

A social work career in mental health

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Abstract: This piece is intended to show how with a commitment to continuous professional development, changing trends and practices in a profession can be reflected in the work of an individual practitioner, and in turn the study of individual careers can provide a wider understanding of the way change has been interpreted and implemented. A single career will see many structural changes of direction and emphasis, and if a practitioner is staying abreast of the twists and turns in policy, these should be reflected in their practice. This can become even more apparent when an individual, with promotion, moves through positions with differing levels of responsibility, and therefore engages with policy change from different perspectives. The article highlights a number of good practices encountered in promoting better services for mental health service users, and how an individual can be an agent for improving the implementation of policy.

Keywords: autoethnography; social work; Southwark; the Maudsley; mental health

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My journey to becoming a social worker

It had always been my intention to write an account of a life in social work, but with a particular emphasis on how changing trends and practices in the profession are reflected in the work of an individual. However, on retirement I acquired a new set of commitments, and put this idea aside, but an invitation from *Social Work & Social Sciences Review* to write about my years of working in Mental Health at the Maudsley has provided the prompt I needed.

Although the focus of this piece will be on mental health, it is important to provide some context as to how I reached a starting point at the Maudsley. Growing up considerable inspiration was provided by my godmother, who had been left wheelchair bound after contracting polio in 1946. She went on to become a senior social worker at Guys Hospital. I also grew up with a grandmother, who had developed lifelong mental health problems after contracting tuberculosis and spending a year in isolation.

On leaving school and during a gap year I volunteered at an inspirational Cheshire Home in Hampshire, called Le Court, which looked after people with a range of disabilities. This gave me my first experience of the invaluable additional value that volunteers can provide to social care services. Le Court had a register of 800 active volunteers. A significant number of the residents were enabled to run their own businesses there, and it was a valuable early lesson in a strengths-based approach, which positively connoted the abilities present, whatever someone's disability (Hunt, 1966; Crawford, 2020).

Some experience of 'volunteering' was pretty much a pre-requisite for entry onto a social work course in the 1970s, and at University I took advantage of two other social care opportunities. One was to spend two years 'prison visiting' at Leyhill Open Prison, which provided some familiarity with those going through the criminal justice system, and also heightened my awareness of the need for effective aftercare, to prevent re-admission. I also took part in a detailed survey organised by the Disabled Income Group, to assess the availability of disability access to public buildings in Bristol, which it has to be said, ahead of the Disability Discrimination Act decades later, was extremely poor. Something my godmother was only too aware of.

After University I was lucky to obtain one of six trainee posts at the London Borough of Lewisham. At this time Social Services were going through a huge upheaval as a result of the Seebohm Report, which already had many detractors (Donnison, 1969). The main implication for us was that the previous specialisms of mental health, old age and children's services had been deconstructed, and a generic service was created, meaning that social workers were expected to work with the whole range of social service clients. This system only had a brief 'shelf life', but for those of us who lived through it, it did provide a very broad-based experience. I had the opportunity to attend court for care proceedings, to process an adoption,

undertake an assessment for a visually impaired man, do a Part III application for care in a home for the elderly, and assess someone for admission to a psychiatric hospital, among other things. In years to come social workers were expected to specialise early with specific client groups and this sort of wider experience simply was not available. The other advantage of a trainee post was a guarantee to fund an early opportunity to undertake professional social work training.

I attended the excellent two-year course at Exeter University, led by Jean Packman and Bill Jordan, both of whom were extremely influential in the development of child-care practice and policy (Packman, 1968; Jordan, 1974). The two-year course provided for four placements. Mine included a summer spent in Birmingham at Rubery Psychiatric Hospital on the John Conolly Unit, a ward based on therapeutic community lines. This provided experience of a Gestalt based approach, which provided me with a lifelong nudge to understand that the wholeness of anything is so much more than a sum of individual parts. This was crucial in later work I undertook with colleagues using network theory, where against the prevailing therapeutic practice of working mainly with individuals, we looked to have case conferences and planning meetings with a wider network of individuals, who could support the client. In recent years this has been 'rediscovered' in relation to mental health clients in the Open Dialogue (OD) system developed in Scandinavia (Twamley et al, 2020). Much historic work with psychiatric patients was based almost exclusively around one-to-one interventions, and on the course, we were also encouraged to start learning about working in a psycho-therapeutic way with individuals and families. On placement this involved 'process recording' interviews and analysing the dynamics within whatever family and community systems we were working with. All this was to prove invaluable in years to come.

