programme leading to BSc (Hons) in Occupational Therapy.

Career routes/progression: Occupational therapists can progress through many routes including increased therapeutic skills, education, management and research.

- Level 2 entry on the career map, as a support worker/ OT assistant/ OT Technical Instructor, to commence four-year part time training route to become state registered occupational therapist.
- Newly qualified occupational therapist entering the career map at level five.
- After 2-3 years experience in a particular area, the OT can progress through clinical experience to career map level 6: senior clinician.
- After relevant training and experience, progress to team manager/ advanced practitioner, career map level seven, managing and supporting more than one element of service.
- After considerable clinical experience, may progress to Consultant occupational therapist with remit for research, support and clinical leadership.

Current links with competency frameworks.

- Competence to practice currently regulated by the HPC, the Quality Assurance Agency for Education Bench marking standards for occupational therapy.
- Of those offered a place to study occupational therapy in 2003 43% were over 25 years, 91% were female, 7% had a disability and 82% identified themselves as white (UCAS entry data).

7.3 Traditional expectations of the profession

From the profession

- As an individual clinician – To work in collaboration with service users to determine their strengths, aspirations and support needs, and to plan ways of achieving goals through a joint care plan . To focus on the occupational aspects of the person's life; maintaining and/ or developing personal and domestic abilities, communication, problem solving skills, leisure activities, education, mental and physical health and employment.
- As a group worker – To facilitate a range of activity groups in order to teach, regain or practise skills to support the occupations of daily life.
- As a team worker – Frequently a lone professional worker, able to spend time in generic roles such as CPA, duty worker pro rata.
- As a manager – To manage and support multi-disciplinary working. To develop workers' abilities and strengths for the benefit of service users.
- As a professional lead – To maintain and monitor clinical accountability.

From the refereeing agent

- Detailed assessment and care planning in relation to service users' needs, strengths and aspirations. Focus on activities, occupations and lifestyle skills.

From service users and carers

- Safe, non-threatening role with no statutory powers. Able to focus on successful aspects of life, build on strengths, work to maintain and/ or develop new roles.
- From members of other mental health professions.
- Depending on the location of the service users, to keep people productively occupied.
- Willing and able to take on all types of roles.
- Female.

From society

- Role is very unclear to the general public. The profession is rarely mentioned in policy statements or political agendas. Occupational therapy covers many areas of health and social care, making it difficult to generalise the experience of having contact with OT's in different areas.

7.4 Future aspirations

From the profession

- Increasingly re-focusing on ensuring that there is a focus on occupation as a concept that encompasses all aspects of living, taking account of the social model of disability.
- Increasing evidence and research base for occupational therapy approaches and interventions.

From the referring agent

- To focus on lifestyle and social roles for individuals whose lives have been affected by mental illness.

From service users and carers

- Maintain and/ or develop skills to maximise functioning according to the aspirations of the service user.

From members of other mental health professions

- Able to work across boundaries while ensuring that the occupational needs of service users are addressed.

From society

- Deliver assessment and interventions in order to facilitate occupation in communities.
- Extended role and responsibilities.
- The prescription, administration and supply of medicine. Under the current Patient Group Directives (PGD) occupational therapists are listed as an Allied Health Profession (AHP) that must be named individually to undertake such responsibilities. (COT 2004)
- The Draft Mental Health Bill (2004) suggests that occupational therapists may undertake the role of the Approved Mental Health Professional.

References:

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8.0 Contribution of Specialist Mental Health Pharmacists

8.1 Introduction

Specialist pharmacy services in mental health exist to ensure the best use of psychotropic medicines throughout the population served. Pharmacists are supported in their work by pharmacy technicians (NVQ Level 3) and dispensing assistants (NVQ Level 2).

Pharmacists are the experts in medicines. They can assist service users with respect to choice of medicines. Pharmacists assimilate and apply knowledge regarding efficacy and safety of medication for individuals. They provide an independent review of prescribing and administration. This is achieved by their ability to influence clinical decisions by applying their knowledge of the evidence base.

Pharmacists use their knowledge to minimise risk of harm with medicines. There are approximately 2300 pharmacy degree places available per year. These are oversubscribed annually. Approximately 1600 pharmacists qualify each year and about 500 pharmacists are engaged in mental health activity.

8.2 Education and training and Career routes

Entry qualifications for university pharmacy degree courses:

A Level: Minimum requirements 280 points, mandatory 100 points Chemistry.

Five year minimum training to qualify as a pharmacist

Four year full time course or 5 year sandwich course (incorporates 2 x 6 month work placements), leading to Masters degree in Pharmacy.

For 4 year course add 1 year post graduate competence based training in work placement. This year consolidates undergraduate knowledge into practical training.

Undergraduate course consists of:

- Anatomy and physiology
- Toxicology
- Clinical use of drugs
- Pharmacokinetics – Drug interactions, influence of age, gender, ethnicity
- Pharmaceutical technology – quality control, storage of drugs
– formulation of drugs and appropriateness for individuals
- Pharmacology- the study of drugs in the body
- Pharmacodynamics – Individual patient factors
- Pharmacognosy-study of drugs derived from plant matter
- Social pharmacy
- Law and ethics

Final examination to register with the Royal Pharmaceutical Society GB.

Specialist Mental Health Hospital Pharmacists – Pathway to accreditation

- Newly qualified pharmacists would be expected to complete a Diploma in Clinical Pharmacy (2 years). This entails in depth study of a broad spectrum of disease state and therapeutics.
- Masters in Clinical pharmacy (1 year)
- For specialisation in Mental health, pharmacists would be expected to undertake the 1 year distance learning Certificate in Psychiatric Therapeutics
- Followed by the Diploma in Psychiatric Pharmacy by Distance Learning and Practice
- The British Association of Psychopharmacology Certificate in Psychopharmacology (2 years) may be considered to be an alternative to the Certificate in Psychiatric Therapeutics but not the Diploma.
- Membership of the College of Mental Health Pharmacists
- Consultant pharmacist status

(Statutory requirement 30 hours Continued Professional Development per year as demanded by the Royal Pharmaceutical Society of GB)

8.3 Traditional expectations of the profession

Traditionally hospital pharmacists have not enjoyed as high a profile as nurses or doctors in acute or mental health NHS services. However their role has evolved over time from being bound by the dispensary to being proactive members of the clinical team. Pharmacists attend ward rounds, are part of the multidisciplinary team and provide a valued clinical pharmacy service, consequently the profile of pharmacists has been elevated.

Hospital pharmacists are not plentiful and mental health pharmacists even less so. There may be only one specialist mental health pharmacist serving several hundred beds and a variety of teams, therefore they are limited in the service they can offer. However there is a general move to improve and expand pharmacy services to mental health trusts as the risks involved with medicines management is acknowledged. (Audit Commission: A Spoonful of Sugar, NHS Plan, DoH Management of Medicines 2004)

Pharmacists have traditionally been and remain the acknowledged experts regarding drug use, side effects, interactions, pharmacokinetics, bioavailability etc.

However the traditional role has been reactive rather than proactive. Service users could expect to receive their medicines dispensed in a professional fashion and with advice as to how to take the medicine. Pharmacists have also been perceived as impartial by service users who would thus give them unbiased advice about their medicines.

Other health professions would traditionally seek advice from pharmacists regarding medicine queries or complex cases requiring advice on pharmacological strategies.

8.4 Modern expectations of the profession

The modern expectation for pharmacists from the profession is as a proactive member of the clinical team, who is visible and accessible by staff and service users. Pharmacists at the point of prescribing give medical staff information regarding medication and aid the informed choice of medication for service users. Pharmacists will be present both within the traditional hospital or

community settings as well as through the range of home treatment, early interventions, outreach and home treatment services.

Pharmacists provide information directly to service users and carers at ward level with 'Pharmacist Question times', providing telephone Help Line services, and individual counselling to service users when requested.

The pharmacist can produce medication histories and case reviews with treatment suggestions for complex problems. Specialist pharmacists also have patients referred to them for advice on complex regimens or who appear to be resistant to standard therapy.

The pharmacist can liaise between secondary and primary care regarding medicines management. That is, ensuring that medication prescribed on admission to secondary care is correct, disseminating information regarding medication at discharge to GPs and community pharmacists.

Specialist mental health pharmacists provide advice and medication reviews for mental health clients in primary care, lead benzodiazepine withdrawal clinics, antipsychotic / antidepressant review clinics etc.

Pharmacists can aid concordance with medication regimens by educating service users about their medicines and by providing adherence therapy/training .

Pharmacists are now eligible (after additional training) to become supplementary prescribers and thus can play a pivotal role in the continuing pharmacological care of service users.

Independent prescriber status for pharmacists is planned for 2005. This will also aid the skill mix issue and provide opportunities for pharmacists to expand their traditional role into prescribing. Independent prescribing status will enable pharmacists to provide physical care for patients with mental health problems, e.g. a pharmacist run minor ailments clinics. Pharmacists retain generic knowledge and expertise regarding medication for physical illness as well as specialising in mental health.

Pharmacists can also support the development of supplementary nurse prescribers. Specialist pharmacists can be expected to raise the overall prescribing standards within their areas of responsibility, through both informal and formal education and training sessions of other prescribers and health professionals.

Pharmacists are expected to act as a neutral and independent source of medicine related information, they are free from undue influence from the pharmaceutical industry, through a process of openness and transparency.

Within their sphere of responsibility specialist pharmacists can be expected to lead the implementation of nationally agreed best prescribing practice eg implementation of NICE guidance.

8.5 Expectations of the referrer

Medical and nursing staff refer to pharmacists for several reasons:

- Advice regarding suitable treatment for complex cases.
- Advice regarding rationalising drug therapy to reduce polyprescribing

- Formulation of medication histories and recommendations for treatment.
- Nursing staff may refer to a pharmacist regarding a suspected prescribing error for advice on how to proceed.
- Medical and nursing staff consult pharmacists on audit and research involving medicines.
- Advice regarding the most appropriate method of improving concordance with medicines. As research has shown that patients with mental health problems often have difficulty with concordance with their medication for a variety of reasons eg side effects, complex regimes etc. The pharmacist provides impartial and practical advice to patients to address this.
- Pharmacists are requested to act as SOADs ensuring medication is administered to service users within the terms of the Mental Health Act.
- Pharmacists play an important role on Drugs and Therapeutic Committees, with regard to 'horizon scanning' and the managed introduction of new medicines into secondary care as well as liaison with primary care regarding specialist medicines and 'shared care guidelines'.
- Pharmacists critical analytical skills are used when evaluating trial data for new or existing treatments. Routinely pharmacists provide monographs for new medicines and evaluate their place in therapy.
- Pharmacists regularly provide both formal and informal education and training regarding medication used in psychiatry.

Expectations of the Service user:

The service user can expect a pharmacist to provide informed, impartial information from which a decision can be made regarding the best medication for the individual. The pharmacist would be expected to discuss side effects of the medication as well as efficacy and provide a balanced view in language that is comprehended by the service user.

The service user can expect the pharmacist to continue to monitor their progress during treatment while in the inpatient setting. Side effects would be noted by nursing staff and advice regarding treatment given to reduce these. Any physical monitoring necessary could be instigated by the pharmacist. (eg blood samples for Clozapine, glucose and prolactin monitoring etc).

Service users can expect pharmacists to aid concordance with their medication regimens by counselling them about their medicines and by providing education and training.

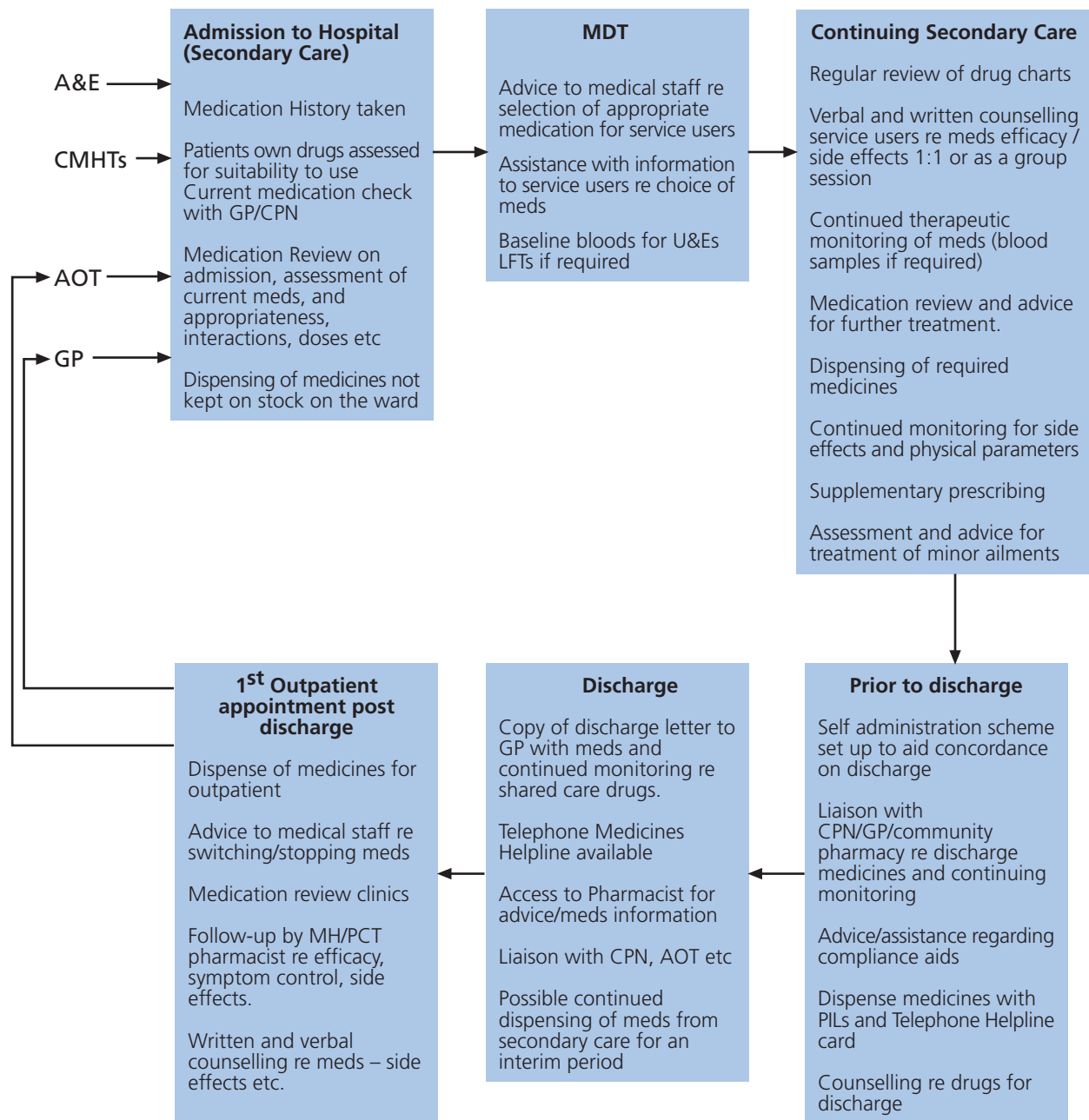
Service users can expect to be able to access pharmacists for advice while inpatients and also via telephone help lines post discharge.

Pharmacists can assist preparation for discharge by setting up self administration schemes in conjunction with nursing staff, assessing and counselling service users on their knowledge of their medication and adherence to treatment regimes.

Pharmacists assist in providing a seamless transfer from secondary to primary care, to ensure supply of medication is not interrupted, by liaising with GPs and community pharmacists.

