BDA The Association of UK Dietitians

Mental Health Specialist Group

Dietetics in Mental Health, Eating Disorders and Learning Disabilities

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Dietetic Workforce Development Programme

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Dietetic roles

Allied Health Professionals (AHP's) contribution to the mental health workforce is vital to deliver the transformation set out in Five Year Forward View for Mental Health (2016). Health Education England (HEE) recognise dietitians as part of the AHP workforce that can support this agenda (Health Education England, no date). With specialist knowledge and skills to identify and treat diet related conditions, dietitians have an integral role within mental health services. The dietetic role within mental health (MH), eating disorder (ED) and learning disability (LD) services can vary depending on dietetic need and commissioning arrangements however dietitians have a crucial role to play across services working with individuals, carers and healthcare professionals. Dietetic services within MH, ED and LD can be trust wide with dietitians working across more than specialist area. Therefore, unless explicitly stated otherwise, when referring to the 'MH dietetic workforce' or 'MH services' in this report, we are encompassing dietitians working in the fields of mental health, eating disorders, and learning disabilities.

Dietetic roles in mental health

People with severe mental illness (SMI) often experience poor physical health. Compared to the general population, they are more likely to present with chronic conditions such as Obesity, Asthma, Diabetes, COPD, Coronary Heart Disease and Stroke (National Mental Health Intelligence Network, 2018). Early mortality is well documented in people with SMI (John et al. 2018) and it is estimated that 2 in 3 deaths are related to preventable physical health conditions (Mental Health Taskforce 2018). Further, the prevalence of common mental health disorders (CMD) is increasing with 1 in 6 reporting CMD (McManus et al. 2016); a figure that has likely now risen further. People with chronic long-term conditions (LTC's) such as diabetes or cardiovascular conditions are more likely to present with CMD (Naylor et al. 2012), thus the relationship between physical and mental health is bidirectional. With diet contributing to many LTC's, dietitians have an integral role within the care of people with SMI and CMD and dietetic support should be available to people with SMI or CMD presenting with or at risk of diet related comorbidities.

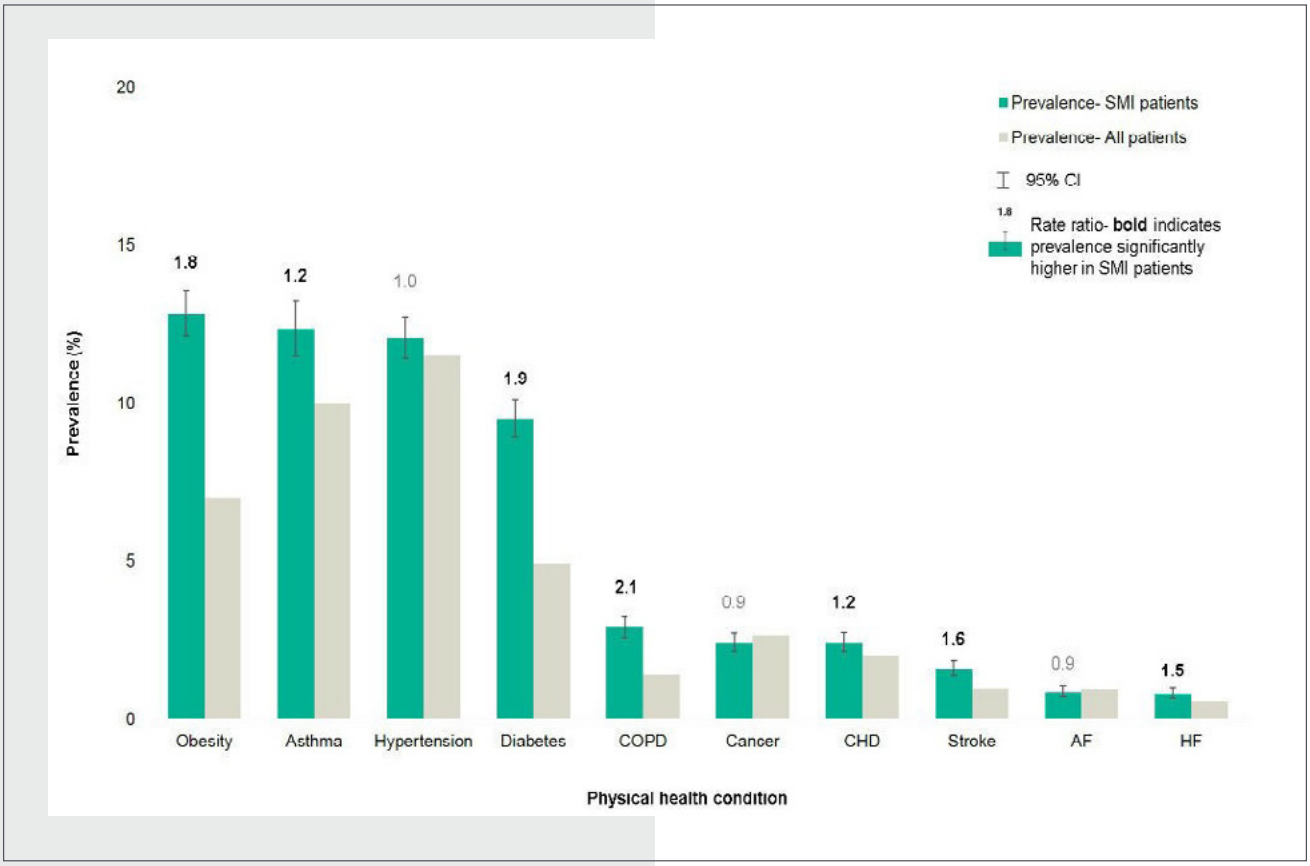

Figure 1: Prevalence of physical health conditions in SMI (Mental Health Taskforce 2018).

Dietetic roles in learning disabilities

People with LD experience significant health inequalities with males and females dying on average 22 and 26 years earlier than the general population, respectively. Dietetic need is high within an LD population with 50% suffering constipation (Robertson et al. 2017), increased risk factors and prevalence of osteopenia and osteoporosis (Srikanth et al. 2011), earlier development of Type 2 Diabetes and a twofold increase in the prevalence of Type 1 Diabetes (NHS Digital 2018). Further, greater risk of obesity is seen in some LD populations whilst those with severe and profound LD are more likely to require enteral tube feeding therefore dietitians also have a crucial role to play in managing risk of under and over nutrition as well as diet related conditions.