Two seminal moments in my training were provided by the reading material which was recommended. The first was the Maria Colwell report about the death of a seven-year-old girl in Brighton after being severely beaten by her step-father (Department of Health and Social Security, 1974). I recall the shock of reading the report and my incomprehension at the failure of services generally to respond to the concerns of neighbours. The other was a book, '*Sans Everything: a case to answer,*' about appalling failures in the care of elders in the hospital and care system (Robb, 1967). These were of course the forerunner for many reports of failures in care, but the lessons were irreducibly the same; failures of communication, inadequate investigation of concerns, failure to protect the vulnerable and the inadequacy of inspection systems. They were a huge wake up call.

On my return to Lewisham in 1977, I spent three years working mainly with children and families, although my workload was generic. Valuable experience linked to future work in mental health services, included two years of supervised work in IT. Not Information Technology, but Intermediate Treatment. Together with three other colleagues we ran a group for children who had been in trouble with the law and were on community-based Supervision Orders. The supervision

of this work focused on identifying and understanding the dynamics of the group, but also identifying the systemic drivers to offending. Another opportunity was to become 'warranted' under the old 1959 Mental Health Act, and to undertake one or two assessments for involuntary admission.

In 1980, I took a sideways move which added a different tranche of experience, giving me a longitudinal perspective on the past development of mental health services which was invaluable. I was offered funding to undertake a three-year PhD study of the Lunacy Commission, a forerunner of all our mental health inspection systems since. This additionally provided a number of publishing opportunities and was the start of an academic career which ran alongside my work at the Maudsley and Institute of Psychiatry (Hervey, 1986a, 1986b; Scull et al, 1996).

The Maudsley: The first ten years

In 1984 I was offered a post working across the Villa, an acute admission locked ward and Ward 5, a recovery ward. I well remember how scared I was approaching the hospital, knowing the considerable reputation it had locally. Once I had accepted the post, the outgoing social worker offered to show me around the locked ward before I started. It provided a lesson I have never forgotten. I was shocked by the number of doors being locked and unlocked, and yet within a few short weeks I was moving around quite unconcerned, with my own bunch of keys. I would often tell staff to remember how patients and relatives must feel coming for the first time to a locked environment. This 'loss of sight' is I believe quite common. As the phrase goes, *'Be careful what you get used to.'* A similar experience sometime later reminded me forcibly of this. I introduced a social worker to the Eating Disorders Unit, where I had worked for some years, to see if she would be interested to work there (she did in fact stay many years) and when I asked her thoughts after the visit, she just kept saying how ill all the women looked. Her shock at their emaciation. I had stopped being shocked some years before, but it was a timely reminder.

Michael Shepherd, the consultant I worked with on this first job, was an internationally renowned psychiatrist, who had held the first chair of epidemiological psychiatry in the world. Like me he had a serious interest in the history of psychiatry (Shepherd, 1985; Bynum et al, 1985). As a result, we got on well, and I was never exposed to the regular, and not so pleasant, 'grillings' he dished out to junior doctors. He provided me with an opportunity to publish in a three-volume history of psychiatry and also to do reviews in the journal of Psychological Medicine. This post also provided the opportunity to work with the well-known psychologists, Liz Kuipers and Til Wykes who both developed pioneering psychological approaches to work with psychotic patients on our wards, who were experiencing 'voices' (Wykes, 2004). Later I was also to work with Liz on

an Institute of Psychiatry Carers website, which provided information and support to carers, including posting answers to their online queries.

At this time, the Department of Social Work, which I was later to head, was still hanging on to its 'almoner' past, its separateness from the London Borough of Southwark, which had been its employer since 1974, and its past status within the hospital. We were still expected to undertake training, either in individual psychotherapy or family therapy as part of our progression, and also to take students. The Department had a long-standing link with the London School of Economics, and I took on a number of students. I found Janet Mattinson's book, *The Reflection Process in Casework Supervision*, absolutely invaluable for this work (Mattinson, 1975). It came out of the Institute of Marital Studies and encouraged supervisors to analyse the initial transference process between client and worker, and then the subsequent transference between the worker and their supervisor. It was surprising how often feelings passed from a patient to a student, were subsequently acted out in the student's interaction with their supervisor. The Department had a support group for supervisors, which provided a safe space to really analyse any supervision work we were undertaking. In all respects the Social Work Department at the Maudsley was an ideal place to marry up learning from my training at Exeter, do further reading on the job, and absorb the insights provided by my own supervisor. This was a process enshrined in the British Association of Social Work's recommendations for best practice.