Worked example of pharmacist input to the service user pathway:

Referral:



9.0 Contribution of Physiotherapy

9.1 Introduction

Physiotherapy is a rehabilitation profession concerned with identifying and maximising movement potential through education training and rehabilitation. It aims to promote the well being and autonomy of people with a physical dysfunction associated with mental and physical illness. Using a variety of evidence based therapeutic means, and by taking a holistic person centred approach we aim to influence the psychological health of individuals.

Physiotherapists in mental health are uniquely placed through their knowledge of mental health conditions and their expertise in the management of physical conditions to provide an extensive range of approaches to treatment aimed at relieving symptoms and improving quality of life. They are well placed to advise and support staff, service users and carers on both the physical manifestations of mental health conditions and on the management of physical conditions in mental health settings.

The number of physiotherapists, associated members and students in the UK now tops 42,000 with 19,139 qualified physiotherapists in employment in 2004 a rise of 6.8%. The profession is growing with more places being offered at universities for training in line with Chartered Society of Physiotherapy (CSP) target of 24,000 by 2009. It is difficult to identify the exact number of physiotherapists working in mental health at this present time, but anecdotal evidence suggests that there is an increasing demand for the role of physiotherapy in mental health as well as demand from students and staff grade physiotherapists for work placements in this area. The estimated figures are approximately 400 qualified staff and approx 500 assistants.

Universities are now also beginning to recognise the role of the physiotherapist in mental health with many delivering modules at undergraduate level as part of the core training but also extended specialist modules at postgraduate level allowing physiotherapists to enhance their skills within the field.

The development of the role of physiotherapy within mental health has been supported further by the emerging evidence related to physiotherapeutic interventions, one such key area is exercise. The publication of the consensus statements from Somerset Heath Authority following their academic symposium in January 1999, the NICE guidelines for depression (2004), Choosing Health (2004) and Health Body Health Mind (2004) have led to the recognition of exercise as an affective intervention in the management and treatment of mood disorders.

Physiotherapists working in mental health are members of the CSP. The CSP have now achieved protection of the title 'Physiotherapist' under the regulations of the Health Professionals Council (HPC). The HPC publishes standards of Conduct Performance & Ethics as well as Standards of Proficiency. Core standards of Physiotherapy Practice (2005), the Rules of professional Conduct (2002) and the Physiotherapy Assistants Code of Conduct are CPD advice is given by the CSP and re registration by the HPC in future will be subject to the appropriate CPD being undertaken.

Physiotherapy is provided by both qualified staff and technical instructors and assistants and is delivered across a wide range of services. These range from the traditional areas such as acute wards, community mental health teams, rehabilitation to newer areas which include early intervention psychosis teams, crisis and self harm services, eating disorder clinics, alcohol services, forensic services and assertive outreach teams as well as providing stand alone services addressing issues such as weight gain and healthy living in adult services. In old age psychiatry

physiotherapists have a key role to play in falls prevention utilising physiotherapeutic interventions but adapting programmes to meet the abilities of the clients. With dementia sufferers maintaining functional independence and newer developing roles in intermediate care and memory clinics.

The service will also provide physiotherapy treatment for clients whose mental health problems prevent them from accessing general physiotherapy services and where there is a need to understand the complexities of the psychological health in order to deliver patient centred care.

The development of new services emphasises the whole range of needs that the clients have which in turn highlights the potential role of the physiotherapist.

People with mental illness are a vulnerable and a health disadvantaged group. They often exist on low incomes and suffer from poor motivation both fitness and health limiting factors. They are at high risk of physical illness and three times more likely to die prematurely from 'natural causes' such as coronary heart disease, cancer and obesity. (Saving Lives- DOH Modernising Mental Health Services).

In addition prescribed medication for mental health problems, which can cause marked increased appetite and weight gain. The physiotherapists have a vital role in delivering healthy living and weight management programmes working alongside their dietetic colleagues.

9.2 Education, Training & Career Routes

Entry requirements may vary depending on the course undertaken

- Full Time undergraduate five GCSE's grade C or above in one sitting which must include Maths, English language and a spread of science subjects. Four A1 at grade B or above and three A2 minimum grade C with one biological science.
- Full time accelerated masters courses require first level degrees
- Part time courses require same as Full time undergraduate courses.

Other postgraduate courses may be recognised but this is dependent on the establishment.

Training

- 3 – 4 year Full time courses BSc Hons in Physiotherapy
- 2 Year accelerated course MSc in Physiotherapy
- 2½ – 5 year part time course may be work based learning programme leading to BSc in Physiotherapy

Following their core training, many physiotherapists undertake post graduate training in aspects of mental health care, and enhance their skills by developing extensions of their scope e.g. Cognitive Behavioural Therapy, Acupuncture etc

An M level course is run as part of University of Nottingham Physiotherapy masters programme.

Career Routes and Progressions

Newly qualified physiotherapists enter career map at level five. They initially work on a rotational basis either in an acute hospital setting or within a PCT. An increasing number of establishments are now offering rotations into mental health.

Following approximately 2- 3 years experience the physiotherapist can progress on to either a senior II rotation or may chose to work as a senior II in a specific area. Level six

After approximately 2-3 years and adequate training and experience the physiotherapist may then apply for a level 7 post as an advanced practitioner,

After considerable experience, the physiotherapist may progress to clinical specialist however; there are currently no Consultant Therapist Posts for Physiotherapists in mental health.

9.3 Traditional Expectations of the Profession

Physiotherapists have been traditionally viewed as part of the physical health care teams, and have not always been recognised as key workers within the field of mental health

9.4 Future aspirations.

With the increasing emphasis on managing physical healthcare and the evidence base for exercise, physiotherapists are now establishing their own independent role within the teams. Due to the still small numbers of physiotherapists working in mental health staff work in different ways either independently or as part of the teams however often with high caseloads.

From the profession

- As a clinician

To respond to individual referrals and to work with the service user to develop a programme of care to meet their individual needs. This may be as part of an existing care plan, or to develop a new care plan in the role of a care co coordinator.

To assess the motor skills, mobility and functional ability of patients with physical dysfunction associated with mental/physical illness

To use physiotherapy modalities to maximise physical potential and promote mental health well being.

To promote links between physical and, mental well-being encouraging participation in leisure activities, physical activity etc..

To work with clients with complex conditions and needs e.g. chronic pain, M.E, substance misuse, somatisation, eating disorders, anxiety disorders, mood disorders, self-harm
Physiotherapists often have skills in these areas but are often not recognised.

To constantly be aware of new and emerging evidence and research for physiotherapy approaches and interventions

To address the above working as members of the MDT

- As a group worker – To facilitate a range of groups such as exercise, leisure, anxiety management, anger management, falls prevention programmes dependent on the individual's skills.

- As a team worker – to be able to contribute to the team offering advice on lifestyle and physical health needs, some physiotherapists may take first line referrals from GPs as a member of the CMHT, taking the referrals where there is a physical and mental health problem, and having the skills to assess both components.
- As an educator – to provide education and teaching to students, staff physiotherapists and other staff as well as advice to service users and carers.
- As a manager – to manage disciplinary working or multi disciplinary teams. To maintain and monitor clinical accountability.

From the referring agencies

- Detailed assessment and plan of care with objectives and goals.
- To provide evidence based treatment based on the outcome of the assessment
- To provide information for patients and carers on services delivered
- To provide advice and feedback to referring agencies as to the outcome of the assessment and the [plan of care

From the Service Users and carers

- Safe, non-threatening environment with supportive approachable staff.
- Development of therapeutic relationship that will allow reflection and engagement in the therapeutic process
- To have a whole person approach
- To offer a comprehensive range of therapeutic interventions in order to meet the clients needs taking into account gender, cultural needs etc.
- To promote confidence building and self-esteem, to have skills to motivate service users

From other mental health professionals

- To be a resource in aspects of physical health, physiotherapeutic approaches and exercise
- To work as members of the MDT
- To provide evidence based information and training when required
- To work closely with staff providing information on the role of the physiotherapist
- To work as a liaison between physical health and mental health if identified

From society

- To offer advice and information on the role of exercise in mental health
- To provide advice and information on the role of the physiotherapist in mental health
- To respond actively to emerging evidence and research to continue to improve services and care delivered
- To work to promote health and well being for clients with mental health problems

The profession is not widely recognised yet in the field of mental health however, physiotherapists continue to strive to provide the evidence and the information in promoting the profession to the wider audience.

9.5 Extended Roles

The Physiotherapy profession now recognises the role of extended scope practitioners in specialist areas of practice. Within mental health, clinical specialists may have an extended role if they deliver interventions that have required experience and training outside their core skills for example;

Physiotherapists use cognitive behavioural therapy as part of their work.

Physiotherapists carry out first line mental health assessments.

They may be trained to order bloods and x rays thereby supporting the role of the junior doctors on the wards, in out patient clinics.

Prescription, administration and supply of medicines. Physiotherapists are now able to access training for supplementary prescribing.

Provide specialist physiotherapy advice to other members of MDT on complex cases.

In memory clinics, physiotherapists may carry out diagnostic tests, advice, and follow up medication checks.

References

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DOH (2001) Making it Happen a Guide to Delivering mental health Promotion

Mentality (2004) Healthy Body Healthy Mind

Nice Guidelines on Depression 2004

DOH (2004) – Choosing Health – making healthier choices easier

10.0 Contribution of the Consultant Psychiatrist

10.1 Introduction

The Consultant Psychiatrist occupies a role that has evolved out of a marriage between that of “Physician Superintendent” whose responsibility to provide medical oversight of the health and well being of asylum inmates supported a position of considerable corporate power, and that of “Personal Physician”, which is one of directly specifying the “treatment” of individuals “under their care”. Growing interest in less medically oriented approaches to mental health and related multi-disciplinary practices, and socially wider “post modern” approaches to the role of the professional are challenging these orthodoxies.

10.2 Education, Training and Career Routes

Entry qualifications.

A medical qualification recognised by the GMC, which for conventionally placed British school leavers requires:

- Entry into medical school
- Success as a medical student; five to six years higher education.
- One (soon to be two) years’ pre-registration work, essentially as a probationer.

Overseas graduates and mature students can reach this point by different routes. There are significant changes in medical education in response to Tomorrow’s Doctors (1993) and Modernising the New Doctor (2004). Encouragement of universities to reflect wider society in their intake is affecting medical schools, with increasingly more entrants coming via non-traditional routes, and from non-traditional backgrounds. The implications of these various changes for the future psychiatry workforce can only be surmised.

Length and type of training

The conventional route to Consultant Psychiatrist is for a registered medical practitioner to complete some three years as an SHO, during this time succeed in the MRCPsych. Examination, and then undertake some three further years training as a Specialist Registrar (SpR). External forces influencing the structure and content of post registration training may well alter this.

Completion of SpR training results in the award of a Certificate of Completed Specialist Training (CCST). This qualifies the individual to apply for consultant posts. Overseas graduates can qualify for a CCST if they can show evidence of equivalent training to the satisfaction of the Royal College of Psychiatrists and the GMC.

Throughout training, there are opportunities to resign aspirations to a CCST, and become a Staff Grade, with the opportunity of progressing to Associate Specialist.

Some choose a clinical/academic career, which would involve appointment to a Senior Lectureship in parallel with their appointment as an NHS Consultant and subsequent career progress as an academic.

Locum Consultant Psychiatrists vary in background from substantive consultants choosing to earn a little extra during a period of annual leave to non-CCST holders of a variety of sources and

backgrounds. Formal constraints inhibiting the appointment of a non-CCST holder to a consultant post do not apply to locum appointments.

Career routes/progression

Once appointed, an NHS Consultant has protected tenure in a senior position. Prestige, remunerated additional responsibilities and discretionary awards can follow depending upon performance in training, management, service and practice improvement and academic roles. In addition to their senior clinical roles, career opportunities for consultant psychiatrists include appointments to teaching roles such as clinical and college tutors, management roles as clinical or medical directors, and national policy and governance roles as Royal College officers, clinical and specialist advisers, and associates of the DH, Healthcare Commission, NIMHE, Mental Health Tribunals, BMA, GMC and other such organisations.

A qualified pre-registration doctor might be equivalent to level 5 or 6 of the NHS Career Map, rising to level 8 as a consultant with no, or only limited additional responsibility.

Current links with competency frameworks.

At present, the medical profession does not have any explicit competency framework links with other professional groupings, apart perhaps from general issues of probity and health. There are, however, numerous informal overlaps between the psychiatrist's competencies and those of other mental health professionals. These include mental state assessment, history taking, use of standardised assessment processes, knowledge of the Mental Health Act, pharmacology, risk assessment and psychotherapeutic skills and training.

10.3 Traditional expectations of the profession

Traditionally, the doctor has assumed primacy of place in health care endeavours. This is an extension of traditional views of 'illness' as a specific diagnosis responding to specific treatment, and the doctor as the expert professional, whose access to knowledge and skills concerning illnesses and their cure confirms this role.

This is reflected in key social expectations of the doctor:

- That they hold, apply and maintain a high degree of skill and knowledge pertinent to the study of illness.
- That they act primarily for the welfare of the patient and community rather than in their own, self interest.
- That they are objective and clinically detached; that they do not judge patients' behaviour in terms of their own personal value systems.

In this professional role, the doctor enjoys certain rights:

1. To examine patients physically and to enquire into intimate areas of physical and personal life.
2. Considerable autonomy in professional practice.
3. A position of authority in relation to the patient, their families and carers, and the wider society.

Expectations that flow from this background are:

From the profession

Respect and maintain key social expectations of the doctor, thus ensuring the continuing public respect, social standing and authority of the profession.

From the referrer

Accept the authority and responsibility inherent in assuming a position of power that will determine and guide therapeutic endeavours.

From users and carers

Demonstrate expert knowledge, which will prove effective in alleviating suffering, and act as an authoritative leader of others using that knowledge.

From members of other mental health professions

Hold superior therapeutic knowledge, and accept responsibility for ordering treatment in return for a position of respect and power.

From society

Act as both an expert and a socially conferred office-holder who accepts responsibility for the treatment, care and containment of the 'mentally ill'.

In terms of corporate actions, these have had the following implications:

For individual case management

Traditionally the consultant is seen as the individual patient's personal physician who directs and determines all aspects of their treatment, and who takes responsibility for its outcome.

For team participation

As the traditional consultant determines and takes responsibility for all aspects of the individual patient's treatment, those providing that treatment do so under delegated power and are responsible to the consultant for following instructions.

For participation in the wider service/organisation

The traditional model is one in which the organisation exists to provide an environment that supports the consultant. As the traditional consultant is the one who determines the treatment of every individual provided for by the organisation, the traditional consultant's "clinical judgement" determines the activities of the organisation. This has placed the consultant in a position of considerable informal power.

10.4 Future aspirations

Recent times have seen a growing acknowledgment of limitations to a simple illness model of mental health difficulties and the importance of a multi-disciplinary and client-centred approach to delivering high quality mental health services. This is reflected in:

- Policy priorities, which include the NSF, NHS plan and NICE protocols.

- New legislative frameworks, including the proposed new mental health bill, Mental Health Capacity Act, consequences of the Bournewood judgement, and green papers on social care and public health.
- The need to reduce stigma, focus on self management, recovery and social inclusion, and embrace the skills of ‘expert patients’
- Recognition of the limits to a “medical” approach to mental health problems.
- A changing social ethos around the ‘power of the professionals’.
- Interest in preventive medicine.
- Self help movements.
- Whole patient perspectives.

At the same time there is continuing need for expert contributions that recognise and address the contributions of the genetic, biochemical, physical, and neuro-developmental dimensions of mental health difficulties.