Dietetic roles in eating disorders

Beat (no date) estimate that 1.25 million people in the UK suffer from an eating disorder with median age of onset during transition from adolescence to early adulthood (Davies et al. 2021). Admissions to hospital for eating disorders have increased by 84% in the last five years (NHS Digital 2021). Individuals affected by eating disorders may suffer severe complex nutritional difficulties and may be more vulnerable to incorrect or unhelpful dietary messages, making dietitians key members of the multidisciplinary team. Dietitians can support the management of nutritional risk and restoration of health within specialist eating disorder services. However, many people with eating disorders suffer a significant delay in access to said specialist services, an issue that is hugely impactful for individuals, carers and families and NHS spending (Beat 2017). Due to delays in access to specialist services and presenting symptoms typically relating to food and nutrition, dietitians outside specialist eating disorder services are very likely to become involved in the care of people with eating disorders. Non-ED dietitians are often crucial members of the multi-disciplinary team (MDT) in feeding related decisions and/or onward referral to specialist services. As such, it is imperative that dietitians across the workforce understand principles of care relating to people with eating disorders.

2. Project aim and objectives

Project aim

Workforce scoping was last undertaken by the British Dietetic Association (BDA) Mental Health Specialist Group (MHSG) in 2016 (Smith and Jowett 2017), supporting dietitians to benchmark their services. However dietetic practice continues to grow and develop with more dietetic posts evolving within MH and dietitians being recognised as a key profession within the MH workforce. On behalf of the BDA's Dietetic Workforce Development Programme, a project was undertaken to scope and increase the profile of the role of dietitians in mental health services in order to demonstrate innovation and the impact of new ways of working. Included in the project and presented in this report are findings of a scoping exercise exploring current and future practice within the profession and a series of recommendations.

Project objectives

Scope

- Current roles and responsibilities of dietitians in mental health
- Future opportunities for dietitians in mental health
- Barriers and enablers for dietitians working in mental health
- Innovative practice examples in mental health
- Current BDA curriculum, preceptorship, and post registration professional development framework to identify any gaps and make recommendations to where MH can be incorporated further.

3. Scoping activity design

A two-stage workforce scoping activity was developed and undertaken between September to November 2022. This included an online survey followed by a series of roundtables.

Online scoping survey

A novel, mixed methods, online scoping survey was developed by the project consultants in consultation with the BDA MHSG committee and BDA project manager. The survey was hosted via Survey Monkey and piloted by four members of the UK MH dietetic workforce before wider distribution. Distribution was achieved via a mailer sent to all BDA MHSG members as well as distributing across BDA and MHSG social media platforms. Participants were aware that survey completion was entirely voluntary and of how their responses would be utilised within the scoping project. Personal identifiable information was not gathered for the purposes of the survey however respondents were invited to offer an email address should they wish to partake in a follow up roundtable. Quantitative survey results were analysed by project support officers using Microsoft Excel. Qualitative results generated from free text questions were analysed by the project consultant alongside roundtable information.

Roundtables

Survey results were used to inform a roundtable question guide to enable further exploration of key findings. Roundtables were hosted by Microsoft Teams and moderated by the project consultants. Project support officers acted as minute takers and recorded perspectives during the group discussions. Dietitians partaking were also invited to add key thoughts to a Padlet throughout roundtables. Roundtables did not undergo in-depth thematic analysis due to the scoping nature of the project however notes obtained from the project support officers and Padlet entries were collated and interpreted by the project consultant where commonalities within perspectives were identified. This information was triangulated with survey data including free text comments.

4. Results

150 members of the MH dietetic workforce took part in workforce scoping activity. This is a significant increase compared to previous MHSG workforce scoping in 2016 (n=82), 2015 (n=38) and 2014 (n=49). However, previously only one member from each provider was requested to complete the survey on behalf of their employer.

Demographics

Demographic information gathered within roundtables was limited to geographics as a means of establishing the extent of UK wide representation. Representation was achieved from Scotland, England and Wales. No MH dietitians from Northern Ireland took part in the roundtable series. As geographical location was not gathered within the survey, it is not known whether Northern Ireland representation was achieved here. All other demographic information presented was gathered within the survey.

Experience

Years of dietetic experience varied across the participating MH dietetic workforce (table 1). Early career dietitians (qualified <2 years) had the lowest representation, making up only 7% (n=10). This is likely reflective of fewer early career posts being available nationally. Where participants responded 'N/A' it is assumed that they are support staff.

Table 1: Years of Dietetic Experience

Years qualified as a registered dietitian	Number of participants(n)	Percentage (%)
<2 years	10	7%
2-5 years	21	15%
6-10 years	27	19%
11-20 years	45	31%
21-30 years	24	17%
>30 years	7	5%
	150	

A large proportion of the participating MH dietetic workforce were relatively new to MH (table 2) with almost three quarters (72%, n=108) joining MH within the last 10 years and only 7% (n=10) having more than 20 years' experience within MH dietetics. This suggests that many dietitians are entering the MH workforce with prior experience in other areas. Again, this is likely reflective of the job opportunities available.

Table 2: Years practicing as a Dietitian

Years working within MH dietetics	Number of participants(n)	Percentage (%)
<2 years	33	22%
2-5 years	36	24%
6-10 years	39	26%
11-20 years	32	21%
21-30 years	8	5%
>30 years	2	1%
	150	

Banding of staff

Those employed in band 6 and 7 roles continue to make up much of the MH dietetic workforce (69%, n=103) (table 3).

Since 2016, the proportion of the workforce employed at band 7 and above has increased whilst those employed at bands 3-6 has decreased. Where participants responded 'N/A' it is assumed they are employed out with an agenda for change role e.g., private sector.