In 1988, I became a team manager, with responsibility for a team of seven staff, but also acquired clinical responsibility as social worker for the Eating Disorders Unit. By this time, I had experience of well over 150 assessments for compulsory admission, and the management of numerous discharge arrangements to the local community, gaining knowledge of the whole range of community support available. One of the main critiques of social work in recent years, is how often social workers leap into management posts, as the route to an improved salary, but with limited experience to draw on. This post was in effect an early example of the 'nurse consultant' or 'senior practitioner' role, that has been developed in recent years, allowing me to supervise less experienced colleagues, whilst continuing to develop my own practice. Within the Eating Disorders service, I worked initially with Professor Gerard Russell. He published one of the first descriptions of Bulimia Nervosa, and after whom Russell's sign was named (the calluses on the knuckles or back of the hand which indicate repeated self-induced vomiting). Later I worked with Professor Janet Treasure, who has contributed an immeasurable amount to the development of family friendly eating disorder services and voluntary organisations, such as BEAT (Treasure and Russell, 2011).

Two years later the National Health Service and Community Care Act introduced a requirement for social workers to develop packages of care in the community, whilst means testing and controlling access to the limited available resources. This Act followed on from the Griffiths Report (Griffiths, 1988) and the White

Paper 'Caring for People – Community Care in the next Decade and Beyond,' both of which had been debated at length in the department (Department of Health, 1989). This was a considerable change for our staff, although they had always been integral to the planning of patients' aftercare arrangements. It meant a much closer alignment with the Local Authority's aims and was a major change for the Borough, as Social Services now had to split its purchaser and provider functions.

As a worker on the Eating Disorders Unit, I was privileged up to that point to have been involved in the development of therapeutic interventions for patients. These included being included in a research trial in which we were trained to deliver Cognitive Analytic Therapy (Ryle, 1990), a detailed psychotherapeutic intervention and also an information-based package of support, the two being compared in a randomised controlled clinical trial. I was also routinely involved in the delivery of family therapy interventions to the families of all the eating disorder in-patients. This more therapeutic work did survive for many years after I left, but now had to be married with the additional responsibility for designing packages of care and means testing access to community services.

The advent of these changes also provided further linked academic opportunities. One was to co-author a book with three colleagues at the Maudsley, *Collaborative Community Mental Health Care*, which analysed various aspects of the on-going implementation of the Community Care Act (Watkins et al., 1996). This involved writing the introduction, and working closely with four authors, who in their different ways contributed a huge amount to mental health social work. Rob Brown, who ran high quality Approved Social Work (ASW) training courses for many years, wrote on the development of the voluntary sector to meet community care needs. Phil Fennell from the University of Wales wrote on the use of compulsion in the community. Michael Sheppard, from Plymouth University, described the influence of the Act in Primary Care. Shulamit Ramon, who ran the social work course at the LSE, contributed an evaluation of its overall impact.

I was also invited in the mid-1990s to join the Board of the Master's Course in Mental Health Social Work with Children and Adults in the Institute of Psychiatry (IOP), run by Alan Rushton, who had produced pioneering research on adoption and fostering. This involved interviewing students, marking coursework, and lecturing to participants. The course was pretty much unique at the time in expecting social work students to undertake quantitative research. We also ran social work conferences and pioneered e-learning research courses. It was through Alan that I inherited his role as a reviewer of psychiatric journals for the British Journal of Social Work (Hervey, 1993-1998).

I could not be more grateful for the opportunities provided by the Maudsley and Institute of Psychiatry (IOP), now called the Institute of Psychiatry, Psychology and Neuroscience, to have a career which perfectly integrated practice, research, teaching, and further learning. It was also in the late 1990s that I was encouraged to become involved in developing new services in the community, starting with

a walk-in mental health community centre. This was the beginning of a major interest in developing user and carer led services, which I had first become aware of at Le Court and was a role which I was later to expand when I became Head of Southwark's Mental Health service.