Changed expectations that result might include:

From the profession

Uphold standards and ethics by acting with integrity and probity. Hold, maintain and develop knowledge specifically pertinent to the genetic, physical, neuro-developmental and legal aspects of mental illness. Mediate between traditional, medical expectations of the consultant and that required in the multi-disciplinary, multi-agency environment of modern mental health services.

From the referrer

Act as medical expert in mental health services and work with the multi-disciplinary team to ensure a comprehensive, expert assessment of need, formulation, implementation of a therapeutic care plan, and clear, timely communication of roles and responsibilities to the service user and the referrer.

From users and carers

Be available as one of the senior members of the multi-disciplinary team who can answer specific questions about medical assessment, treatment and management, and act as advocate in relation to other elements of the health, social care and legal systems.

From members of other mental health professions

Act as a full contributor to multi-disciplinary processes through a disciplinarily relevant contribution, and at the same time respect the complementary contributions of other experienced disciplines’ contributions. Support the team in needs assessment, audit, research and evaluation.

From society

Act as a senior member of the clinical and management team, where appropriate acting as its representative able to articulate its corporate aims, intentions and resource needs in relation to specific cases and services in general. Capable of acting as an expert in relation to medical aspects of mental illness, evidence based service models, mental health legislation and support to inter-agency community safety programmes and reduction of stigma.

In terms of particular corporate actions, these might involve the following:

For individual case management

- Contributions to clinical assessment where indicated.
- Mental Health Act assessments and on going management.
- Assistance with developing an hypothesis or formulation of how problem/need has developed and should be addressed.
- Involvement in formulating an effective holistic management plan and its implementation and review.

For team participation

- Support the team manager in developing team 'intelligent information' reports of caseload/casemix to ensure service user focussed, needs led, intensity of support and empowerment.
- Flexible availability for consultation, providing advice, training, and support in a timely and responsive manner.
- Contribute to the creation and maintenance of a positive culture of multi-disciplinary collaboration, with proactive resolution of disagreements about clinical management.
- Representation of the multi-disciplinary team at tribunals and other legal forums.
- Audit, quality assurance and clinical governance.
- Training, supervision and mentoring.
- Service and practice development and improvement.
- Evaluation and Research.

For participation in the wider service/organisation

- On Call service provision to the NHS and criminal justice system.
- Advice on evidence base for service models and practice.
- Service development, improvement, and reflective review.
- Clinical governance.
- Clinical and other contributions to management.
- Teaching, training, mentoring.
- An advocacy and ambassadorial role.

11.0 Contribution of Clinical Psychology

11.1 Introduction

The clinical psychologist is the psychological intervention expert member of the MDT, by virtue of the length, breadth and nature of her training (see below). This is not to deny or belittle the competent use of psychological interventions by other members of the MDT (which is widespread and essential), but simply to recognise that the clinical psychology profession is unique in having a single focus on psychological processes and the systematic study of mind and behaviour throughout a lengthy and high-level training path. Whilst clinical psychologists are well-versed in the medical model and its application to abnormal behaviour, they are often critical of this approach, and offer psychological perspectives to broaden and improve understanding and treatment efficacy.

So for example, whilst most clinical psychologists are competent to make a psychiatric diagnosis, they choose to engage in psychological formulation as an alternative, which draws on a broad range of psychological models, and which drives intervention. Clinical psychologists have a critical understanding of, and competence in, a broad range of psychological interventions and are not confined to any single school. The common ethos is that of the reflective scientist-practitioner, in which intervention choice is informed by the evidence-base and systematically evaluated during the course of therapy in order that the best outcome for the client can be obtained. Such competence is developed partly as a result of an extensive training in applied clinical research intrinsic to pre-registration training in clinical psychology. Assessment, formulation, intervention and evaluation¹ are conducted in collaboration with the client, and the client's perspective is seen as a central component in all of these processes. The profession has a longstanding tradition of skills-transfer to non-psychologists, and is keen to offer consultation, training and supervision in psychological intervention to other members of the MDT. Another area in which clinical psychologists have become involved is the provision of supervision to teams. Such supervision may focus on how best to work with individual clients or may assist the team in examining its own processes and issues to enable more effective working. It is of particular value to teams working in an in-patient or residential setting or who adopt a whole team approach to working with service users, such as assertive outreach teams.

1 These terms have specific meanings for clinical psychologists which are not necessarily the same as those for other MH professionals:

Assessment The use of a wide range of methods for obtaining information and data regarding the client and their problem, including interviewing (client and collaterals), observation in vivo, self-monitoring and carer monitoring, inspection of medical files, etc. There is more of an emphasis on the collection of quantitative data (although not exclusively so), through the use of standardised psychometric instruments, time sampled observation, self-monitored frequency, intensity and duration, etc.

Formulation A detailed description of the presenting problem and its history culled from the various sources of data as listed above is posited. A series of alternative explanatory hypotheses deriving from a range of biological, psychological and social perspectives are assembled. Evidence from the assessments is used to dismiss or support one or more of these explanatory hypotheses, and those remaining are then elaborated into an individualised model, which takes account of aetiological and maintaining factors, precipitants, risk factors and strengths. The model is developed with the collaboration of the client. This model is then used to plan and design intervention.

Intervention Actions and behaviours by the psychologist or other MDT members in association with the client and/or carer(s) which are intended to change the presenting problem and/or the psychosocial context of the problem, and which are consistent with and prescribed by the formulation described above. Intervention can occur at an individual, couple, family, ward, institution, organisation or community level.

***Evaluation* Repeated procedures for assessing the impact of the intervention using methods listed under assessment, often (although not necessarily) quantitative in nature. If evaluation data suggest an absence of change, or negative change in the presenting problem, revision of the formulation should ensue, and a new intervention implemented.**

At the time of writing (2005) there are approximately five and a half thousand qualified clinical psychologists in the UK, with fifteen hundred in training at thirty two University centres. The profession is predominantly female numerically. Arrangements for statutory registration under the Health Professions Council are in progress.

Although this document concerns primarily clinical psychologists, it is important to note that a range of applied psychologists is increasingly working within health and social care, including counselling psychologists (1,600), health psychologists (200), educational psychologists (1,500), forensic psychologists (1,500) and occupational psychologists (3,500)². This paper does not attempt to discuss these groups' varied roles and competences, other than to point out that there are many common competencies and similarities in training pattern. These are specified in the BPS Benchmark Statements and National Occupational Standards for Applied Psychology and the reader is referred to these.

11.2 Education, Training and career routes

Entry qualifications:

1. Three A levels (average offer of three B grades) are required for entry onto a three-year undergraduate university course in psychology;
2. at least an upper second class degree plus relevant healthcare experience are then required to gain entry to the three-year postgraduate doctor of clinical psychology professional training.

Entry into undergraduate psychology is increasingly competitive: psychology is now the second most popular subject choice (after Law) of university applicants.

Competition for entry into postgraduate clinical psychology training is notoriously severe, with only one in four of well-qualified psychology graduate applicants being successful. Many of the successful applicants already have PhDs and the majority have at least one publication in a peer-reviewed journal. It is unique amongst mental health professions in having many more high calibre applicants/potential recruits than training places, and this has been the case for many years.

Length and type of training:

Clinical psychology involves a minimum of six years' pre-qualification/pre-registration training (as indicated above) in psychological models, assessment and treatment. The first three (undergraduate) years have an emphasis on normal psychological processes, whilst the latter three (postgraduate) years emphasise abnormal psychological processes and intervention. Commonly there is substantial training in CBT including the treatment of depression, obsessional compulsive disorder, post-traumatic stress disorders and other anxiety states. There is also foundation training in a broad range of other psychological interventions including psychodynamic psychotherapy and systemic interventions as part of pre-qualification/pre-registration training.

Throughout the six years there is training in research methodology and, in the latter half, experience of conducting applied clinical research at doctoral level. Trainees also learn to design and implement small scale research and audit projects relevant to local health service needs (including service evaluation) and critically evaluate literature pertaining to the evidence base for

² These figures are estimates of the numbers of applied psychologists (other than clinical) in England and Wales and are believed to be broadly accurate at the time of writing (2005). Although many counselling and health psychologists work in health and social care settings, the majority of educational, forensic and occupational psychologists do not.

clinical practice. During the postgraduate three-year phase, typically trainees spend two days a week on academic study and research, and three days working in a wide range of clinical placements with a wide variety of client groups.

Although closely supervised, they are expected to carry their own caseload and gain direct experience of assessment, formulation and intervention, making a substantive contribution to NHS services.

Career routes/progression:

Once qualified, a clinical psychologist may choose to specialise in one or two of a wide variety of areas. The profession is much broader than adult mental health: many clinical psychologists work in medical and surgical settings, neuropsychological rehabilitation, forensic and prison settings in addition to working with children, families, older adults, people with a learning disability, etc.

The first post-qualification year is considered an extension of training, and there is heavy emphasis on CPD and on-going supervision (AfC band 7).

Many newly qualified clinical psychologists will seek generic or split first posts and delay specialisation to later in their career. Newly qualified psychologists are encouraged to obtain further specialist postgraduate training, such as in psychotherapy or neuropsychology, and may register for a further part-time degree, whilst continuing to increase their clinical experience with client work.

Normally after two years, the clinical psychologist may attend supervisor training and begin to supervise her own trainees (AfC band 8). However she would normally continue to work within a speciality led by a consultant grade psychologist. After a further four years of experience and CPD, she would be eligible to apply for a consultant grade post (AfC band 8c to 9) herself (i.e. a total of six years post-qualification experience minimum).

11.3 Traditional expectations of the profession

From the profession

Variation in settings and types of work and responsibilities. A combination of MDT collaborative work, one-to-one work with clients and project work (e.g. applied research and audit). Contribution to CPA, but not normally designated as a care co-ordinator. Referrals from colleagues of complex cases and personality disorder [PD], Teaching, advice, consultancy and supervision of other MDT members. Limited involvement with severe mental health problems and in-patient work. Not normally involved in emergency on-call and out-of-hours work. Not involved in Mental Health Act and sectioning duties.

From the referrer

GPs often seek and would prefer direct referral to clinical psychologists but direct access is now uncommon – access is via the MDT. Most referrals are now from MDT CPN's who assess and decide on initial disposal. CPN's tend to expect psychologists to manage complex cases and PD within the context of the MDT.

From users and carers

Surveys suggest that many users would like to see a clinical psychologist if given the option (but rarely are). A large proportion of users and the public would prefer non-pharmacological,

psychotherapeutic interventions for their problems, and see psychologists as being able to provide these (however unrealistic).

From other mental health professionals

Management of complex cases and PD. Cognitive therapy and psychometric assessment experts. Source of advice and supervision for psychological intervention. Organisational and research expertise often overlooked.

From society

Often confused with psychiatrists. Generally widespread ignorance of the role and competences of clinical psychologists, largely because the profession has been very poor at communicating these, and also because of the diversity of roles of the profession.

11.4 Future aspirations

From the profession

Increasing involvement in SMI problems, especially CBT for psychosis. Clinical Supervisor role in new MH legislation. Greater involvement in determination of capacity and use of neuropsychological assessment. Recognition of non-face-to-face work by service and Trust management. Greater influence on Service and Trust strategic decision-making is aspired to, along with more clinical leadership

From the referrer (MDT)

Greater flexibility and willingness to play a fuller part in CPA, etc. Greater contribution to the management of SMI including psychosis. Provision of supervision to team members involved in providing PSI (psychosocial interventions). Greater involvement in primary care services and teams.

From users and carers

Greater ease of access in a variety of service settings including primary care. Support with developing user/carer involvement in service monitoring/development.

From other mental health professionals

Greater flexibility and willingness to play a fuller part in CPA, etc. Greater contribution to the management of SMI problems including psychosis. Involvement in emergency on-call and out-of-hours work, Mental Health Act and sectioning duties. Viewed as a resource by service managers in supporting and enhancing team working.

From society

A clearer and more widespread understanding of the profession, its competences and contribution. Assistance and support with widening access to and choice in psychological therapies. New legislation looks to clinical psychology for the first time to make an important contribution to the planning and co-ordination of detained patients' care and in the determination of capacity. These statutory roles imply greater clinical leadership. Greater emphasis on risk assessment and clinical governance.

12.0 Service User contribution

12.1 Introduction

The service user is seen as an “add-on” in the delivery of their own care, traditionally the last person with whom the team consults about their treatment and care. Of course leaving the service user out of the debate about their care until the end of the process, defeats the object of delivering a high quality treatment that fosters a more positive approach to treatment to bring about an improved quality of life for the service user that could lead to less demand upon the medical system.

Current practices of the service do not deliver individual care packages largely due to the stereotypical ways in which professionals view the individuals they serve. This is due to a mixture of the professionals in their working capacity and the theories that govern their practice.

The culture & attitudes of society, which govern our lives both inside and out of the psychiatric system, can allow stigma & discriminatory behaviour to stifle creativity and the potential for development of a modern approach to the delivery of care in the 21st Century.

12.2 Qualifications & Training

The service user’s qualification in the management of their care is that they are “the expert” in their own sufferance and are therefore key in the planning, delivery & review of their individual care package.

The individual’s experience brings a unique perspective to how the professionals can develop and deliver a higher quality service delivery, which would include packages of care, to meet the patients’ need.

Helping service users to better understand their experiences will assist them to develop stronger coping strategies. This in turn will help them to take better care of themselves, thus reducing their need for the mental health system to be part of their lives. The insight of the service user has the ability to inform and expand the knowledge & understanding of the professionals as well as contributing to the improvement of their practice.

12.3 Traditional Expectations

Current practice allows poor quality of service by creating an artificial divide (“Them & Us”) between the patient & the professional, thus guaranteeing poor communication that does not foster constructive planning to deliver effective treatment.

The “Them & Us” barrier has prevented both “sides” achieving their common goal, namely to enable the patient to live a quality of life that is self-defined and reflects their own hopes and ambitions.

12.4 Modern Expectations

Modern practice is about having the service user at the heart of every aspect of their care, as an equal partner in the processes required to deliver an effective service fit for purpose in the 21st Century.

A service user's vision as an equal partner would be, being at the heart of:

- Setting the agenda for their individual CPA.
- Scrutiny of service delivery.
- Service design & delivery.
- Education & training of the workforce.
- Inclusion/entry into mental health workforce.
- Recruitment & selection of all mental health staff.

Whilst these are widely considered to be the core components for modernising practice today, it must be remembered that modernisation is an ever changing world, with which the workforce will need constantly to keep pace.

13.0 Contribution of Mental Health Social Worker and the Approved Social Worker.

'...the role and status of social work are determined by wider social, political and economic forces. More than any other profession I can think of, the boundaries of social work are not fixed in stone but a result of historical change – influenced by shifts in political priorities, social needs, economic constraints and academic learning'. Muijen (2003).

13.1 Introduction

The first qualified mental health social workers were employed in the UK in the 1920s with the first mental health social work training course in the United Kingdom beginning at the London School of Economics in 1929. The training was influenced by psychosocial explanations of mental distress. Social workers were employed in the community in child guidance clinics as well as psychiatric hospitals. At the time, hospital-based social workers were the only professional group of mental health workers to bridge both the hospital and community settings. Much of their work was focussed on the assessment of family and social circumstances.

Even in the beginnings of the profession, mental health social workers had a clear identity grounded within an explicit value base. For example, in 1939 the Association of Psychiatric Social Workers turned down the suggestion from the British Medical Association to become registered as medical auxiliaries.

Social work as a profession grew rapidly throughout the post Second World War era along with the social policies to provide for a universal public welfare system.