Table 3: Banding of staff

Agenda for change banding	Number of participants (n)	Percentage (%)	Change from 2016 (%)
Band 2	2	1%	+1%
Band 3	0	0%	-6%
Band 4	7	5%	Static
Band 5	9	6%	+2%
Band 6	37	25%	-14%
Band 7	66	44%	+6%
Band 8a	12	8%	+4%
Band 8b	5	3%	+2%
Band 8c	1	1%	+1%
N/A	11	7%	
	150		

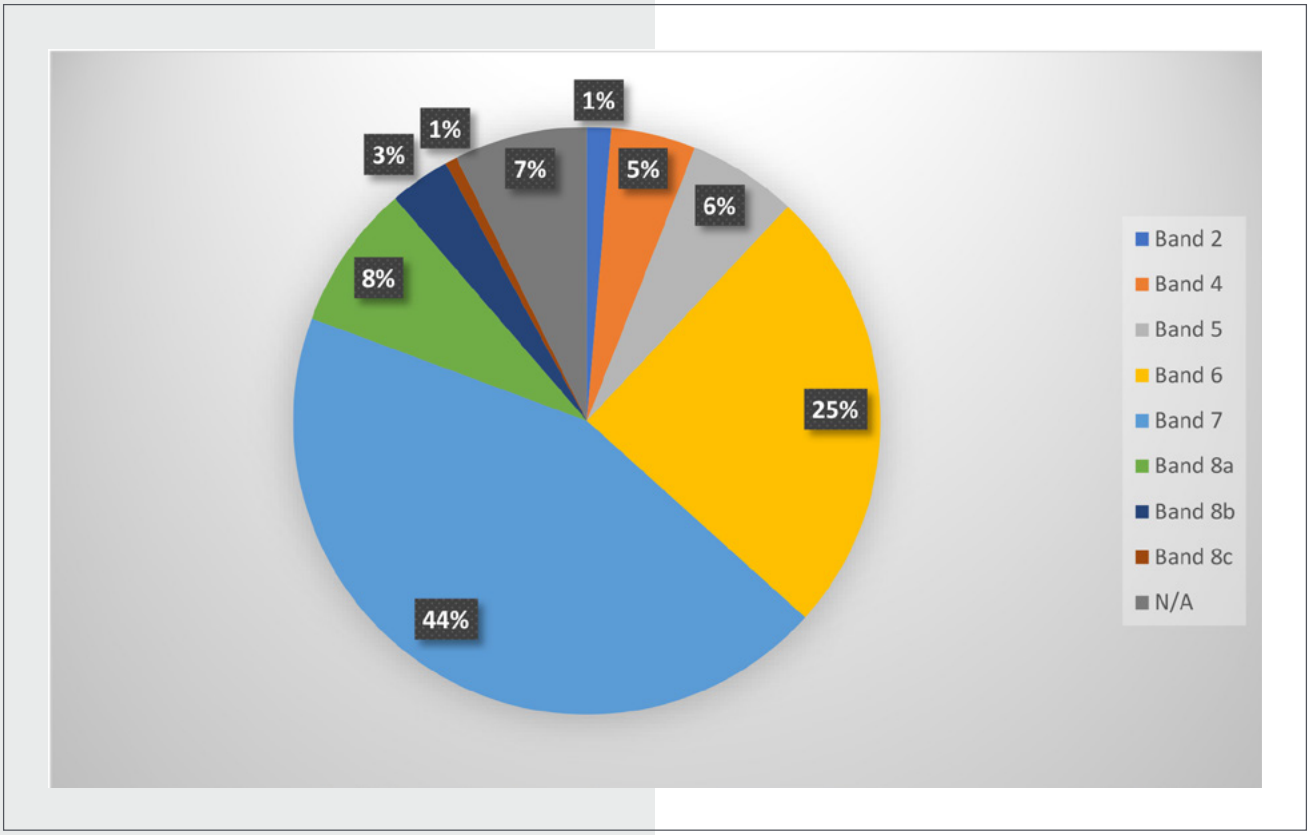

Figure 2: Percentage of MH workforce employed at AfC bands 2-8c

Areas of work

Whilst the majority (77%, n=116) of the participating MH dietetic workforce were employed within the NHS, many were employed within a freelance or private capacity and to a lesser extent, the third sector (table 4). Where respondents selected 'other', free text comments indicated they were employed within primary care.

Table 4: Areas of work

Organisation	Number of participants(n)	Percentage (%)
NHS Mental Health and Learning Disabilities Trust	34	23%
NHS Mental Health Trust	23	15%
NHS Health Board	17	11%
NHS Community and Mental Health Trust	16	11%
NHS Partnership Trust	14	9%
Freelance Dietitian	13	9%
Private Provider	11	7%
Charity	7	5%
NHS Acute Trust	7	5%
NHS Community Trust / CCG	2	1%
Other	2	1%
NHS Mental Health	2	1%
Learning Disabilities and Social Care Trust	1	<1%
Social Enterprise	1	<1%
	150	

The participating MH dietetic workforce were spread across many specialisms (table 5). Where respondents worked across more than one area, they were invited to select more than one specialism. With 320 selections and 150 participants, it appears common for the MH dietetic workforce to work across more than one specialism.

Table 5: Area of specialism

Specialist area	Number of participants(n)
Adult Mental Health	57
Adult Eating Disorders	57
Paediatric Eating Disorders	38
Older People's mental health	35
Adult Learning Disabilities	30
Child and Adolescent Mental Health Services	28
Forensic Mental Health	22
ARFID	22
Forensic Learning Disabilities	11
Manager / Professional Lead	9
Other	7
Paediatric Learning Disabilities	4
	320

Understanding of roles

Most (62%, n=91) who answered questions surrounding understanding of roles, felt their non-dietetic colleagues had a good understanding of the dietetic role within MH. One in 4 (26% n=38) disagreed or strongly disagreed and the remaining neither agreed nor disagreed.