In 1992, I was appointed manager of the social work service across the Bethlem and Maudsley Hospitals, allowing me to extend my knowledge of the full range of wards and clinics run by the Trust. This was invaluable later when I returned as Head of Southwark's integrated service. The IOP continued to extend academic opportunities including reviewing for Michael Shepherd's, *Psychological Medicine*, and I was lucky to be asked to review an early paper by Simon Wessely, 'Old wine in new Bottles,' examining the links between the early twentieth century diagnosis of neurasthenia (often implicated in shellshock) and the modern diagnosis of chronic fatigue or myalgic encephalomyelitis (ME). Simon has gone on to become the world's leading authority on 'battle fatigue' and was one of a number of junior doctors I worked with, who were later to become leading figures in the profession. Another whose interests closely reflected my own in community care, was Graham Thornicroft. At this time there were many who felt community care was unwise, but Graham did some pioneering work following up patients discharged from Friern Barnet and Claybury hospitals, and later on researched the newer crisis resolution and home treatment teams and was to publish memorably on another of my interests, the discrimination suffered by so many people who have mental health issues (Thornicroft, 2006). Some years later he also very kindly agreed to be interviewed by my son for an undergraduate project on stigma.

North Southwark

In 1994, I became Principal Care Manager for North Southwark based at Guys, with a brief to move the mental health social work staff out of the hospital into the community. I was offered a building near Surrey Quays and spent a year working with a group of inspirational service users, including Pete O'Shaughnessy, who was well known locally as one of the founders of Mad Pride. Over time work with Pete, and other local service users, introduced me to some key figures in the mental health user or survivor movement, including Jan Wallcraft, Diana Rose and Peter Beresford (Wallcraft, 2009; Rose, 2017). The ground floor of the building became a user-led day centre, and the social work team moved in upstairs.

In the late 1990s I was then tasked with a health colleague and a worker from the Sainsbury's Mental Health Foundation, to develop a model for Integrated Community Mental Health Teams (CMHTs). Senior Management asked me to present the research base for the effectiveness of CMHTs. It was decidedly thin, but they had already decided that CMHTs were the way forward. Having integrated

our services, I then managed one of the two new CMHTs in North Southwark until 2000. One major issue was still the lack of community-based replacement services for the old asylum system. Many of the frameworks proposed, such as the Italian model from Trieste, had had particular funding initiatives that would not necessarily be available to a wider roll-out in the UK (Mezzina, 2014; Sashidharan, 2021). Despite all this the CMHTs worked well, and although all staff were expected to take part in the care management of patients, there were still individual roles for social workers and nurses. Mental Health Act assessments for the former and phlebotomy clinics for patients on Clozapine for the latter, spring to mind.

In my last two posts I became further immersed in developing community resources. From 2000-2002 I was Southwark's Head of Mental Health Partnership, Planning and Integration. This meant being Commissioner for the Borough's twenty-four contracted mental health services (including the Government's Homeless Mentally Ill initiative), sitting on the Joint Mental Health Partnership Board, and completing the integration process in South Southwark, in conjunction with managers based at the Maudsley. I was also responsible for co-ordinating the Social Services Inspectorate inspections of our Approved Social Worker arrangements, and for the commissioning of new services. The latter involved, amongst other things, chairing a working group to develop two forensic aftercare hostels driven by the Reed Report produced in 1992 (Chiswick, 1992). I remember at the time being concerned at a push by forensic psychiatrists to develop ever larger medium secure units, but with little or no concomitant planning for effective discharge facilities. It was a 'red letter day' when we were able to push through planning permission, and open two new hostels to start the process of moving patients out of the local medium secure provision.

The Maudsley: The last ten years

In 2002, I returned to the Maudsley in a joint appointment as Head of Mental Health for Southwark and a member of the senior management team at the South London and Maudsley NHS Foundation Trust (SLaM). My main line manager on a day-to-day basis was Isobel Morris, a psychologist who had been instrumental in developing community resources to assist in closing down two major former county asylums. These were the psychiatric hospitals Cane Hill and Bexley, both of which I had worked with in the 1970s. We were both committed to integrated services, and she gave me many opportunities to grow into the new role. My early experience was that the majority of the excellent managers I worked with were very hospital oriented and focused on nursing care and hospital therapeutics and knew much less of the workings of the local community or Local Authority. I well remember being asked by Isobel to give a presentation to this group about the implications

of the Local Government Act (2000), and their disbelief that one of the powers of Overview and Scrutiny Committees, was to require the attendance of senior NHS officers to account for services being delivered or developed in the area under their responsibility, to promote economic, social and environmental well-being.