The statutory powers contained within the Mental Health Act (1959) gave social workers a legal role in the compulsory detention of someone experiencing mental distress. These powers were later re-defined in the 1983 Act with the provision for Approved Social Workers (ASWs). The underlying principles of ASW work is to have specialist knowledge and skills needed in order to assess the person within their social and environmental contexts and to identify the least restrictive alternatives to compulsory detention to hospital.

13.2 Education, Training and Career Routes

Qualifying training:

About 4,000 social workers were trained each year in the UK during the 1990s, a quarter of them doing post graduate Master's programmes, and the others a two year Diploma in Social Work at DipHE level.

The new three-year degree level qualification, or two years Masters programme, is in its first year of implementation. The new degree is about **practice** supported by academic learning. The curriculum is individually developed by universities in consultation with stakeholders including service users, to meet the Requirements for Social Work Training, the National Occupational Standards for Social Work and the QAA Benchmark Statement for Social Work. The aim of training is to produce well-qualified social workers whose practice is underpinned by a sound value and evidence base, who can use research and also maintain a critical stance.

The Requirements specify key areas of study:

- Human growth, development, mental health and disability
- Assessment, planning, intervention and review

- Communication skills with children, adults and those with particular communication needs
- Law
- Partnership working and information sharing across professional disciplines and agencies

All social workers at the point of qualification should, at a minimum, be able to:

- theorise about the possible presence of mental health factors as a dimension to all situations, needs and problems encountered;
- practice with the self-awareness and confidence to acknowledge the reality and impact of mental illness, for individuals, families and the wider community as well as on self;
- demonstrate a basic understanding of psychiatric diagnoses, causes, symptoms and treatments, and be basically familiar with the psychiatric vocabulary;
- recognise when people are becoming mentally ill;
- show a basic awareness of the need to promote mental health and of the social work contribution to the prevention of breakdown in mental health;
- apply a basic knowledge of mental health legislation and of mental illness in order to know whether, when and how to consult others including ASWs/MHOs, other social work colleagues, or medical personnel;
- apply a basic knowledge of mental health legislation and of mental illness in order to know whether, when and how to consult others including ASWs/MHOs, other social work colleagues, or medical personnel;
- understand racism and discrimination in relation to mental health, and the care and treatment of people who are mentally ill.

From: CCETSW (1994) *The Mental Health Dimension in Social Work*

Practice placements provide the opportunity for specialist experience. Each student has three placements during the degree, and there is significant investment in ensuring the quality and quantity of practice learning placements.

Post qualifying training – the Mental Health Social Work Award

Following accredited qualifying training, a social worker must complete Part One of the Post Qualification Award in Social Work. This requires the social worker to demonstrate that they have improved and extended their level of competence beyond the point of qualification. It includes an evaluation of the effectiveness of their practice using a relevant knowledge base and an understanding of legal and policy contexts and appropriate research. Social workers also need to demonstrate explicit adherence to social work values and ethically sound practice.

After gaining Part One of the Post Qualification Award, they then have to complete 600 hours of training in which they have to meet 25 competencies in order to gain the Mental Health Social Work Award. These competencies are clustered into five main areas:

- Application of the values of social work
- Exercising the duties, powers and responsibilities of an ASW
- Making informed decisions

- Working to identify, influence and use networks and collaborative arrangements
- Working effectively in complex situations.

Once they have successfully completed their training, they then need to be appointed by the local social services authority before they can practice as an Approved Social Worker. In order to retain authorisation to practice, each approved social worker is required to attend 20 days training within a 5 year period.

All qualified social workers are currently being registered with the General Social Care Council.

13.3 Traditional expectations of the profession

“One of the unique factors in social work is that the knowledge of other sciences and professions – economics, sociology, anthropology, political science, psychology, psychiatry, medicine and the biological sciences – have blended together with the knowledge gained from the field of social work itself. In addition, social casework has developed a method of helping the individual achieve maximum self determination compatible with the individual’s own capacities and the demands of society.’ (Knee; 1953, p 45).

Traditional expectations from social work itself, have been to empower service users and carers through a range of value-based and evidence-based interventions within a social model and understanding of mental distress. The ‘social’ element in our culture (and title) has often been interpreted and polarised by some as assisting people with housing, financial and childcare issues. For others, social workers are seen as non-conforming, interfering politically correct risk-takers. Added to this is the ‘necessary nuisance’ a social care perspective brings to a service culturally dominated by the medical model, and which is particularly evident in the statutory framework.

13.4 Future aspirations

The distinctive strengths of the contribution of modern mental health social work can be described as follows:

- An emphasis on the preferences and choices of service users and carers (sometimes summarised as ‘the social work approach’) grounded within anti-oppressive practice
- Working in partnership with service users and carers towards meaningful change
- Strong advocates for the ‘social model’ of disability, the social inclusion and recovery agenda and the strengths approach – social workers work with people within the context of their families and wider communities to promote inclusion (not reinforce exclusion)
- Initiatives which actively promote service user and carer involvement in consultation and service planning and service evaluation
- Positive record on anti-discriminatory services, promoting the needs of ethnic minority communities and disabled people
- Explicit value base embracing (amongst others) human dignity and worth, respect, social justice, integrity, partnership and equality.
- A strong tradition of staff supervision and training
- Specialist social work roles and responsibilities within the legal framework (see below).

(adapted from Gilbert, 2003).

The Statutory Dimension of Mental Health Social Work: *Approved Social Workers (ASWs)*.

An ASW has overall responsibility for co-ordinating an assessment under the Mental Health Act (1983). This service is available 24 hours a day, 7 days a week and 365 days a year. Although appointed by a local authority the approved social worker is personally liable for their actions. Following an assessment and in consultation with other professionals, families and carers, they make an independent decision ensuring that any intervention is the least restrictive necessary in the circumstances.

An ASW has the duty to make an application to admit someone to hospital, having regard to the wishes of relatives. The ASW must identify and where practicable, contact the person's nearest relative, where a formal admission to hospital is being contemplated. Before making an application the ASW must have interviewed the person in a suitable manner and satisfy themselves that detention in hospital is *in all circumstances of the case* the most appropriate way of providing care and treatment.

An application for compulsory detention in hospital must be made by an ASW or the person's nearest relative accompanied by at least one medical recommendation from a registered medical practitioner (s.4), but usually two recommendations. The Code of Practice (1993) states that the ASW is the 'right applicant' in preference to the nearest relative. Even where medical recommendations have been made, the ASW has a duty to make a decision whether or not to make an application for admission.

Where an application is made, the ASW must ensure that legal requirements are met and that the person is conveyed to hospital in the most humane and least threatening way.

Conclusions

The contribution of social work knowledge, skills and values are integral to the reform and future of mental health services. However, new language and concepts in recent policy documents contain unacknowledged influences of social work. For example, 'Patient Choice' is a re-working of user self determination (which is in social work literature some 50 years ago). The Social Exclusion Unit Report (2004) emphasises the need to embrace the social model of mental distress and values-based practice IS social work practice.

Social work itself also needs to recognise these strengths. In a system whereby integration can feel synonymous with submersion, effective social care leadership in mental health services is crucial in championing the social perspective.

The British Association of Social Work Mental Health Special Interest Group.

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14.0 The Voluntary Sector contribution

14.1 Introduction

The voluntary sector employs roughly 10% of mental health staff nationally. National mental health charities employ a wide range of people – from those whose key qualifications are life-experience, understanding and expertise by their own use of mental health services, to those who are qualified professionals eg nurses, social workers, doctors, psychologists, therapists. Their roles within the voluntary sector are as support/care staff, outreach workers, advocacy workers, forensic workers, service managers and, where employed for their particular professional roles and expertise, as nurses, doctors, consultants, trainers etc.

It is not possible therefore to adopt a single professional perspective on behalf of the voluntary sector for this exercise without duplicating some of the single professional perspectives of colleagues “across the boundaries”. So, in an effort to illustrate what is distinctive about the voluntary sector role in mental health services, I will primarily focus on perhaps the most characteristic features of our contribution to multi-agency mental health services (although this may risk attracting the label of non-professional):

- **service-user expertise**
- **social inclusion and well-being**
- **advocacy**

These activities are not exclusive to the voluntary sector, but are movements which the sector leads and which help define our values, objectives and contribution to multi-disciplinary work.

Other than these “values-driven” roles, I would suggest that it is the **management role** in the voluntary sector which is most distinct from its statutory counterparts in its generalist scope, including business development, business management, marketing and campaigning.

14.2 Qualifications

More important and fundamental than formal qualifications in performing roles relating to service-user expertise, social inclusion and advocacy are

- personal experience of mental disturbance and services, assessed and processed by the individual,
- appreciation of inclusion and access into ordinary community resources, and anti-stigma practices,
- knowledge and understanding of the rights of people with mental health needs.

Relevant (but not required) formal qualifications include related NVQs and professional training, but these would usually be secondary to the essential personal qualities and experience.

Similarly, operational and business managers will often hold professional and/or management qualifications but these may be considered secondary to their experience of delivering and developing community mental health services in qualifying them for the generalist management role.

Competency frameworks

For roles relating to service-user expertise, social inclusion and advocacy, NVQ level 3 in Social Care / Promoting Independence applies but is not an essential requirement. For advocacy workers specifically, a Level 3 NVQ in Advocacy provides a basic framework which organisations may supplement with more specialist competencies for mental health advocacy. Additionally, the national Skills for Care (ex-TOPSS) induction framework can be followed for all new support staff. For middle / senior managers, Level 5 NVQ can be applied as a broad competency framework.

14.3 Traditional Expectations

The voluntary sector's overall contribution to mental health services has traditionally been considered a "charitable" supplement to statutory provision. "Charitable" can mean kindly, helpful, well meaning but marginal. At best, the voluntary sector has been traditionally regarded as an effective voice for service users, their families and friends.

14.4 Future aspirations

Contracts for care and support since the 1990's have brought about expectations of value for money from the voluntary sector, high standards of practice, business management, innovation and flexibility. The voluntary sector in mental health services has led the way on social inclusion, advocacy, service user and carer involvement, and flexible-role development within a progressive workforce culture (eg STR-type workers).

Finally, and perhaps uniquely, the statutory sector and the public look to the voluntary sector to **campaign** for rights and services, to research need, lobby decision-makers, and promote collective aspirations in order to achieve advances, solutions and, occasionally, small revolutions (eg the carers' movement of the past 20 years, and the recent Alliance against the Mental Health Bill).

The voluntary sector seeks to sustain this fertile mixture of the skills of a professional workforce and efficient business management with the passion and commitment of the experts by experience, with significant overlap between the two.

John McKelvie,
Regional Director, MACA (Now "Together – Working for Wellbeing")

Appendix 3 (b)

Primary Care Liaison and Interface Issues

This paper aims to summarise concisely the issues of importance regarding liaison between primary care and specialist services. It is based on an analysis the literature, patients' pathways through services and personal experience. It does not address the important issues regarding liaison with counsellors and psychologists and graduate mental health workers who are often already based in primary care, and the need to liaise with the increasing number of specialist community based teams. It only touches on the need for liaison with more community based sources of support.

Patients' paths and liaison

The following are elements of patients' pathways through care where an effective liaison is important:

- *Those presenting to GPs and primary health care teams in acute distress or with more long-standing common mental health problems require a competent assessment and treatment.*
While most GPs may cope alone with much of this work, others may lack the skills and interest. Some practices, competent in providing standard care for depression might wish to provide enhanced services for depression. In both situations patients could benefit from the GPs having access to timely specialist advice or a full specialist assessment. While mental health services are generally able to provide good advice and access to assessment in those with psychosis or high suicidal risk, assessment for other patients may be patchy, inaccessible or delayed. Specialist services may also lack skills, knowledge and appropriate attitude in primary care mental health presentations, particularly in addressing patient centred consulting and somatic disorders. Where appropriate this kind of service could be integrated with an educational and service development input for practices. (EG support to practice nurses taking on a depression role)
- *Those presenting to a GP and primary care teams with significant psychological distress but not requiring specialist assessment.*
- There is a very large volume of presentations making up to 1:4 consultations. This group are typified by not quite satisfying any specific diagnostic criteria but having high levels of anxiety often associated somatic symptoms and recent multiple minor life events. They also include those people about to enter acute distress or in the recovery phase following an episode of acute distress. This group are often frequent attendees to primary health care and are often over treated with medication or unnecessary physical treatments. Links with community developments, leisure, employment and support of recovery-focused model are needed. The lack of focused attention to this group places a drain on primary care resources preventing engagement with more severe mental illness.
- *A further group of users with complex non-psychotic problems, including psychiatric co-morbidity, personality problems and drug and alcohol problems may benefit from specialist input.* This is the group of patients potentially causing most angst for primary care. Most will not be on specialist services caseloads, and yet often specialist assessments, followed by rapid discharge back to primary care, will have been made on a number of occasions. Different models of shared care need to be developed for this group of patients to ensure that jointly agreed plans with time for reflection and review are made and that timely advice and referral routes are available in times of crisis.

- *People with mental health problems are at increased risk of physical illness.* Primary care has a clear role to play in making its services accessible and being proactive in review. This work, through use of registers for recall, is rewarded under the new contract. However some users are engaged with specialist but not primary care services. Joint work at an organisational level to ensure systems of review and also to help individuals engage with primary health care teams are likely to be useful to ensure that all individuals gain the most from primary care.
- Many people with SMI under specialist care may benefit from shared mental health care. This may involve the proactive engagement of GPs into the care programme approach, setting up crisis and recovery plans, engagement of families who may be better know to members of the primary health care team, and liaison with GPs at times of relapse, crisis or discharge. A variety of systems involving patients, primary health care team and specialists need to be developed in order to ensure appropriate involvement of primary health care teams for patients whose care is being managed by mental health teams.
- Other patients with SMI are not engaged with specialist services either because they were discharged long ago or have lost contact. Primary health care teams have responsibility for the care of this group and the new contract now rewards this work and the development of the registers required. Even if the primary health care team have the skills and interest to work with patients with long-term mental illness the patients themselves might benefit from structured liaison between specialist workers and primary health care teams.

Principles of liaison:

- Joint working leads to the trust which is required to underpin successful liaison
- Overall aims are defined by patients' needs and journey (as above):
 - During acute presentation of emotional distress/psychosis/physical ill-health – initially or at times of relapse or crisis
 - In times of stability when recovery, health promotion and crisis planning are important
- Should be underpinned by principles of shared care and chronic disease management
 - Practice redesign where appropriate
 - Patient involvement and empowerment
 - Access to specialist knowledge
 - Information availability and exchange
- Primary care and mental health services will learn from each other
- There is little evidence to guide us as to benefits – arrangements will need to vary according to local needs, systems and resources.