Only 32% (n=46) of respondents felt there was a good understanding of the dietetic role within MH amongst the wider dietetic profession. Roundtable discussions further highlighted this issue whereby dietitians outside of MH were reported as often presenting apprehensive in providing dietetic care to MH patients on presentation to general hospitals or community services. Several benefits of raised role awareness amongst the wider dietetic workforce were suggested; dispelling myths and reducing healthcare stigma, raising awareness of dietetic need and management within populations, growing the MH dietetic workforce and reducing fear and uncertainty within wider dietetic workforce. Increasing awareness of the dietetic role in supporting patients with eating disorders in non-specialist settings was identified as a priority. Several awareness raising strategies were suggested including shared Practice-based Learning (placements) across MH and neighbouring trusts, holding shared study days locally and nationally, offering CPD slots to local dietetic teams, joint working with acute colleagues, increased research and evaluation output and better joint working within BDA specialist groups.

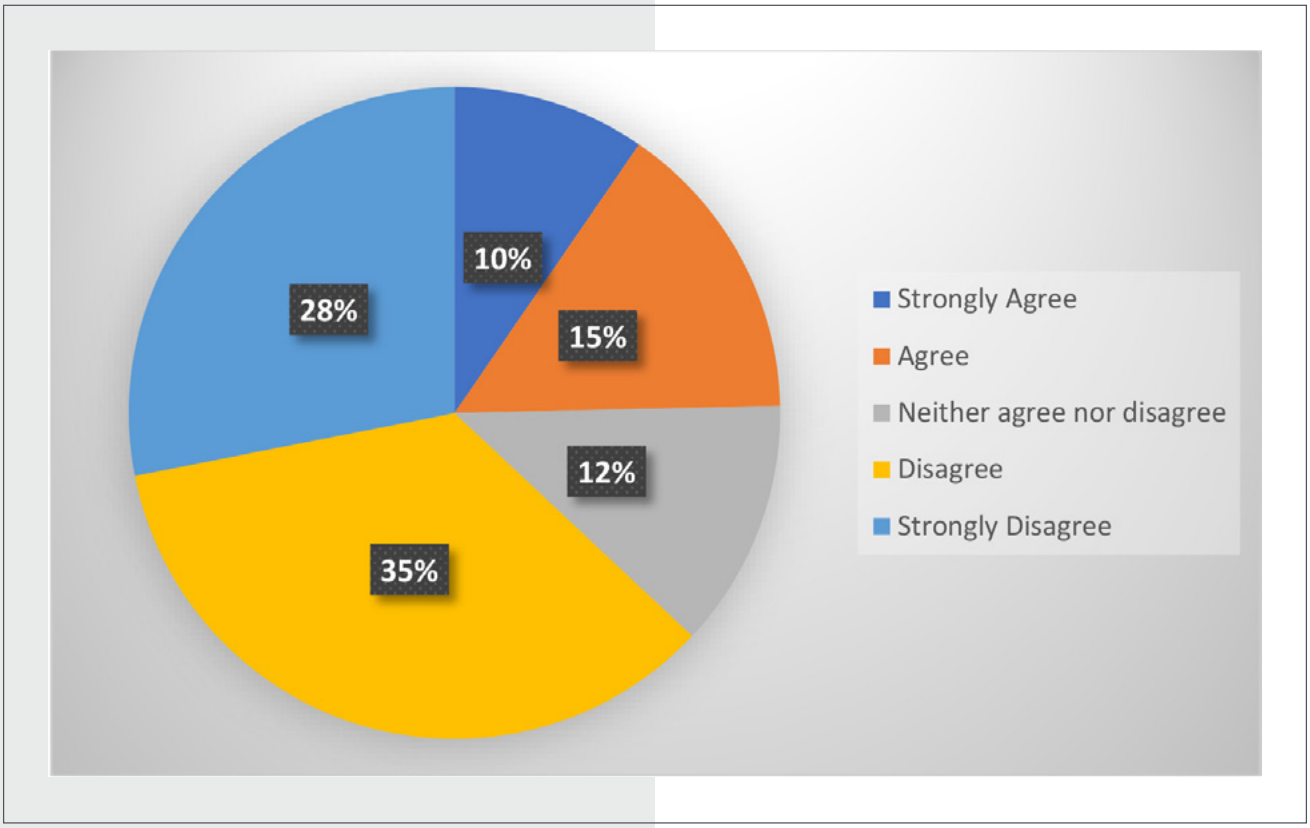

Figure 3: Percentage of workforce which felt they had a good understanding of the MH dietetic role at pre-registration level.

Workforce development and retention

Lack of role understanding, and lack of skills/previous experience were most cited barriers to entering the MH dietetic workforce within the survey. Free text comments also suggested stigma or fear towards MH served as a barrier. Some reflected upon a lack of service structure whereby all dietitians were employed at the same banding in turn leading to a lack of graduate posts and progression opportunities. This was also reflected within perceived barriers to retaining the MH dietetic workforce. Lack of progression opportunities were again observed during roundtables where it was discussed that most trusts did not recognise dietetic roles beyond band 7 and the workforce experience challenges navigating progression routes from beyond band 7.

However, when explicitly asked about opportunities for career progression, 42% of survey respondents (n=62) felt there were opportunities for progression whilst 32% (n=46) either disagreed or strongly disagreed. Free text comments surrounding barriers to retention offered further context to the idea of feeling unsupported where several reported risk of burnout due to increasing workload and clinical complexity. Some reflected upon feeling isolated, as above, in the absence of a tiered service structure with senior supervision.