Over time many of these managers became good friends and grew to become much better linked with the local community. Access to senior management in the Trust brought with it a lot of interesting opportunities. At different times I was given lead responsibility for the implementation of children's safeguarding, which I then passed on to a health colleague who did a superb job embedding safer practice in the Trust for adult safeguarding. This involved sitting on the Safeguarding Partnership Board as a representative for the integrated mental health service, and for leading the Capital Volunteers programme with a £450K budget. The latter involved enhancing social capital locally by embedding volunteers in a range of community mental health projects.

The Maudsley's USP (Unique Selling Point) as far as I was concerned, was its link to any and all new developments in mental health. It was not always comfortable to be in an institution which expected to be at the cutting edge, and it sometimes felt like visiting inspectorates held us to a higher standard, but to me that was always a positive. From 2003 through 2007, I was involved in discussions and recommendations to the Government's planning team for the 2005 Mental Capacity Act and the 2007 Mental Health Act. This was an exciting period because Tony Blair's government had provided a ten-year funding programme for a range of new services including Improving Access to Psychological Therapy Services (IAPT), and early intervention and crisis teams. I was involved with health colleagues in setting those up, most of which had social work staff embedded in them.

Of all the management leads I was given, the one which I became known for, was as 'champion for user and carer involvement.' The Government White Paper, '*Shifting the Balance of Power*' (Department of Health, 2001), had begun to promote the idea of Patient and Public Involvement and I was asked to implement this. Over time we began to embed service users in all aspects of service provision and my fellow health managers started to accept the real benefits of involving users and carers in the planning and development of services (Hervey, 2004; Hervey and Ramsay, 2012). I also helped 'capacity-build' three extraordinary user-led groups in Southwark. Creative Routes, Cool Tan Arts and Mental Fight Club. I have written elsewhere of these, but the platform of support I got within the Trust, including some funding initiatives from the Maudsley Charity, helped these groups blossom. Creative Routes appeared on television with Jo Brand, who I had worked with for several years in the Emergency Clinic at the Maudsley, and developed an extremely successful street festival in Camberwell, called *Bonkersfest*, which attracted 6,000 people at its height. Cool Tan Arts through its patron, the artist Maggie Hambling, established a very successful gallery where service users could produce and sell art. Mental Fight Club, who were named after a poem by their patron, the novelist, Ben Okri, produced a

highly original series of one-off events to engender support for people living with mental health issues, and then established the hugely successful Dragon Café, in the Crypt of St George the Martyr in Borough High Street. This continues to provide a non-judgmental space for service users to perform, make art and seek healing.

My involvement in this work as a social care lead in the Trust, led to an invitation in 2007 to become the social care lead for the South London and South-East Hub of the Mental Health Research Network. The Hubs existed to support large scale national mental health studies, and this involved working with the wonderful Lambeth based psychiatrist, Professor Tom Craig. My role was to go out to teams and services who would be willing to identify potential participants for the research studies (most of which were randomised controlled trials), sell the project to them, and then support them with information, research protocols, and the provision of clinical study officers. I was involved in a number of important national projects including, the Treatment Foster Care Study, which I pitched to Kent's senior children and families planning group (Biehal et al., 2012). This trialled an intervention to provide better education and training for foster parents. Another study looked at the development of user involvement since its early beginnings in user pressure groups and another evaluated the effectiveness of the Independent Mental Health Advocacy Services developed after the 2007 Act, amongst many. Together with our Hub Co-ordinator, I also devised a system for greater user and carer involvement within the Research Network, which was then adopted nationally.

It was very satisfying to feel that whilst promoting the growth of community services in Southwark, I was also able to contribute to the growth of a wider evidence-based practice for mental health social care. One of the projects which came out of the Capital Volunteers initiative, which I named, Msaada, the Swahili word for 'giving back,' was a volunteer programme within the Trust to visit and befriend patients from the Black and Minority Ethnic communities in Southwark. The project is still going strong. It was important to ensure that some of the Capital Volunteer schemes were directed at people from minority ethnic backgrounds, as they formed a significant percentage of the Trust's patients. Many of the research papers on migrant and minority ethnic groups which I had reviewed, emphasised the double discrimination suffered by members of these communities. All, without exception, also pointed out the enormous discrimination mental health users generally suffered in employment and personal relations within their families and communities.