Liaison can be considered at Trust, team and patient levels:

- Heterogeneity of skills and interest of PHCT/ specialist resources and structure will contribute significantly to defining (flexible) structure/process of liaison at trust and team level
 - Configuration of specialist teams needs to be considered
 - PHCT team size, interest and skills in mental health
 - Location and LTMI prevalence

- But individual patients' needs/ wishes will contribute further, through shared decision making, to the liaison arrangements for each individual:
 - Location of joint review or CPA
 - Individual carrying out regular mental health monitoring

Liaison can and should occur in a number of forms:

- Written and electronic communication (IM&T advances will allow transfer of coded data, reminders and eventually shared access to records)
 - GP referrals
 - Out-patient clinic and CMHT initial assessments
 - Admission and discharge from hospital
 - CPA/crisis plans/
 - Summary of community contacts
 - Significant primary care or specialist contacts
 - Critical incidents
 - Discharge planning / letters
- Regular formal meetings. This may include:
 - Linked workers attending practice meetings
 - Practice based mental health meetings – discussing problem cases, new referrals (pre or post assessment), and reviews for stable patients – future service developments, unmet need.
 - Meetings to agree and review liaison arrangements
 - Clinical audit meetings
- Informal or ad hoc communication
 - Contact either way in crisis or with concerns to gain advice or pass on information
 - To discuss potential new referrals
- Educational
 - Informally in meetings
 - As a part of consultation liaison (potential for short term consultation-liaison by psychiatrists, primarily as an educational tool)
 - At PHCT and CMHT meetings
- Direct clinical work
 - Specialists seeing patients in primary care settings (and liaising re shared plans)
 - Specialists seeing patients with PHCT members
 - Shared co-ordination of case management
 - GPwSIs contributing to specialist work

A variety of structural models of liaison can be considered:

- One to one liaison according to patient need between responsible clinician in each team
- Link worker assigned from CMHT/PCLT to PHCT – but not seeing patients preferentially from linked practice. May or may not be involved in filtering referrals
- Linked worker from cmht/pclt who are preferentially assigned patients from linked practice. Role includes a range of consultation liaison activities. Meaningful relationship derived from shared cases.
- Practice based specialist mental health workers as part of the PHCT or a primary care mental health team (including counsellors, cbt therapists, graduate workers etc).

Richard Byng and David Smart

Appendix 3 (c)

Social Inclusion for Psychiatrists

Psychiatrists' contribution to social inclusion and recovery work

Despite the growth in research and consequently evidence-based treatments, psychiatry remains an area of medicine which is marginalised, stigmatised and discriminated against. This occurs in terms of attitudes and resource allocation. The emphasis by the General Medical Council on training medical students to develop skills to interact effectively with patients may tend towards countering this but there is a long way to go. Psychiatrists are therefore familiar with social exclusion within their profession, few having not met this at some stage in their training and subsequent career, and therefore they are in a good position to identify with their patients who are subject to more global effects of exclusion every day of their lives.

Psychiatrists, amongst others, have been instrumental in highlighting this situation and ways of combating it, e.g. Warner (1991) in promoting the recovery agenda, Drake and colleagues (Bond et al, 2001) in focusing on supported employment and the Royal College of Psychiatrists with its report 'Rehabilitation and Recovery Now' (CR121) and Changing Minds campaign. These issues were described in the recent Social Exclusion Unit report on Mental Health. This posed the questions:

- How can adults with mental health problems secure the same opportunities for social participation and access to services as the general population?
- What more can be done to enable adults with mental health problems to enter and retain work?

Further questions include:

- What more can be done to enable adults with mental health problems to enter and retain education and social networks?
- How are we as a society to reach a significant reduction in stigma and discrimination currently prevalent towards people who have a mental illness?
- Updated understanding of recovery is focused on enabling people with mental health problems to be more in control over their lives; how can our mental health system be enabling the implementation of such a direction?
- What should be the contribution of psychiatrists towards achieving these objectives?

The social inclusion and recovery initiative is designed to go far beyond the NHS and Social Services to include key departments, e.g. the Department for Work and Pensions which now has targets to increase the employment rate of people with disabilities, to work to improve their rights and to remove barriers to their participation in society.

The report also provided the context in which discrimination against people with mental health problems occurs (Table 1)

Table 1 Stigma and discrimination

People with mental health problems are more likely to be victims than perpetrators of violence.

Prevalence

Severe mental health problems such as schizophrenia are relatively rare, affecting one in 200 adults each year. But depression and anxiety can affect up to one in six of the population at any one time, with the highest rates in the most deprived neighbourhoods.

Cost

Mental health problems are estimated to cost the country more than £77 billion a year through the costs of care, economic losses and premature death.

Latest figures show that prescriptions for mental health problems cost around £540m per year.

Employment

Only 24 per cent of adults with mental health problems are in work - the lowest employment rate for any of the main groups of disabled people.

For people using secondary mental health services this is even lower:

- 16% of users of community mental health services in employment. (Thorncroft et al, 1999)
- 14% of people with longer term mental health problems in employment. (Scott et al, 2000)
- 8% of longer term mental health service users in employment – a decrease from 20% in 1990 (Perkins & Rinaldi, 2000)

Fewer than four in ten employers say they would recruit someone with a mental health problem.

Families and community

People with severe mental health problems are three times more likely to be divorced than those without.

People with mental health problems are three times as likely to be in debt as those without.

Disability Discrimination Act

The Disability Discrimination Act 1995 (DDA) was a milestone in reducing discrimination against people with disabilities (Sayce & Boardman, in press). It outlaws discrimination against disabled people in employment, in relation to the supply of goods, facilities and services, in the disposal of premises, in education, and contains measures designed to facilitate access to certain types of public transport. It includes a duty on employers, education/training providers and the providers of other goods and services and other services to make 'reasonable adjustments' to enable disabled people to work and access services. Each year, between 10 and 15 per cent of all calls to the DRC helpline relate to people with mental health problems. 23 per cent of employment cases brought by the DRC are related to mental health. Analysis found that employment tribunal applicants with 'depression, bad nerves and anxiety' had a success rate of 18 per cent, compared with 39 per cent for diabetes, the most successful applicant group.

35 per cent of respondents to the Social Exclusion Unit consultation, preceding the publication of report, felt that health and social care services placed a low priority on employment, and only 6 per cent felt it was a high priority within these services. Even now, 'vocational services' can too often include a succession of training courses that are designed to fill people's time but do not provide a platform for moving into open employment. However, the best projects bring together key partners to meet clients' health, employment and other needs. They can have a critical role in persuading clients to interact with 'Jobcentre Plus' and overcome fears about benefit loss, both of which can be barriers to work.

A further report 'Action on mental health A guide to promoting social inclusion' from the Social Exclusion Unit has provided more practical detail and provides a series of specific fact sheets on areas such as stigma, employment, families, social networks.

Barriers to employment

There are a number of reasons why people with mental health problems have difficulties finding or keeping a job.

- The impact of the mental health problems on the individual, leading to loss of motivation and confidence. Side effects of some medication (such as drowsiness) can rule out certain jobs.
- Fear that employment will lead to worsening mental health, even though unemployment is actually likely to be more detrimental to mental health.
- Low expectations of staff. Lack of understanding about the benefits of employment can lead health and social care staff to advise against employment. Jobcentre Plus staff can have poor awareness of mental health issues. This can lead to a culture of low expectations, with the assumption that some individuals will 'never' be able to work. Yet an 'Individual Placement with Support' approach to employment can lead to 58% of people with serious and enduring mental health problems who wish to work getting open employment (Crowther et al, 2001) or possibly even higher levels (Bond, 2004)
- Employer attitudes. Many employers are reluctant to employ people with mental health problems. Occupational health departments might also raise concerns that the individual would be unable to cope or would take too much time off sick.
- People with mental health problems lacking awareness about available support.
- There appears to be low usage of Jobcentre Plus among people with mental health problems, who may not be aware of recent initiatives to ease the transition to employment.
- Benefit reviews. Although automatic benefit reviews are not the policy of the Department for Work and Pensions, there is a widespread fear that looking for employment, including unpaid work, will trigger a benefits review. Similar concerns occur about Disability Living Allowance (DLA), although this can be paid to those in or out of employment.
- Financial implications of leaving benefits. Many people feel that leaving benefits represents a real threat to their financial security. They have concerns either that they would be worse off in employment, or that the job would not work out and they would need to reclaim their whole benefits package, which might have been difficult to secure in the first place. People claiming through their health insurance fear having higher premiums or being unable to get health insurance in future if they return to employment. Action to address these issues includes the Working Tax Credit, which tops up the wages of people on low incomes working for 16 hours or more, and the linking rules for people on benefits.

How to break the cycle

“People whose symptoms continue or recur can and do live satisfying lives, and contribute to their communities in many different ways, [but] the alleviation of such symptoms does not necessarily result in the reinstatement of former, valued roles and relationships” (Social Inclusion Unit, 2004b).

People with mental health problems can regain the things they value in life regardless of their diagnosis or symptoms. This requires a positive response from society to accommodate individual needs and differing contributions. There are a number of building blocks needed to promote social inclusion.

- Inclusive communities: a reduction of stigma and discrimination within the local community to support reintegration and the acceptance of people with mental health problems as equal citizens.
- Early intervention: offering support and help before people reach crisis point in a way that is non-stigmatising and easily accessible.
- Empowerment and the right to individual choice: breaking the perceived link between mental health problems and incompetence, to provide individuals with control over their own care and future.
- A focus on employment: recognition that jobs provide a sense of worth and identity as well as financial security. Employment is associated with better health outcomes and reduced need for health and other services. There is evidence in the UK (Rinaldi et al, 2004) and elsewhere (Bond et al, 2004) that a lot can be achieved in targeting employment within early intervention and within supported employment.
- Promoting broader social participation: education (Mather and Atkinson, 2003), training or volunteering, particularly in mainstream settings, can increase employment prospects as well as being valuable in their own right (Aldrige and Lavender, 2000). They can help build self-confidence and social networks, as can sports and arts activities. Sports can help improve people’s physical as well as mental health.
- Securing basic entitlements: decent housing, basic financial and transport services, and ensuring people are aware of their rights.
- Acknowledging and supporting people’s social networks and family relationships: recognising the central role that family members and friends can play in reintegration into communities.
- Building confidence and trust: making services more welcoming and promoting understanding of different needs to encourage people who may mistrust statutory services, such as some ethnic minorities or parents, to engage with services earlier.

The role of health and social care services in tackling social exclusion

The Social Exclusion report describes how the advice that people with mental health problems receive from health and social care professionals can set the tone for the course of their illness and its impact on their lives. Support for reintegration into the community is an integral part of the work of effective mental health services. A change in the focus of mental health services required by the social inclusion agenda is a logical extension of the current national process of integration of health and social care. However such integration has often only occurred at a structural level (with statutory agreements, pooled budgets, single management etc.). Full integration of health and social issues requires a more substantial change in the guiding philosophy and day to day practice of services that has implications for both health and social care professionals. The specific knowledge and skills psychiatrists have means that they have a central role to play in delivering these changes of focus.

Implications of a Social Inclusion and Recovery Agenda for Mental Health Services

If mental health services are to promote social inclusion then there needs to be a change in the focus of services in the following direction:

The aim of mental health services is to 'cure' people

- Treat illnesses
- Reduce symptoms (cognitive and emotional problems)
- Decrease deficits and dysfunctions
- Reduce skills deficits



The aim of mental health services is to help people with mental health problems to do the things they want to do, live the lives they want to lead and access those opportunities that non-disabled citizens take for granted. (Repper & Perkins, 2003)

An emphasis on identifying problems



An emphasis on identifying strengths and possibilities

A emphasis on care



An emphasis on opportunity

An emphasis on changing the individual to fit in



An emphasis on changing the environment so it can accommodate the individual: supports and adjustments to facilitate access.

An emphasis on prescribing what is good for people



An emphasis on enabling people to take control of their own lives and the support they receive to live them

The reduction of distressing and disabling symptoms is one means by which inclusion and recovery can be promoted. However, recovery is not solely about clinical recovery but with the process of rebuilding of a meaningful, valued and satisfying life in the face of mental health problems. Recovery and social inclusion can be pursued whether or not symptoms persist or recur. It cannot be assumed that symptom reduction will automatically mean that a person is able to resume their former roles and activities. Neither can it be assumed that people must be 'well' before they can do things like work, go to college and engage in ordinary leisure pursuits. For example, in relation to work:

- It is worth noting that the assumption that symptomatology has to be controlled before people can be supported to return to work is not supported by the research literature. Bond (2004) in his review of literature shows that the outcomes of supported employment are not related to diagnosis, symptomatology, age, gender, disability status, prior hospitalisation or education – factors that have typically been used to determine 'work readiness'.
- Service users may therefore be discouraged from seeking competitive employment in the mistaken belief – in evidence-based terms – that they need a very gradual introduction to employment through sheltered work or training placements until they have proved to themselves and others that they are 'ready for work'.
- Those whose symptoms take some time to abate are likely to lose the things they value in life. For example, DWP research shows that the longer a person is off work the less their chance of returning: after 6 months of sickness leave the likelihood of a person returning to work is less than 50% – and less than 10% after 1 year. Thus early intervention is essential if a person is to retain those social roles that they value.

The elimination of symptoms does not guarantee that a person can return to work: discrimination exists and people remain excluded because of a history of mental health problems (especially if experiencing the more serious ones).

As indicated in the Social Exclusion Report, too many mental health professionals have very low expectations about what people with mental health problems can achieve in their lives. In one study, 40% of people with mental health problems who were actually in open employment had been told by a mental health professional that they would never work again. Hope and opportunity are critical if people are to rebuild their lives with mental health problems.

The trouble is that the low expectations of mental health professionals set up a kind of vicious circle that erodes hope and diminishes opportunity. For example, in relation to employment, if the expert professionals say that people with mental health problems are unlikely to be able to work, then this has two effects.

- People with mental health problems believe them and give up trying to get jobs – ‘If the experts say I cannot work then what hope is there?’
- Employers believe them and are reluctant to hire people – ‘If the experts say they cannot work, then what is the point in employing them?’

If people with mental health problems give up applying for jobs and employers stop taking them on then this guarantees that there will continue to be very few people with mental health problems in employment.

Health and social care services will tackle social exclusion through:

- improvements in vocational services in line with the evidence base in the area and the provision of a choice of services to meet diverse needs;
- access to an employment adviser and social support for everyone with severe mental health problems;
- redesigning mental health day services to promote social inclusion and community participation.
- improved access to vocational and social support in primary care;
- strengthened training on social inclusion for health and social care professionals;
- measures to tackle inequalities in access to health services³; (and)
- closer working with the criminal justice system, including strengthened police training on mental health issues.

Relevance of interventions by psychiatrists

Whilst treatments for mental disorders have improved substantially over the past few decades with effective medications and psychosocial interventions becoming available to treat symptoms, the opportunities for patients to make substantial gains in their quality of life are often negated by inability to access employment, leisure and financial benefits.

3 The Disability Rights Commission (DRC) have just initiated an investigation into health inequalities experienced by people with mental health problems (www.drc-gb.org)

Psychiatrists are members of multidisciplinary teams, and hence there is a need to demarcate their specific contribution to these areas, rather than expect them to undertake most of it. Furthermore, although psychiatrists may feel that they can have little influence over these areas of patients' lives, many of them do believe that these areas are relevant to them (Kingdon et al, 2004). In particular, there is a key motivational role which psychiatrists have in relation to recovery and social inclusion. Service users, who are told – implicitly or even explicitly – that they are seriously mentally ill for life by their psychiatrists where individual prognosis is so uncertain, are less likely to be motivated to try and improve their quality of life, their abilities, and their relationships with other people. Those patients who have psychiatrists who convey hope and belief in their strengths can be expected to do much better. As an example of this, those employed tend to have far fewer relapses, regardless of the severity of the diagnosis (Warner, 1985).