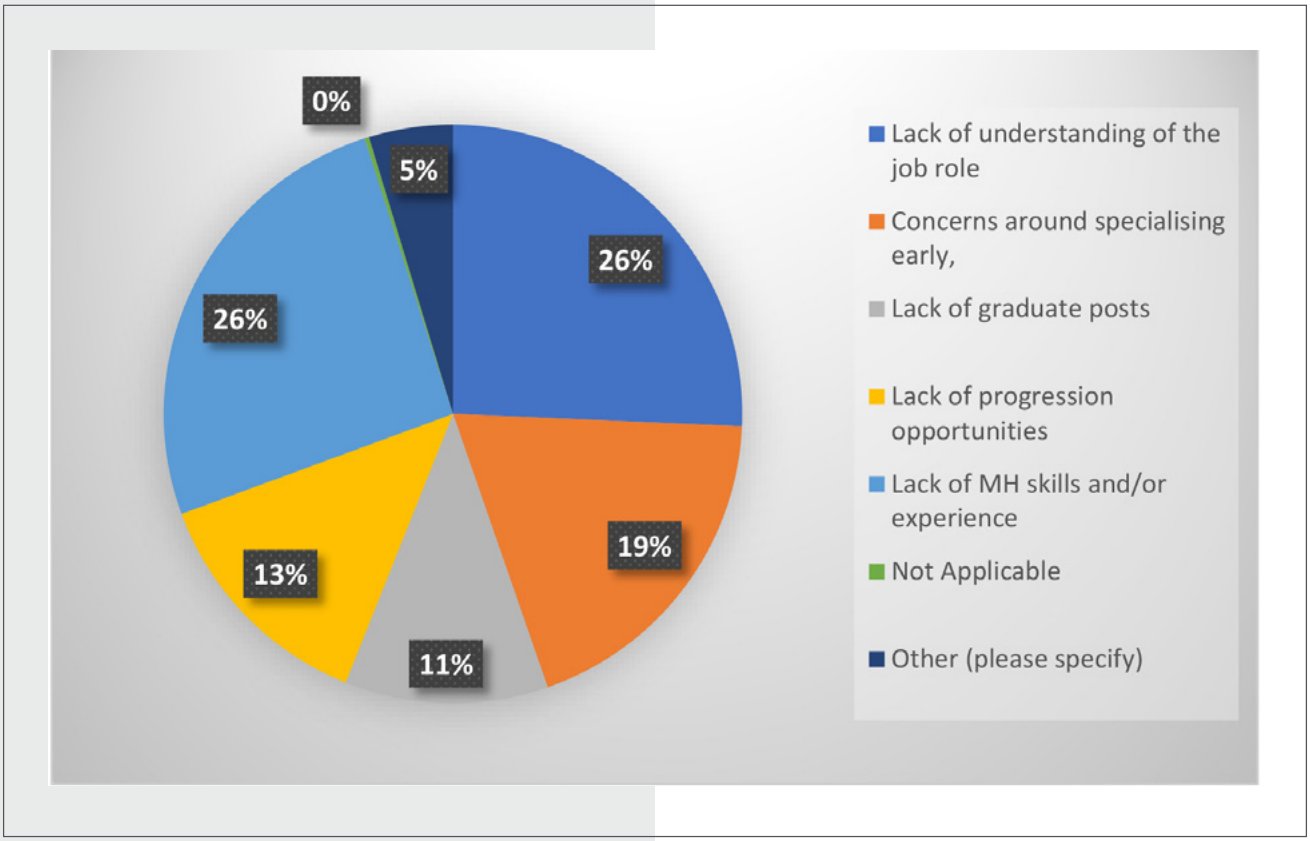

Figure 4: Perceived barriers to entering the workforce

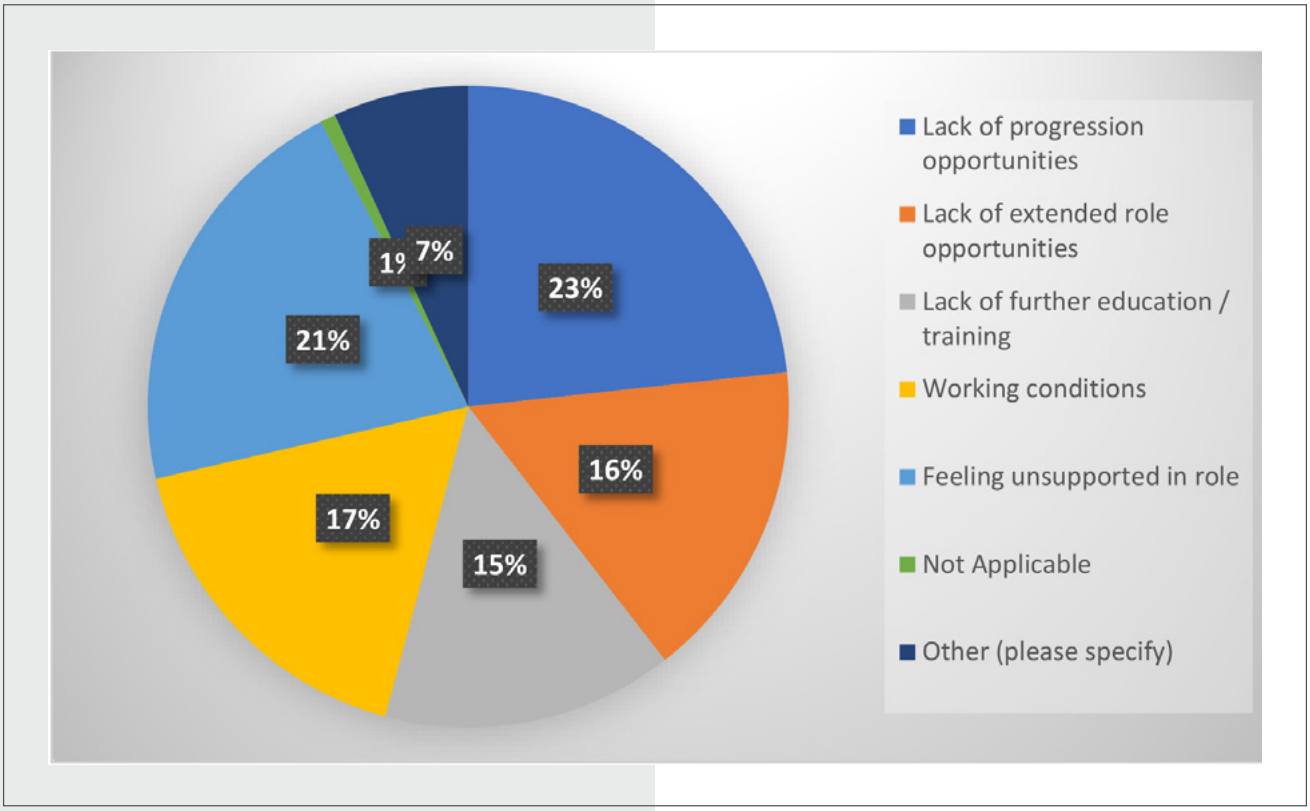

Figure 5: Perceived barriers to retaining the profession

Better access to further education and progression opportunities were identified as opportunities for enhancing retention. Survey free text comments again highlighted a sense of burnout and a need for better structured and appropriately resourced services to enable the workforce to engage in meaningful activity outside of clinical duties such as research and health promotion. Roundtable discussions suggested better use of progression posts e.g. Band 5 to 6 roles and rotational roles as opportunities to grow and retain the workforce.