In 2009, I became heavily involved with staff from the Maudsley in promoting the national *Time to Change* campaign in Southwark, including memorable visits from Ruby Wax and Stephen Fry. We ran a series of street events to educate the public about the project. The appearance of Graham Thornicroft's book, *Shunned*, the previous year, had highlighted once again the appalling discrimination created by fear and ignorance of mental illness. This campaign, and the more recent development of the Prince William supported charity, *Heads Together*, have finally, it

seems, begun to change the public discourse about mental illness, and highlighted the need for dialogue and support to those who live with mental health challenges.

It is hard to encapsulate a whole career, but one thing I always enjoyed was the opportunity to use knowledge and insights from one area to inform another. In 1999, I had been invited to become a Trustee of the Bethlem Museum. At the time it was in a tiny building, and was, to be frank, an irrelevance as it impacted on so few people. Eventually, after a second attempt at a Heritage Lottery Fund, we began to make headway. In 2009, I became Chair of Trustees, and in 2015 we were finally able to move into the magnificent Administration Building at Bethlem, thanks to a great deal of hard work by Jill Lockett on the building development side and a small group of Trustees planning the permanent display. It was re-branded as 'Bethlem Museum of the Mind' and it now plays a major role in interfacing with the local community, bringing people on site, delivering a major mental health promotion agenda for the South London and Maudsley NHS Trust, and providing a space for people to explore mental health issues. The opportunity to understand the many false paths that psychiatry has taken over the years, in a non-judgmental environment, is humbling and instructive, and the Museum should be an early port of call for all new staff. In 2016 we were one of five shortlisted for the Museum of the Year award, not too 'shabby' in the end. The Museum also hosts the Recovery College, another initiative to provide training for users, staff and carers in a model of co-production, in which all learn together, and users' strengths are enhanced.

The spirit of Simon Wessely's paper, 'Old wine in new bottles' (Wessely, 1990), could apply to much that is recycled in health and social care. The origins of personalisation and self-directed support can be found in the Adult Care Green Paper, *Independence, Well-Being and Choice*, in 2005, although the idea of giving a service users control over the resources they have been assessed to need, took me right back to the disabled residents at Le Court, and the amazing things they had done with the support of funders and volunteers (Department of Health, 2005). Personal Budgets came in over the last 18 months of my working career and, despite the bureaucratic nature of the process, I firmly believed they were the way forward. They represented at last a recognition, already found in many of the user initiatives we had set up, that service users need to manage their own choices and care, with support provided where necessary.

Within the South London and Maudsley Trust (SLaM) I helped promote a number of other User Led initiatives. In Southwark we recruited the largest number of users onto SLaM's Involvement Bank, and they were funded to undertake many roles. We had patients involved in the Service User Training Opportunities scheme, who were trained to deliver courses to staff improving their user awareness. As with many Trusts we had user representatives on most planning and development groups, including the Borough Partnership Board, but also within the Institute of Psychiatry there was a whole unit Service User Research Organisation run by Professor Diana Rose (a service user researcher). This was dedicated to research

projects whose agendas and research were driven by service users, and not big Pharma or doctors/psychologists. We also had service users involved in a group which oversaw Ethics Committee applications, to ensure that researchers had taken user issues into consideration.

The Maudsley had an endless capacity to produce new initiatives and it was always a pleasure to become involved in these. Maudsley International, now known as 'Implemental', was set up in 2007. It works with governments, providers of health services and employers in many different countries. I was involved in its early development and in providing training to international visitors, educating them about our mental health and social care systems. Once again this was driven by a desire to share the knowledge and expertise contained in the Maudsley and Institute of Psychiatry, with countries which were still struggling to modernise their services.

Working at the Maudsley in its various health iterations provided me with a standard to aspire to and live up to. The SLaM NHS Foundation Trust has really sound values, aspires to be the best it can be, and provided me with incredible career opportunities. The Local Authorities in which it operates are very lucky to have such a responsible dedicated organisation in their midst, and I personally found it a remarkable place to learn and grow as a professional.

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