Role of psychiatrists in promoting social inclusion

Psychiatrists can contribute to recovery and inclusion by:

- getting to know peoples' wishes/ambitions/strengths and working with these;
- focusing in the assessment process on identifying strengths as well as weaknesses;
- developing their motivational role, which includes exploring the person's social and psychological situation whenever meeting him/her, i.e. not only about symptoms and medication, but also social networks, education, employment, volunteering and other forms of community participation;
- conveying hope through exploring strengths, protective factors and unrealized potential and focusing on positive aspects;
- increasing knowledge of social networks, training/education, employment, benefits, advocacy in terms of what exists and where to refer people to⁴;
- monitoring the use of medication to minimize adverse effects on drive and personal presentation;
- much greater use of psychological interventions by developing and using their own skills and through appropriate referral to other specialists;
- actively working to change the impersonal, boring and passive atmosphere of the mental health service environment itself, particularly and most pressingly acute admission wards;
- actively supporting the creation of safe alternatives to hospitalisation, which continues to be a source of stigma and fosters chronicity;
- supporting access to general medical services, including health promotion – e.g. to reduce smoking and improve diet and exercise;
- working with service users in partnership style and content which enables the latter to have more control – and hence also more responsibility – over their lives;
- providing leadership, where appropriate, in enhancing the quality of service provided to service users and carers.

⁴ A DWP desk guide for assisting GPs on employment issues has valuable information relevant to psychiatrists: <http://www.dwp.gov.uk/medical/hottopics/dwp-desk-aid-time-line-2003-4.pdf>

There are a variety of other specific ways in which psychiatrists can assist:

- Employment:
 - by being aware of the impact of employment on individuals' lives:
 - early intervention to prevent patients losing their jobs when they first become ill: often job loss happens after the acute period when they may be seen in out-patients.
 - linking the person with appropriate supports, e.g. vocational advisers, disability employment advisers, employment support schemes.
 - providing reports promptly to employers and Employment Tribunals to support employment.
 - advising clients how to find out about and assert their rights under the DDA (the DRC has a help-line – see www.drc-gb.org for details – and also Sayce & Boardman, in press).
 - reminding an employer, college or other provider of services of the existence of the DDA which is often enough to change their behaviour.
 - helping employers to meet their obligations to make reasonable adjustments to accommodate people with mental health problems, e.g. individualised advice on working hours (later in the day avoiding rush hour may be better for some) or conditions (crowded offices may be problematic), provision of in-work support or flexibility to contact care coordinator.
- Benefits:
 - ensuring that patients are being assessed for appropriate benefits, e.g. Disability Living Allowance – and
 - understanding how to optimize supporting DLA and other reports required.
- Promoting mental health and reducing barriers to recovery:
 - early intervention teams have remits to improve access to mental health services and mental health promotion in schools, colleges, primary care, etc, are a key part of this;
 - paying attention to the individual strengths and potential of service users' and factors that might promote their quality of life and opportunities for participation and recovery;
 - stimulating across agencies strategies to support preventive action;
 - Many psychiatrists have involved themselves in campaigns to promote mental health, e.g. those run by the Royal College of Psychiatrists: 'Changing minds' 'Defeat Depression';
 - World Mental Health Day has also provided local opportunities to influence communities.

More generally, in terms of psychiatric practice:

- optimal use of medication can reduce stigmatisation – most psychiatrists believe that polypharmacy and use of medication above BNF levels occurs too frequently (Kingdon et al, 2004) yet many continue to prescribe this way. This has a major effect on patients' presentations of themselves with increased weight, tremor, and tardive dyskinesia interfering with their, and others, perception of themselves and lethargy reducing their potential for involvement in leisure and employment activities.
- unduly negative perceptions of illnesses like schizophrenia can impair recovery. A range of studies from Britain (Harrison et al, 2001) continental Europe (Ciompi, 1981), and North America (Harding et al, 1989) have demonstrated that many patients can make substantial recoveries from

even the most severely ill states. Appropriate 'normalisation' is an important component in effective psychological treatments and can be used in relevant situations.

What form should training for psychiatrists to promote social inclusion take?

- in generic medical training
- in psychiatric training
- as part of continuing professional development (CPD)

The requirements of the General Medical Council are increasingly focusing on practices in communication, collaboration, consideration of social factors. Therefore, medical schools to meet the requirements have to adjust their curricula to allow more focus on community and public health medicine. There is a similar emphasis emerging in psychiatric training but in a piecemeal fashion. Training to promote social inclusion and recovery needs to be given broader consideration.

Its impact on CPD, which is participant and peer group-driven, is not apparent but is particularly important as the training that most psychiatrists will have received has had a narrow medical and more specifically biological focus. Understanding the evidence-base and practice of psychosocial treatments needs to be a focus in training at each level. Emphasising the social inclusion agenda could be a way of radically improving psychiatric practice to bring it in line with the views of what service users and carers say that they want from services.

Training

Psychiatrists' working together with service users, carers, and other members of the multidisciplinary team in small project-oriented groups is a particularly effective way of training and developing new initiatives, already used in primary care (the Trailblazers project developed by NIMHE). Learning sets in which small groups work out their learning objectives in advance and in which each participant contributes to the learning process, could be another effective way of training. Psychiatric trainees (e.g. Specialist Registrars as part of their research commitment) could learn through a participatory Action Research approach.

Conclusion

In determining the role of the psychiatrist therefore, each of these areas needs to be identified and provision made in job contracts and training to enable psychiatrist's inclusion in this wider social agenda.

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Appendix 4

Products from the Development/ Pilot Sites

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PRODUCTS FROM PILOT/DEVELOPMENT SITES

Appendix 4 (a)

Bromley and Greenwich Medical Staff Outpatient Clinic Audit Tool

DETAILS OF PARTICIPATING DOCTOR																
Full Name										Position						
Directorate										Date						
Patient	Duration of Appointment (mins)	DNA	New Assessment	Carer/family education/support	Court report preparation	CPA or preparation for CPA	Crisis Resolution	Medication Review	Physical healthcare check	Reassurance/support	Risk Assessment/risk monitoring	Report: benefits or other reports	Session of therapy as part of an ongoing therapeutic plan	Other (state)	Could this session have been done by another discipline/staff member (if yes state who)	What would have made it more efficient (e.g. blood results available, electronic prescribing)
1																
2																
3																
4																
5																
6																

Appendix 4 (b)

Oxleas NHS Trust Bromley and Greenwich Medical Staff Work Substitution Diary Tool

To save paper and printing only two days of the seven needed are set out below, others can be produced as required from these by changing day.

DETAILS OF PARTICIPATING DOCTOR	
Full Name	
Directorate	
Position	

The following tool has been designed to help you monitor the work that you do and encourage you to think of alternative ways of working.

Completing the diary

Firstly, fill in your personal details above.

Secondly, on each page you will see a table which breaks up the day into one hour blocks. For each day you should:

1. Enter the date at the top right of the table
2. Assign a relevant activity code to each half hour block of the first column using the table to the right. Alternatively, provide details of what you were doing if it is not reflected by the activity codes provide. (Note: you may have more than one code within a one hour block)
3. In the second column write your on call status
4. In the last column comment if appropriate on any alternative ways your work may have been completed
5. Please note that there is a separate section at the back of this document where you can record any on call work that you have undertaken outside of the hours of 8:00am and 7:00pm.
6. Once you have completed the diary return via internal mail to:

CODES	
Direct clinical care	
Emergency assessment & treatment	C1
CPA	C2
Out-patient or other clinic	C3
ECT	C4
Ward round	C5
Other patient treatment or carer consultation	C6
Telephone advice	C7
Multi-disciplinary meetings about direct patient care	C8
Investigative, diagnostic work	C9
Travelling time between sites	C10
Patient administration	C11
Supporting professional activities	
Training/supervision	S1
Continuous Professional Development	S2
Study Leave	
Teaching	S3
Audit / Clinical Governance	S4
Job Planning / Appraisal	S5
Research	S6
Clinical management	S7
Additional responsibilities	
Audit lead or Clinical governance lead	A1
Clinical tutor	A2
Clinical directors' and lead clinicians'	A3
Other	A4
Other duties	
Trade union duties	D1
AAC external member	D2
NCAA, GMC, Health Care Commission	D3
Work for Royal Colleges	D4
Work for NIMHE	D5
Work for other national policy body	D6
Other	D7
Additionally remunerated work (see notes on p1) (e.g. private practice P1, Category 2 work P2, and other additionally remunerated work P3)	
	P
Non-work activity	
Absent from work (annual or sickness leave)	N1
Other (i.e. time spent not working)	N2
On-call status (column 2 - see notes on p1)	
Predictable on-call	1
Unpredictable on-call	2

New Ways of Working for Psychiatrists: Enhancing effective, person-centred services through new ways of working in multidisciplinary and multi-agency context: Appendices

MONDAY			
Date / /2005			
Time	Work Code What were you doing? If 'you have selected the 'other' code please provide details	On call?	Substitution Who else or what else would have needed to be put in place for you not to have had to do this?
08:00-08:30			
08:30-09:00			
0900-0930			
09:30-10:00			
10:00-10:30			
10:30-11:00			
11:00-11:30			
11:30-12:00			
12:00-12:30			
12:30-13:00			
13:00-13:30			
13:30-14:00			
14:00-14:30			
14:30-15:00			
15:00-15:30			
15:30-16:00			
16:00-16:30			
16:30-17:00			
17:00-17:30			
17:30-18:00			
18:00-18:30			
18:30-19:00			

New Ways of Working for Psychiatrists: Enhancing effective, person-centred services through new ways of working in multidisciplinary and multi-agency context: Appendices

TUESDAY			
Date / /2005			
Time	Work Code What were you doing? If 'you have selected the 'other' code please provide details	On call?	Substitution Who else or what else would have needed to be put in place for you not to have had to do this?
08:00-08:30			
08:30-09:00			
0900-0930			
09:30-10:00			
10:00-10:30			
10:30-11:00			
11:00-11:30			
11:30-12:00			
12:00-12:30			
12:30-13:00			
13:00-13:30			
13:30-14:00			
14:00-14:30			
14:30-15:00			
15:00-15:30			
15:30-16:00			
16:00-16:30			
16:30-17:00			
17:00-17:30			
17:30-18:00			
18:00-18:30			
18:30-19:00			

Appendix 4 (c)

Avon & Wiltshire Assessment tool

West Wiltshire Locality Adult Services, Red Gables Trowbridge. 01225 354354
Multi Disciplinary Initial Assessment

Service User Name:		Record No.:	
Address:		MHIS No.:	
Postcode:		DOB:	
GP:		Nearest Relative:	
GP Practice:			
Assessed by:		Date:	

Presenting Problem:

History of Presenting Problem:

Treatment received, including medication:

Family of Origin:

Trauma/Loss:

Education & Work History:

Accommodation/Living Arrangements:

Relationships/Children:

Alcohol & Drugs:

Forensic History:

History of Mental Illness & Treatment:

Family Psychiatric History:

RISK INDICATORS – aggression/ violence & suicide								
(place an 'X' in the appropriate column for each category)	Yes	No	Don't know		Yes	No	Don't know	
Previous violence (any)				Violent fantasies				
Previous violence (serious)				Violent command hallucinations				

RISK INDICATORS – aggression/ violence & suicide							
<i>(place an 'X' in the appropriate column for each category)</i>	Yes	No	Don't know		Yes	No	Don't know
Non-violent offences				Admission under MHA			
Threats to specific persons				Poor adherence to treatment			
Alcohol &/or drug misuse				Disengaged from services			
Poor anger control				Lack of family/ social support			
Impulsivity				Others concerned about risk			
Age under 35				Male gender			
Previous suicide attempts				Family history of suicide			
Previous attempt (violent)				Unemployed/ retired			
Suicide plan/ expressed intent				Separated/ widowed/ divorced			
Suicidal ideas				Access to weapons			
Hopelessness/ helplessness				Chronic ill-health/ pain			
Depression				Evidence of psychosis			

Assessment of Risk: <i>(place 'X's in the appropriate column(s))</i>			
	LOW	MODERATE	SEVERE
Risk of Deliberate Self-Harm			
Risk of Violence			
Risk of Self-neglect			

Any other risk areas of concern? (self neglect, exploitation/abuse, risk to children, risk driving)
Give details:

Mental state examination (appearance and behaviour, speech, mood, sleep, appetite, thoughts, perceptions, cognition, insight):

STRENGTHS & NEEDS	
User's view of needs:	
Carer's view of needs (if appropriate):	

Summary and Formulation:

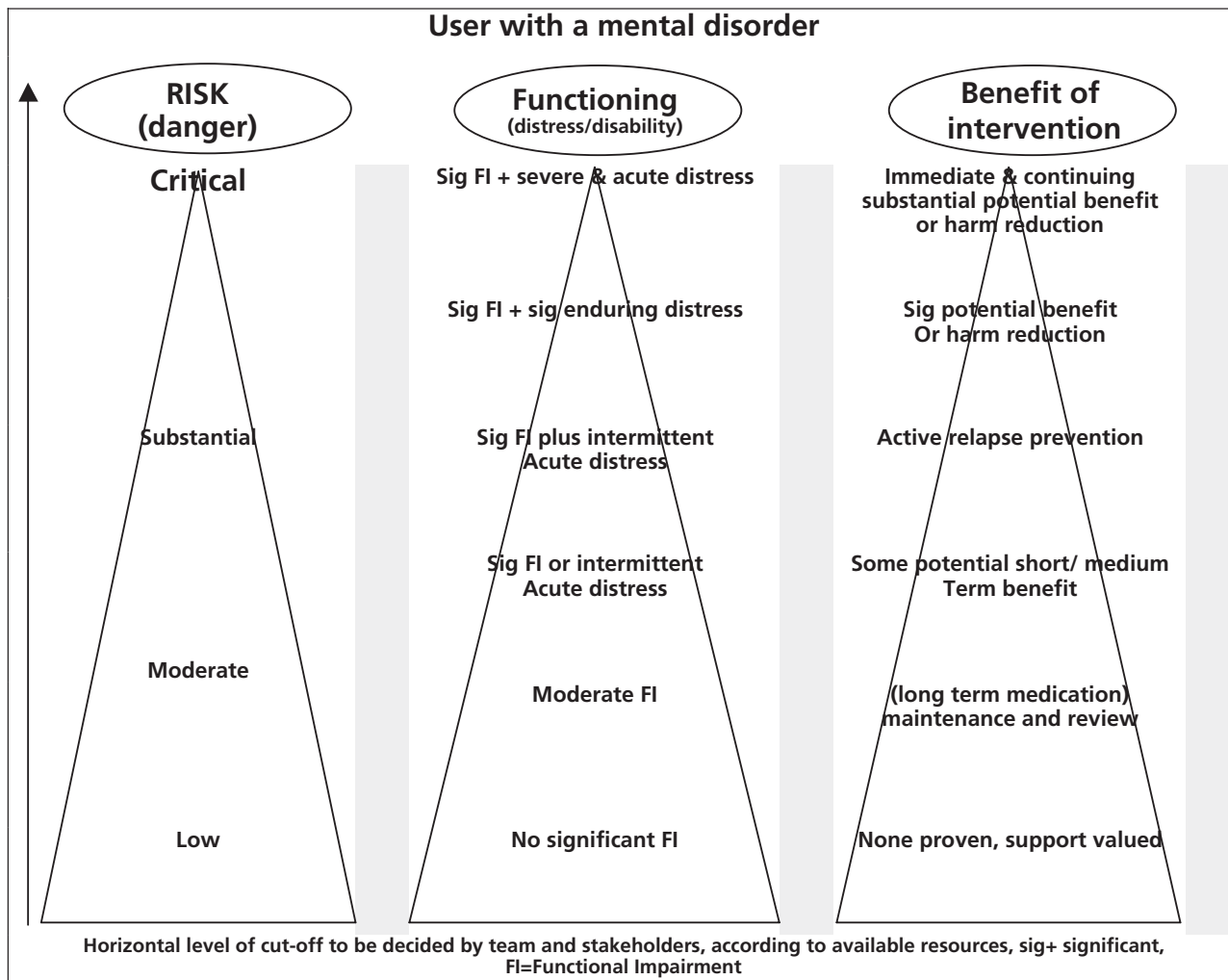
Meets entry criteria for service (Y/N):	(click HERE to see diagram)
IMMEDIATE PLAN (Secondary service or alternative, arrangements for follow-up, immediate measures to reduce risk, immediate requests to GP, medication):	

Copy of plan to Service User? (Y/N):	
Copy of plan to GP? (Y/N):	
Plan represents initial CPA? (Y or N/A):	
Review Date:	

Signed:	Designation:
----------------	---------------------

FOR INTERNAL USE ONLY

Place an 'X' in the greyed columns where appropriate for each criteria.