5. Education

Pre and post registration education were prominent topics across a range of survey questions and roundtable discussions. Inadequate MH related pre-registration education was identified as a significant barrier to entering the dietetic workforce. Access to post registration education and development opportunities were also discussed.

Pre-registration education

Most survey respondents (61%, n=88) were unable to access sufficient MH learning at pre-registration level and only one in four (25%, n=36) felt there was a good understanding of the dietetic role within MH at pre-registration level. When asked about opportunities to raise role awareness, increasing role visibility at pre-registration level was most popular followed by increased offerings of Practice-based Learning. On exploration of learning that could be better included within the pre-reg dietetic curriculum, most people selected all four presented options as being helpful inclusions; overview of common mental health conditions and relevance to dietetic assessment and intervention (89%, n=130), overview of eating disorders and relevance to dietetic assessment and intervention (85%, n=124), overview of learning disabilities and relevance to dietetic assessment and intervention (82%, n=120) and overview of SMI and relevance to dietetic assessment and intervention (81%, n=118). Free text comments were wide ranging however several respondents felt communication skills and how/when these may be adapted in MH dietetics was a priority for pre-registration learners. Some shared this in the context of reasonable adjustments within MH whilst others noted communication skills being a key consideration of to build confidence and 'demystify' MH whereby non-specialists can often fear 'saying the wrong thing'.

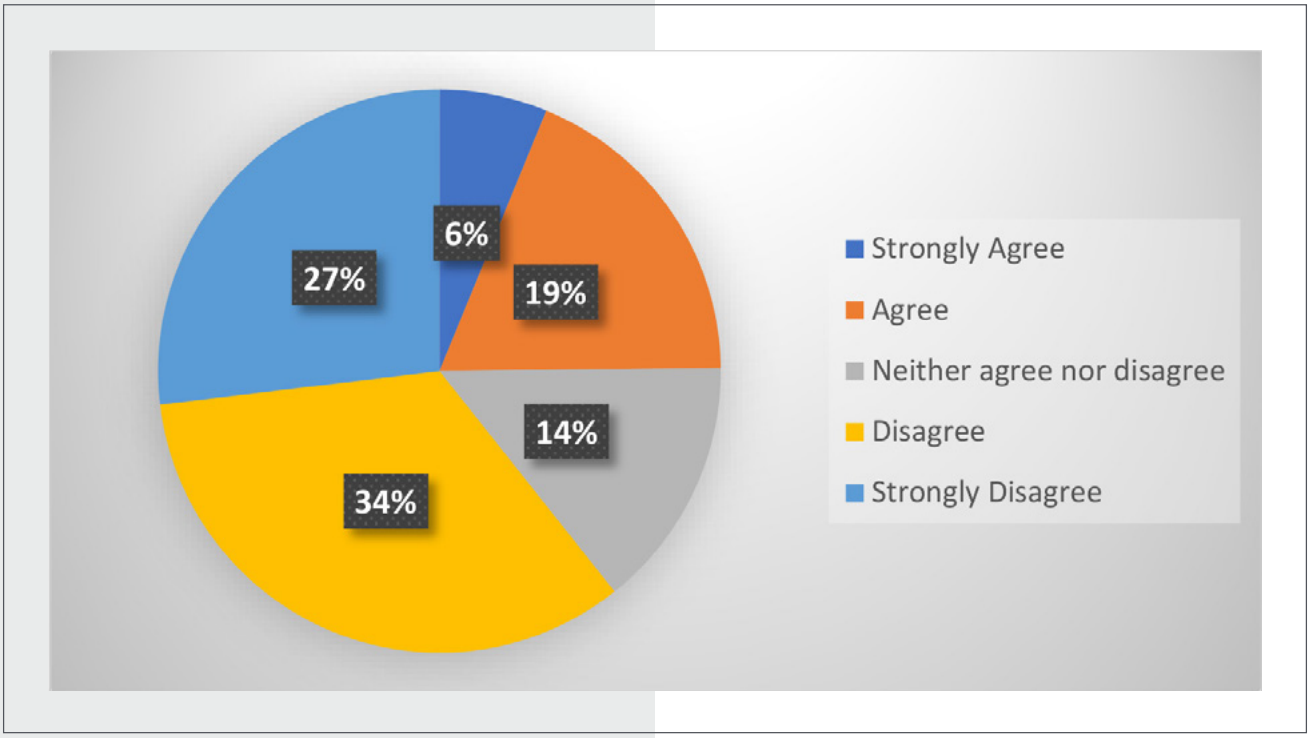

Figure 6: Respondents able to access sufficient MH learning at pre-reg level

Roundtable discussions highlighted a consistent view that more must be done on a curriculum level to address MH knowledge and awareness gaps within the dietetic profession. Whilst explicitly incorporating learning around the role of nutrition in mental health and vice versa, there was a shared understanding of the need for mental health not to be seen as a standalone specialism. Instead, the mental health of individuals and groups must be a core consideration across all dietetic interventions and this learning must begin within HEI's. Increasing practice-based learning within MH was also identified as a supportive factor with offerings varying considerably across the UK. There was a recognition of the need for MH dietetic services to be supported to offer Practice-based Learning where they have not previously hosted dietetic learners. Many shared that they would welcome guidance surrounding the practicalities of offering practice-based learning. Some were unsure whether their service would allow sufficient breadth of learning opportunities to meet practice-based learning outcomes for example where dietetics was only commissioned within one patient population such as eating disorders. Others shared examples of initially hosting A placement learners or hosting a longer placement jointly with a neighbouring acute trust. Several suggestions were made regarding resources to support MH dietetic teams to offer Practice-based Learning including learner and host guide books, tutorials, example timetables and case studies. Discussions also highlighted the need for HEI's to understand the MH Practice-based Learning offering, acknowledging that where role awareness is limited across the dietetic workforce, HEI's may not be aware of the Practice-based Learning opportunities within MH dietetics.

Pre-registration education

Half of respondents (51%, n=74) felt able to access sufficient post-registration training. A quarter (23%, n=34) either disagreed or strongly disagreed and the remaining (26%, n=38) neither agreed nor disagreed. Behaviour change (9%, n=50), MHSG annual study days (9%, n=50) and MHSG Introduction to MH, ED and LD (9%, n=49) were the most commonly attended CPD opportunities. 10% of (n=53) respondents utilised free text comments, collectively detailing a wide range of additional CPD undertaken including a range of psychological therapy courses, communication skills, MH comorbidity awareness courses and coaching and leadership.

Lack of time was identified as a barrier to undertaking CPD by 59% (n=86) of respondents, closely followed by lack of financial support (26%, n=74) and a lack of relevant courses (24%, n=69). Free text survey comments and roundtable discussions indicated that courses were often hard to find or booked up, namely the BDA Advancing ED course.

Only 40% (n=58) of survey respondents were confident that their service offered preceptorship. A lack of awareness and uptake of preceptorship was again highlighted within roundtables. Some felt that MH specific competencies would support services to embed preceptorship. Others shared examples of utilising AHP wide preceptorship. Limited uptake of the BDA preceptorship program within the MH dietetic workforce was identified.

6. Extended roles

Half of respondents (47%, n=68) either agreed or strongly agreed that there are opportunities for extended roles within MH dietetics. However, one in four (27%, n=39) neither agreed nor disagreed, possibly indicating a lack of understanding. Roundtable discussions identified several extended role opportunities for the MH dietetic workforce and a shared view that these should be encouraged. Some dietitians practising within eating disorders deliver psychological interventions such as CBT-E, Family Therapy for Anorexia Nervosa or DBT. Other members of the workforce, namely within LD, were involved in undertaking capacity assessments and informing best interest decisions though noted a lack of formal training and governance surrounding this. Extended roles within the physical health care of service users were also identified including citing NG tubes, supplementary prescribing, and advanced practitioner roles. Most roundtable discussions highlighted dietitians being well placed to bridge the gap between physical and mental health within MH services, particularly where fewer physical health trained staff were employed. Others identified MH dietitians being well placed to lead on service development but noted a knowledge gap around creating business cases. Some discussed whether a lack of knowledge, experience, or support in creating business cases maintained lack of service structure issues.

7. Supervision

Most respondents (71%, n=103) agreed or strongly agreed that they can access regular and appropriate supervision. 14% (n=20) disagreed and 4% (n=6) strongly disagreed. The remaining respondents were either unsure or neither agreed for disagreed. However, on exploration, most (74%, n=108) noted barriers to receiving supervision including a lack of suitably skilled supervisors (28%, n=65). Barriers were reinforced within free text comments where many identified having access to supervision but that it was either not facilitated by someone with MH specific skills and experience i.e. professional dietetic lead outside of MH, or, was not facilitated by a dietitian e.g. GP or Psychologist. Some respondents within the private or freelance sector shared financial cost as a barrier to supervision. Others discussed accessing peer support groups and networks as a means of supervision. Discussions surrounding the necessity of regular and appropriate supervision was present throughout all roundtable discussions whereby difficulties accessing appropriate supervision appeared more widespread than survey results suggested. A crucial need to update BDA supervision guidance in liaison with members of the MH dietetic workforce or, create bespoke supervision guidance for those practicing within MH was identified. Many felt that offering a directory of specialist dietitians who were willing to provide supervision would be helpful.

8. Resources

Sixty-one percent of survey respondents (n=89) reported that practice guidelines would support increased role confidence within the MH dietetic workforce. Respondents also identified more robust evidence (55%, n=80), better patient resources (54%, n= 79) and accredited courses (53%, n=77) as supportive factors. Roundtable discussions highlighted a need for professional and practice guidelines to recognise nuances within MH, many felt that these were often unsuitable for use within MH dietetics namely, outcome tools, model and process tools and supervision guidance. Roundtable discussions suggested job-planning and safe caseload resources would be valuable. There was a shared view that many services likely hold resources locally and a need for resource development to be better joined up across the workforce.

9. Research

Improving research and evaluation output was identified as a supportive factor in raising awareness of the value of the dietetic role within MH and improving workforce retention. Particularly in the context of increasing clinical acuity and pressures, making space for research and evaluation was seen to be important in reducing burnout and increasing job satisfaction. Survey respondents utilised free text comments to identify increasing Clinical Academic roles as a means of strengthening research within MH dietetics. Another shared dietetic learner dissertations / major projects as an opportunity to increase research and evaluation output.

10. Discussion

Opportunities exist for dietitians across a range of MH services with many working across more than one specialist area and a significant proportion within freelance or private practice. Extended roles in dietetics can provide positive outcomes for a range of stakeholders and require advocacy and support (Ryan, Pelly and Purcell 2016). Mostly practicing at specialist and advanced level and with knowledge and skills in both physical and mental health, the MH dietetic workforce are well placed to take on extended roles. Whilst literature predominantly exists within Australia and the USA, a systematic review identified the dietetic role within eating disorders to include assessment, treatment, management of nutritional requirements, working collaboratively within an MDT and providing education on a range of topics; nutrition, weight changes, body image, metabolism, normalising eating, challenging misinformation, coping strategies and anxiety management (Heafala et al. 2021). Workforce scoping identified that much of the MH workforce practicing within ED undertake additional training to support a psychological therapy informed dietetic approach. Workforce scoping also identified that the MH dietetic workforce practicing within LD are well placed to complete capacity assessments. However, consistent with literature (McCormick, Bose and Marinis, 2017; Jayes et al., 2020), confidence and role clarity varies. That said, the revised HCPC Standards of Proficiency which come into effect on 1 September 2023, put greater importance on capacity in care delivery across the AHP professions. Further, scoping identified that the MH dietetic workforce are well placed to lead upon physical health components of patient care within MH. With early mortality in SMI often being related to physical health conditions (Mental Health Taskforce 2018) of which many are nutrition and/or weight related, embedding dietetic input within MH services offers an opportunity to reduce health inequalities in MH.