Comments on above:

Click [HERE](#) to return to form.

Appendix 4 (d)

THE CREATING CAPABLE TEAMS TOOLKIT

The Interim Report on Guidance on New Ways of Working for Psychiatrists in a Multi-disciplinary & Multi-agency Context August 2004, referred to: – “the challenge to map capabilities that meet the needs & preferences of service users”.

This challenge has been taken forward through the work of the Cross Boundary Subgroup & the development of the Creating Capable Teams Toolkit.

The Cross Boundary Subgroup comprises representatives of all the main mental health and social care disciplines. It has looked at the existing roles of all professions and non-professionally affiliated staff, exploring the flexibilities of competencies, roles and responsibilities together with the potential for multi-disciplinary team working in new and changing models of mental health care.

Thus the Creating Capable Teams Toolkit has been developed in the context of existing professional frameworks and registration bodies and acknowledges their impact upon new ways of working and new roles. However, it does provide a process which, it is hoped, will help manage the transition from existing roles and responsibilities to that of the emerging new roles and new ways of working for the Consultant Psychiatrist and others within the modern multi-disciplinary mental health services.

The Creating Capable Teams Toolkit has been designed:

- to provide a user-friendly toolkit
- for use by NHS Trusts & other mental health service providers & stakeholders;
- to enable providers to be creative in developing new ways of working & new roles within new and existing teams;
- to make most effective use of the expertise & experience of all team members;
- to work within the context of their particular model of service & within their own particular organisational context & setting.

The approach is service user centred in that it focuses on the skills & competencies required within a team, to deliver the designated service to the individual team's defined group of service users in order to meet their identified needs and achieve the required outcomes. It is fully informed by the Ten Essential Shared Capabilities and requires service user and carer participation as part of the process. It provides a systematic and stepped approach to ensure a methodical review of service within the context of national initiatives and guidance as well as local circumstance.

The work on the Creating Capable Team Toolkit also supports and is supported by current work on mapping skills & competency sets across mental health services. This is being jointly undertaken by the Department of Health, Skills for Health and NIMHE. It maps the National Occupation Standard competences against the NHS Knowledge & Skills Framework dimensions and the Ten Essential Shared Capabilities.

This will allow teams wishing to use the Creating Capable Team Toolkit to access a web-based mental health National Occupational Standards database that incorporates a search facility against mental health functions and interventions, as part of the toolkit process.

There have been significant expressions of interest from over a dozen mental health providers across England to trial the Toolkit in a variety of settings. Currently the Joint Workforce Support Unit is pursuing approaches with the North East London Mental Health Trust (NELMHT); the Leicestershire Partnership Trust; the South Staffordshire Trust & the Lincolnshire Partnership Trust. As the trials progress, they will be evaluated and learning materials developed to complement the effective use of the Toolkit. The Toolkit will also be made available in its test format on the NIMHE Knowledge Community site, where it will be regularly updated as the trials progress.

The completed Creating Capable Teams Toolkit, comprising a user guide & handbook that details guidance on the individual steps of the approach, together with the learning & worked examples from the trial sites, will be published as a separate document in December 2005.

Contact: Judith.watt@scmb.org.uk

Appendix 4 (e)

COMPLETE DEVELOPMENT SITE APPLICATION FORM

NIMHE London Program for the changing professional role of psychiatrists in the context of multi-disciplinary working	
Name of Lead Psychiatrist	Dr. Geraldine Strathdee, Clinical Director, Bromley Dr C Ify Okocha, Clinical Director, Greenwich Dr Hashim Reza
Full postal address	Dr. Geraldine Strathdee, Dr Ify Okocha, Oxleas House,
Name of host or employing organisation	Oxleas NHS Trust
E mail	Geraldine.stradhee@healthcare commission.org.uk Ify.okocha@oxleas.nhs.uk
Telephone and fax numbers	Geraldine Strathdee: Tel..... Mobile: Dr Ify Okocha Mobile:
Named lead in the NIMHE Development Centre	Gemma Hughes
Please answer the following questions as fully as possible	

1. What would be some of the key development issues locally that this pilot program would seek to address?

This proposal has two areas of focus:

- The development of individual senior medical staff optimal effectiveness, efficiency and job satisfaction
- Service development and choice around primary care and inpatient care.

Individual development focus:

1. The development of a methodology, which allows individual clinicians to determine their optimal effectiveness and efficacy and achieves the improving working lives program for senior doctors.
2. The development of a methodology, which facilitates MDT optimal working to ensure best outcomes for service users, and meets the new systems of inspection developed by the Healthcare Commission.

Service development focus:

3. Service re-design of outpatient clinics and new models of working with primary care including the development of models of choice in intervention for service users on standard CPA.
4. Service redesign of ward rounds and new models of working with inpatient units including scenario planning for the new mental health legislation.

2. What is the Background and context of this project?

- a. Within Bromley and Greenwich directorates of Oxleas NHS trust there has been a major expansion of the senior medical staff workforce, and we have, within the past 2 years recruited a new, multi-cultural workforce. The time is now right to develop our systems and process to ensure that we have effective team building with effective use of medical time to ensure best outcomes for our service users with optimal support to our MDTs.
- b. We have a track record as an organization that uses evidence based methods to design junior staff medical workforce time (see appendix i.e. the substitution process for shift implementation) and we would like to build on that process for senior medical staff time.
- c. The consultant team has started to developed an approach to evidence based appraisal where by we have attempted to develop a rigorous and evidence based process to deliver optimal approach along the categories defined by the GMC appraisal documentation i.e.
 - Good medical practice (Intelligent reporting)
 - Good medical care
 - Service user relationships
 - MDT relationships

We wish to further develop and complete this work.

- d. We seek to be a national leader in our assessment of core standards by the Healthcare Commission.
- e. In Greenwich we have just embarked on a process of redesigning our model of service delivery, emphasizing function of our teams following a recent review of our services by the Sainsbury's Centre for Mental Health.
- f. We seek to develop systems of CHOICE in mental health for service users on standard CPA and to change our model of working with primary care and acute inpatient services.

3. Give a brief outline of the aim and objectives of this proposal.

Overall aims & objectives

There are 2 key areas of focus in this project, We believe that services can only be effective and efficient if staff have clear roles and responsibilities which maximize their skills and give them job satisfaction. This project therefore will focus initially on achieving clear individual role definition.

As part of this and the second aim which is to support the development of new service models in both primary care and inpatient services, and within this develop the choice agenda for service users, we would like to explore the possibility of creating non-medical specialist roles in primary care.

Individual development focus aims:

1. The development of a methodology, which allows individual clinicians to determine their optimal effectiveness and efficacy and helps them improve their working lives.

2. The development for a methodology which facilitates MDT optimal working to ensure best outcomes for service users, and meets the new systems of inspection developed by the Healthcare Commission.

Service development aims

4. The service re-design of outpatient clinics and development of new models of working with primary care including the development of models of choice in intervention for service users on standard CPA (depression)
5. The development of new models of working with inpatient units including scenario planning for the new mental health legislation and the development of models of choice in intervention for service users on enhanced CPA (schizophrenia)

The project will require a 4 stage process including in built evaluation framework

Stage 1: The baseline

- Use of Programmed Activities (PAs) by consultants
- A baseline audit work planning tool
- A substitution methodology tool kit
- An audit of outpatient need tool
- An audit of ward rounds effectiveness tool

Stage 2: Supporting individual optimal effectiveness and efficiency

- An intelligent information report
- A service user satisfaction survey
- A 360 degree optimal roles and responsibility within MDTs
- Good practice in preparing for appraisal tool kit

Stage 3: New model of working with primary care for SUs on standard CPA

- Development of choice alternatives for service users on standard CPA
- Audit and evaluation of the non-medical specialist role in primary care

Stage 4: New models of ward rounds

Scenario planning for the implication of the new mental health legislations

4. What is the commitment and capacity of your employing organization to support this project to achieve the aim and objectives of the pilot?

The following departments have promised their support:

The audit department

The business office and IT leads

The service directors Ms Helen Smith & Kay Beaumont in Bromley, and Ms Fenella Trevillion in Greenwich

The HR department

The communication department

5. How would you see this project operating locally? E.g. within a specific team or unit or on a wider locality basis.

This work will be based primarily in Bromley and Greenwich with each leading on particular streams. It is envisaged that depending on the pilot results, all the directorates in the trust will adopt the findings.

6. Please provide detail of the *anticipated outcomes* of the pilot for your locality.

Individual development focus outcomes:

The specific outcomes from this individual focus will include:

An Audit Toolkit to help clinicians determine their optimal methods of working

Personal tool kit:

- Baseline job planning audit tool
- Substitution of core work audit tool
- Outpatient clinic function audit tool
- Inpatient and ward work audit tool
- Intelligent information reports for consultant psychiatrists
- Service user outcome satisfaction audit tool
- Good practice in preparing for Appraisal step by step guide

MDT optimal working tool kit:

1. service user outcome satisfaction audit tool
2. 360 degree optimal role within the MDT tool
3. Baseline job plan for the non-medical specialist role in primary care

Service development focus:

MDT optimal working tool kit:

The specific outcomes from this will include:

- Case scenario planning for working with primary care including :
- Development of a Choice care pathway for the management of depression in primary care
- Re-engineering of outpatient clinics through the development of primary care base non-medical specialists
- Case scenario planning for re-engineering of the inpatient service
- Development of a choice care pathway for the management of psychosis within acute inpatient services
- 360 degree ‘optimal role within the MDT’ tool

7. Give details of how the enabling monies would be used to support achievement of objectives.

We would require financial support for:

- Dedicated project management time
- Dedicated audit time to help design the baseline and other audit tools and to analyze the data and prepare reports
- Away day
 - Venues
 - Facilitators
- Purchase of assessment tools such as
- Mental state assessment and job satisfaction for doctors assessment tools
- Primary care workshops

We would value additional expertise from the modernization and other agencies to:

- Provide a ready literature review in service re-design and substitution
- Develop a service re-design method
- Develop scenario planning for our inpatient service
- Develop & implement substitution techniques
- Support our evaluation plans
- Provide expertise and standardized, reliable validated tools for assessment of the senior medial staff job satisfaction

8. What additional resources would the host organization provide to support this initiative?

The organization has committed to providing:

- audit expertise
- business planning expertise
- IT and data development expertise

- Project management expertise
- Full support of the borough directorates

9. How will you disseminate learning from this pilot initiative locally?

Dissemination will be achieved through the following routes:

Within Bromley & Greenwich:

- the monthly Service Development Forums in which the senior medical staff meet monthly with the senior management teams
- the monthly reflective practice forums in which the senior medical staff meet monthly to implement best clinical practice
- the methodology will form part of the annual appraisal system for consultant staff

The wider Oxleas NHS Trust

- the quarterly Trust wide medical Advisory Committee in which the Trust wide consultant body meets to share good practice
- the monthly medical manager meeting comprising the clinical directors and the medical director, the Trust tutor and senior HR staff

The wider communities especially primary care:

- feedback to the PCT through monthly partnership meetings
- monthly GP locality meetings
- two-monthly meetings between mental health leads in primary care and the directors/managers
- Quarterly GP and directorate meeting (includes psychiatrists, managers and service users)

The wider London consultant community:

- presentations to London region acute care collaborative consultant body and
- presentations to the London region RCPsych (community section)

The national agenda

- presentation to the Clinical leads meeting at the Healthcare Commission which is developing new systems of assessment including the use of intelligent information
- consultant advisory body to Professor L Appleby and NIMHE

10. What process do you plan to use locally to ensure continued development and improvement in the new ways of working for psychiatrists in a multi-disciplinary and multi-agency context?

The process of improvement will continue, as a core part of this project is to:

- Feed into and support to senior medical staff maximize the benefits of the annual appraisal process in which we are seeking to maximize MDT benefit
- Annual appraisal systems

Appendix 5

Policy Guidance Examples on New and Changing Roles

5 (a) Avon & Wiltshire Partnership Trust	127
5 (b) North East, Yorkshire and Humber	133

Appendix 5 (a)

Avon and Wiltshire

TRUST GUIDANCE ON THE ROLE OF THE CONSULTANT PSYCHIATRIST

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Guidance from a variety of national bodies on this topic is not well aligned. The Trust has taken legal advice, which is that the organisation can offer an interpretation of current guidance if endorsed by the Trust Board. The Avon and Wiltshire Mental Health Partnership Trust Board endorsed these guidelines on 26th September 2003 and will review them in September 2004.

Introduction

Confusion exists as to the limits of the role of the consultant psychiatrist. This is evident from listening to the views of doctors and other professionals within and outside the Trust, and from the ambiguous nature of the national guidance that is available.

This confusion has made many think that the responsibilities of the consultant are now so all-encompassing that the goal of producing 'do-able' jobs is receding further and further, at a time when the shortage of consultants means that we need to be striving for the opposite. In order to effect new ways of working for both consultants and their colleagues within the multidisciplinary team, the limits of medical responsibility need to be clarified.

During the national conferences on 'New Roles for Psychiatrists' held in Swindon and Newcastle in March/April 2003, it was acknowledged by their representatives that the Royal College and GMC guidance on this topic was out of step with service developments and needed revising. However, until this is done, and until national guidance from medical and other professional organisations is all in harmony with each other and with the definitions in the Mental Health Bill, the confusion will remain, and the development of NWW will be hampered. AWP staff at the Swindon conference asked the Trust to produce its own guidance to provide clarity in the meantime, and this document has therefore been prepared by the Executive Management Team working with the Trust's solicitors.

The Trust will support its staff in abiding by the guidance in this document.

National statute and guidance

Guidance note: The Mental Health Act 1983 is law, documents from the GMC, Royal College of Psychiatrists etc are GUIDANCE only, to be read alongside this Trust Guidance and considered in the same way.

The Responsible Medical Officer

- **This term refers to the Mental Health Act 1983 ONLY.**
- The Responsible Medical Officer (RMO) is defined in Section 34 as the **doctor in charge of treatment for the patient.**
- This will normally be the consultant psychiatrist but does not legally have to be a consultant.
- In the absence of the consultant, it must be clear who has been delegated this responsibility in the interim.
- A patient detained under the Act can only have one doctor acting as RMO at any one time
- In the case of someone subject to Guardianship, the RMO is authorised as such by the social services authority.
- The RMO does not have to be a Section 12 approved doctor, except in the case of the RMO of a patient subject to supervised discharge.

The Draft Mental Health Bill (2002) states that the managers of the hospital will appoint an 'approved clinician to be in charge of the assessment of the patient and his medical treatment in accordance with the Act.' This person is to be known as the **clinical supervisor**. The term Responsible Medical Officer does not appear in the Draft Bill.

Guidance note: Only use the term Responsible Medical Officer or RMO when referring to the responsibilities of a consultant in relation to the Mental Health Act 1983.

Guidance from Royal College of Psychiatrists

- Medical care of outpatients remains the responsibility of the GP, with consultants acting in an advisory capacity or providing specialist treatment (1996).
- All aspects of the medical care of an inpatient are the ultimate responsibility of the consultant (1996).
- Medical role has ‘primacy in the process of assessment and/or diagnosis’ (1996).
- Consultant can only accept responsibility for ‘a patient of whom they have specific knowledge’ (1996).
- Consultants ‘have the ultimate responsibility to diagnose illness and prescribe treatment. This authority may be delegated to other professionals but the responsibility cannot be abrogated.’ (2001a).

Guidance from the General Medical Council

The General Medical Council guidance in Good Medical Practice and Maintaining Good Medical Practice (1998) states that

- If you lead the team you must take responsibility for ensuring that the team provides care which is safe, effective and efficient.
- Delegation involves asking a nurse, doctor, medical student or other health care worker to provide treatment or care on your behalf. When you delegate care or treatment you must be sure that the person to whom you delegate is competent to carry out the procedure or provide the therapy involved. You will still be responsible for the overall management of the patient.
- Referral involves transferring some or all of the responsibility for the patient’s care, usually temporarily and for a particular purpose, such as additional investigation, care or treatment, which falls outside your competence. Usually you will refer patients to another registered medical practitioner. If this is not the case, you must be satisfied that such health care workers are accountable to a statutory regulatory body, and that a registered medical practitioner, usually a general practitioner, retains overall responsibility for the management of the patient.

Summary of the law and guidance

The Royal College guidance is taken to mean that one of the important roles of the medic in the team is to **diagnose**. The terms ‘primacy’ and ‘ultimate responsibility’ are taken to refer to the fact that an important part of medical training is to train doctors as diagnosticians – this aspect does not have such emphasis in the training of other professionals, and therefore the medic may be considered to be the ‘expert’ in this area, as other professionals will be for other areas of care and treatment. Diagnosis is taken to include the diagnosis or exclusion of organic causes of mental illness. To say that the medical role has ‘primacy’ in ‘assessment’ is both more contentious and more ambiguous.

The term 'prescribe treatment' is taken to mean the prescribing of medication (or a physical treatment, eg ECT). At the moment this is the sole preserve of the doctor, but Department of Health driven changes in prescribing practice will mean that this statement will become out of date. The national guidance therefore uses a very narrow definition of treatment – the Trust interprets 'treatment' in its widest sense as encompassing all therapeutic interventions, and only a minority would in this case be carried out by doctors.

'Medical care' is taken to mean general medical, rather than psychiatric, care – hence that becomes the responsibility of the consultant if a patient is admitted.

If the statements about delegation from both the College and the GMC are taken to refer to the same thing, then we can conclude that they are saying that the responsibility for diagnosis and/or drug treatment can be delegated to another, but remains ultimately a medical responsibility. This is **not** the same as saying that the doctor is responsible for all aspects of the patient's care. Professionals other than doctors will clearly also delegate aspects of care for which they are responsible.

The GMC statement about referral has been written to refer primarily to a general practitioner, but a doctor (or any other professional) can legitimately assume the standards that another individual belonging to a different profession will operate to.

Trust guidance

Responsibilities of individual professionals

Definitions (Onyett, 1995)

Professional responsibilities are defined by a duty of care to users, professional codes of conduct, and in some cases registration requirements.

Legal responsibility forms part of professional responsibility and describes an obligation to recognise and observe the limits of your training and competence and satisfy yourself that anyone else to whom you refer is also appropriately qualified and competent. Certain members of the team will also have additional legal responsibilities, for example the Approved Social Worker.

Individuals, of whatever profession, are responsible for the quality of the care that they provide to individual patients and accountable if it falls below acceptable standards. Team members will have a line manager, and a professional head who may or may not be the line manager.

Doctors are not therefore responsible for the quality of care provided by another team member.

There is therefore no requirement to have the consultant's name on the notes of an outpatient who is not actually been seen by the consultant.

Guidance note: Consultants do not have to consider that their total caseload is the combined caseloads of all the other team members plus their personal caseload.

Individual consultants are encouraged to discuss with their teams the best way of using their expertise and their time. If a consultant does not see a patient, but provides advice, he/she is responsible for the quality of that advice, but not responsible for the ongoing care of the patient provided by others, or for whether the advice is taken or not. The conclusion is frequently drawn,

from team right up to national level, and by users as well as professionals, that care co-ordination is not generally a good use of a consultant's time.

Guidance note: A consultant does not have any responsibility for patients referred to, assessed by, and treated by, other team members where he/she has no input.

Some teams operate multidisciplinary assessments. Where this occurs, it should be agreed between the team members concerned as to which person takes responsibility for ensuring that details of patients assessed as requiring ongoing care are fed back into the appropriate team processes for allocation. Whether or not assessments are done by one or more professionals, it should be discussed with the patient as to how to access help in a crisis whilst ongoing care is being arranged, particularly if this involves being put on a waiting list.

Following the publication of the NICE guidelines for schizophrenia, there has been some confusion as to responsibility for the checks on the physical health of outpatients. Some GPs have assumed that this will be done by the CMHT. Both current guidance, and possession of the requisite expertise and facilities, indicate that the checks themselves should be the responsibility of the GP, but communication about the findings, and the upkeep of case registers, should be seen as an opportunity to promote better shared care.

Responsibilities of the Care Co-ordinator

The care co-ordinator is responsible for co-ordinating the activities of a number of others in order to provide the best package of care for the individual patient. The care co-ordinator is entitled to assume that a fellow professional will provide care to a certain standard, provided that the fellow professional has not been asked to provide something for which he/she is not trained/qualified.

The care co-ordinator will in addition have the responsibilities of an individual practitioner.

Responsibilities of the Clinical Team Leader

Teams need to decide who their Clinical Team Leader is. This person takes responsibility for the organisation of processes within the team to ensure its smooth operation – for example, the systems around single point of access and allocation. This person needs to be a senior clinician within the team, but could come from any profession. Teams must be very clear as to who the Clinical Team Leader is, and referrers should be made aware that this is the person to contact with any queries relating to the referral process itself.

The GMC guidance sets out the responsibilities for the consultant if he/she is the clinical team leader.

New Ways of Working

The guidance above seeks to clarify roles, and thereby free up thinking about possible new ways of working in teams. Examples might include:

- Triaging of referrals by a senior clinician, especially in areas of medical staff shortages
- Multidisciplinary assessments
- The reduction or elimination of 'routine follow-ups' from consultant outpatient clinics, and the redesign of such clinic time to optimise the use of consultant skills

- Improved caseload management within teams, a ‘stepped care’ approach to the provision of secondary care, etc
- Paving the way for crisis team gatekeeping of inpatient beds as well as facilitation of early discharge

Practicalities

- This guidance needs to be shared with PCTs and local GPs.
- Teams need to be clear about who the clinical team leader is.
- Teams need to have robust processes for the allocation of work and the management of clinical risk and integrated care planning. If resources are insufficient to meet demand, this needs to be recorded, and the reasons for not providing care given. In the case of legal challenge, it is often the **processes** which get challenged, rather than the actual clinical decisions, so there need to be clear audit trails.
- Routes for the expression of concerns about team functioning by individuals need to be thought through and agreed proactively. The responsibility of maintaining a functional, as opposed to dysfunctional, team, lies with the members of that team.
- Teams should review together the best use of consultant time, in the light of this guidance.
- Teams will need to ensure that they do not use the consultant’s name as a designation for the team itself.
- Single Health Records should record the team and the care co-ordinator’s name for an episode of outpatient care, and the team and consultant name for an episode of inpatient care.
- Teams need to ensure that they are reviewing the need for patients to remain on Section 117 aftercare. There is a Section 117 policy developed for use in Bristol which could be used trustwide to support this.

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Appendix 5 (b)

North East, Yorkshire and Humber

Clinical Guidance on New Ways of Working

OUTLINE EMPLOYER'S POLICY

To Support Professional Staff in Adopting New Ways of Working in Mental Health Services

Advice to Mental Health Trust Boards produced on behalf of the North East and Yorkshire Division of the Royal College of Psychiatrists, and the North East, Yorkshire and Humber NIMHE Development Centre.

April 2005

Background

The North East, Yorkshire and Humber NIMHE Development Centre recently signed a "Concordat" for joint working on topics of mutual concern with the North East and Yorkshire Division of the Royal College of Psychiatrists. It was agreed that priority should be given to advising local trust boards on what kind of employer's policy would support their professional staff in adopting the new ways of working recommended in national guidance (Interim guidance, 2004; Final report expected June 2005). It is believed that these new ways of working can bring considerable benefits to patients, to working conditions for staff, and to the overall effectiveness and safe delivery of services.

The Division of Psychiatrists nominated the following consultants to represent it on a working group chaired by Dr Peter Kennedy:

Dr Manny McKenzie Consultant, CAMHS, Huddersfield
Dr Mark Appleton Consultant, Adult MH, Durham,
Dr Steve Barlow Consultant, Forensic, Newcastle,
Dr Andrew Talbot Consultant, Old Age, East Yorkshire.

Dr Judith Young, chief executive of South West Yorkshire MH NHS Trust, and Ms Angie Mason, on behalf of the chief executive of Humber MH Teaching NHS Trust, agreed to represent chief executives in the region on the working group.

This document endeavours to identify the main points that need to be covered in a Trust policy developed with local professionals and endorsed by their employing trust board.

A policy of this kind should state objectives and the means by which these objectives will be achieved.

The Objectives for New Ways of Working

The priority to be given to each of these objectives will vary from Trust to Trust and other objectives may need to be added that have unique local importance.

- To tailor the roles of consultants and all mental health professionals to the new values and service configurations which are described in the national service frameworks and NHS Plan, and which aim to address modern-day expectations of patients and the public.

- To eliminate overworking of consultant psychiatrists, reduce their caseloads, and allow them greater focus on more complex, and higher risk cases.
- To respond to the increasing aspirations and abilities of non-medical mental health professionals for autonomy in clinical decision-making and responsibility for patients.
- To build multi-disciplinary teams that can provide patients with the widest possible range of skills in assessment and care programme provision.
- To ensure all professionals have the continuous support from, and surveillance by, other professionals that safe practice requires.
- To eliminate current confusion over the responsibilities of consultant psychiatrists for continuity of care.
- To eliminate over-dependence on locum consultants.

The Principle Components of a Trust Policy

It is suggested that some or all of the following statements are required in a trust employment policy to support staff in transferring to new ways of working.

- Every trained professional is responsible for the quality of care that he or she provides to individual patients.
- Consultants are not responsible for the quality of care provided by another team member (except psychiatrists in training whom they are supervising).
- Consultants will not generally take direct referrals from primary care but rather will agree safe protocols within the multi-disciplinary team for the allocation of referrals.
- Patients on compulsory MHA orders will continue to require a designated responsible medical officer (RMO) – or a ‘clinical supervisor’ who need not be a doctor if the draft Mental Health Bill is passed.
- Every patient admitted to an acute in-patient ward should have a consultant responsible for his/her care along with other members of the ward multi-disciplinary team (not necessarily so for residents of other NHS facilities or day hospitals e.g. crisis, rehabilitation or continuing care beds)
- There is no requirement for a consultant’s name to be on the notes of any *out-patient* who is not actually being seen by the consultant – responsibility for patients within community teams is *distributed* not *delegated*. Trust activity will no longer be measured as ‘Finished Consultant Episodes.’
- Achievement of smaller case-loads for consultants should include reduction of fixed sessional commitments and, therefore, increased availability for *consultancy advice* (not supervision) when requested by other professionals about their patients.
- Where a consultant does not see a patient but provides advice, he/she is responsible for the quality of that advice based on the information available. He/she is not responsible for on-going care of the patient provided by others, nor for whether the advice is taken or not.
- The overall responsibility for *continuity of care* for patients no longer resides with the consultant in the more complex modern mental health service s/he cannot control. The employing trust is responsible for the systems and processes and assignment of

responsibilities that ensure continuity of care for patients with complex needs. The consultant is responsible only in so far as his or her contribution is required in management of the whole system and in contributing to individual care programmes.

- Leadership within multi-disciplinary teams will rarely be confined to a single individual but will be required from different individuals at different times according to their individual special areas of expertise.
- On matters of medical diagnosis and the prescription of physical treatments the consultant clearly has lead responsibility.
- *Risk assessment* is par excellence a multi-disciplinary responsibility for which every team member must be adequately trained: where serious risks to self or others are perceived each team member should have early access to a multi disciplinary assessment usually involving the consultant.
- Consultants and all members of the multi-disciplinary team share responsibility for sound functioning of the team, joint decision-making, and for playing their part in resolving any dysfunction within the team.
- The clinical practices of all professionals should be open to scrutiny by others in the multi-disciplinary team who are obliged to act if they have concerns.
- The trust will be responsible for defining routes for the expression of *concerns* about:
 - the performance of other professionals,
 - dysfunctional relationships within teams or between teams,
 - gaps in service,
 - anything to do with the welfare of patients.

All of the above changes are recommended by the National Steering Group on New Ways of Working which had senior representation from all disciplines involved in providing mental health services, as well as service users and carers.

A Department of Health and NIMHE sponsored final report of the steering group is due for publication in the summer 2005. Meanwhile General Medical Council Guidance is being revised to support psychiatrists in making the changes.

Seen for the first time without preparatory dialogue this document may appear highly controversial for some professionals. It in no way substitutes for locally sensitive approaches to handling major change. Appendix 9 of the "Interim Guidance on New Ways of Working for Psychiatrists" (August 2004) may be helpful in providing background reading, particularly for psychiatrists.

Appendix 6

The Ten Essential Shared Capabilities for Mental Health Practice

Working in Partnership. Developing and maintaining constructive working relationships with service users, carers, families, colleagues, lay people and wider community networks. Working positively with any tensions created by conflicts of interest or aspiration that may arise between the partners in care.

Respecting Diversity. Working in partnership with service users, carers, families and colleagues to provide care and interventions that not only make a positive difference but also do so in ways that respect and value diversity including age, race, culture, disability, gender, spirituality and sexuality.

Practising Ethically. Recognising the rights and aspirations of service users and their families, acknowledging power differentials and minimising them whenever possible. Providing treatment and care that is accountable to service users and carers within the boundaries prescribed by national (professional), legal and local codes of ethical practice.

Challenging Inequality. Addressing the causes and consequences of stigma, discrimination, social inequality and exclusion on service users, carers and mental health services. Creating, developing or maintaining valued social roles for people in the communities they come from.

Promoting Recovery. Working in partnership to provide care and treatment that enables service users and carers to tackle mental health problems with hope and optimism and to work towards a valued lifestyle within and beyond the limits of any mental health problem.

Identifying People's Needs and Strengths. Working in partnership to gather information to agree health and social care needs in the context of the preferred lifestyle and aspirations of service users their families, carers and friends.

Providing Service User Centred Care. Negotiating achievable and meaningful goals; primarily from the perspective of service users and their families. Influencing and seeking the means to achieve these goals and clarifying the responsibilities of the people who will provide any help that is needed, including systematically evaluating outcomes and achievements.

Making a Difference. Facilitating access to and delivering the best quality, evidence-based, values-based health and social care interventions to meet the needs and aspirations of service users and their families and carers.

Promoting Safety and Positive Risk Taking. Empowering the person to decide the level of risk they are prepared to take with their health and safety. This includes working with the tension between promoting safety and positive risk taking, including assessing and dealing with possible risks for service users, carers, family members, and the wider public.

Personal Development and Learning. Keeping up-to-date with changes in practice and participating in life-long learning, personal and professional development for one's self and colleagues through supervision, appraisal and reflective practice.

Appendix 7

7 Joint Guidance on Employment of Consultants

[This Guidance is being published as a separate document]



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