Despite expansive dietetic opportunities within MH, scoping activities suggested role understanding is poor within the wider dietetic workforce. Several benefits in increasing role visibility were suggested. These related to improving patient care and experience when accessing non-MH services, improved dietetic knowledge and confidence and an opportunity to increase dietetic recruitment within MH. Recommendations to increase role visibility within the wider dietetic workforce include MHSG to consider opportunities for shared workstreams with other specialist groups e.g. social media campaigns and CPD events, MH and acute dietetic services are encouraged to work together e.g. via establishing pathways of care for patients accessing MH and acute services. Examples of joint working should be shared as examples of good practice. Dietitians are also encouraged to establish local shared CPD and learning opportunities.

Scoping activity identified that poor role awareness and insufficient MH learning at pre-registration level is common and thought to serve as a barrier to entering the MH dietetic workforce. MH must therefore be better embedded within the dietetic curriculum. This can include communication considerations and reasonable adjustments as well as the bidirectional relationship between nutrition and MH. HEI's should be encouraged to embed MH considerations throughout learning as opposed to only offering as standalone learning. For example, embedding MH considerations within learning related to long term conditions where MH comorbidities are common. MH dietetic departments can also be encouraged to facilitate Practice-based Learning as a means of increasing role visibility and MH knowledge at a pre-registration level. Further, Practice-based Learning has been identified as a strategy for increasing recruitment to specialist areas (Verma et al. 2016) therefore we can expect increased dietetic Practice-based Learning within MH to support workforce growth. Best practice examples of Practice-based Learning within MH should be captured and shared to support MH dietetic services to offer Practice-based Learning.

Whilst a significant portion of the MH dietetic workforce has over 10 years of dietetic experience, only 1 in 4 have spent over 10 years in mental health. Further, with the MH dietetic workforce predominantly practicing at specialist (AfC band 6) or advanced (AfC band 7) level, this indicates that many dietitians come enter specialist or advanced MH roles with experience in other specialties but may not have significant experience in MH. It is therefore imperative that adequate support, supervision, and professional development opportunities are available. Workforce scoping identified time, financial support and uncertainly regarding relevant courses as barriers to accessing CPD. A small proportion of survey respondents who detailed CPD undertaken however demonstrated a wealth of meaningful learning options. As such, it is recommended for MHSG to signpost members to quality assured external learning opportunities. Many respondents engaged with BDA CED courses however some reported difficulties accessing due to courses being booked up, namely Advancing Dietetics in Eating Disorders. A further recommendation is therefore for BDA to review MH

CED course provision, expanding to meet the increased demand. Several respondents noted a lack of further education opportunities for dietitians in MH. In order to support the development of a highly skilled workforce, it is recommended that BDA explore accreditation of CED courses e.g. scope opportunities for development of a BDA post graduate certificate in MH, ED or LD dietetics. Further, in recognition of aforementioned challenges, opportunities for informal, free or low-cost peer CPD and learning should be encouraged and maximised with MHSG e.g., case discussions, journal clubs etc.

A prominent discussion across the survey and roundtables was a lack of service structure leading to the workforce feeling unsupported and contributing to supervision issues. Lack of service structure was felt to serve as a barrier to both recruitment and retention. With a lack of AfC band 5 roles, early career dietitians face an immediate barrier to entering the MH dietetic workforce. Further, with dietetic apprenticeships offering an exciting opportunity for trusts to grow their workforce, a lack of support worker and AfC band 5 roles could inhibit this within MH dietetic services. Representation from those employed across band 7, 8a, 8b and 8c all increased since workforce scoping was previously carried out in 2016. Positively, this suggests increased availability of senior roles for MH dietitians. However, many respondents felt unsure regarding progression opportunities and that their trust did not recognise the dietetic role beyond band 7. To promote the dietetic role within MH, a series of 'career case studies' is recommended showcasing dietetic practice from entry to consultant level. Further, support should be offered for dietetic leads to create business cases to support the growth of a structured dietetic service. Limited preceptorship knowledge and uptake could be reflective of limited entry level posts within MH however if services are to grow and more entry level posts be established, services are advised to adopt preceptorship. This is particularly prudent due to limited MH learning within pre-registration practice-based and classroom learning.

Clinical supervision is essential for lifelong learning and safe practice across all of healthcare. However, MH clinicians are often involved in complex decisions bound by ethical and legal standards and are at an increased risk of burnout due to the emotionally taxing nature of their practice. The MH workforce also experiences unique challenges if employed within a poorly structured service or as a lone MH practitioner. Where service structure does not enable the provision of in-house safe and effective clinical supervision, dietitians must be supported to access externally however this does not always happen.

It is recommended that the BDA supervision document be updated in conjunction with MHSG to address supervision issues.

11. Recommendations

- MHSG to signpost members to quality assured external learning opportunities
- BDA to review CED course provision, expanding offering where courses are often full
- BDA to scope opportunities to develop a post graduate certificate in MH, ED or LD Dietetics
- MHSG to scope opportunities for informal free or low-cost peer support and CPD
- Opportunities to better embed MH within the dietetic pre-registration curriculum to be shared with BDA and MHSG to be consulted at next curriculum review
- Resources to support MH dietetic departments to offer Practice-based Learning are recommended including best practice examples and a dietetic PBL in MH guide
- Development and promotion of 'career case studies' showcasing the MH dietetic role from entry level to consultant
- Production of an educational resource supporting members of the MH dietetic workforce to create business cases to grow and develop their service
- Update of BDA supervision document in conjunction with MHSG
- MHSG to scope opportunities for shared workstreams with other specialist groups e.g. social media campaigns and CPD events
- MH and acute dietetic services are encouraged to establish local pathways of care for patients accessing MH and acute services.
- MH and acute dietetic services are encouraged to establish local shared learning opportunities such as CPD sessions
- Examples of joint working across MH and acute dietetic services should be shared as examples of good practice.
- MH dietetic services are encouraged to adopt a preceptorship programme for dietitians new to MH
- Preceptorship education should be made available to MH dietetic services

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