Mapping of Education and Training for Mental Health Practitioners in the South West

Dr Charles Musselwhite

Professor Dawn Freshwater

Kate Schneider

Professor Kate Galvin

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Bournemouth University

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Executive Summary

In March 2003, the Institute of Health and Community Studies (IHCS) at Bournemouth University was commissioned by Mental Heath South West to analyse the commissioning, purchasing and provision of education and training for mental health practitioners of all levels in the South West region of England. A selection of 82 courses representing education and training for mental health practitioners in the region were mapped against established criteria for working effectively in the area of mental health; namely the Capable Practitioner Framework (SCMH, 2001) and National Occupational Standards (NOS) for Mental Health (Skills For Health, 2004). This was achieved through in-depth qualitative analysis of course literature, and interviews and focus groups with course leaders. Findings confirmed that a number of gaps in education and training exist in the following key areas:

- Supporting individuals in managing their lives;
- Mental health promotion;
- Family issues and mental health;
- Complex issues and management of change (including acute inpatient workers);
- Assessing and managing risk at work;
- Physical and mental health relationships;
- Supporting clinical supervision, professional development and developing research skills;
- Interdisciplinary and multi-agency working in mental health.

This report makes some key recommendations:

- To address whether the gaps need to be addressed by changing courses or National Occupational Standards;
- To investigate service user involvement in education and training for mental health practitioners;
- To provide a database and, ultimately, a website of the local provision of education and training for mental health practitioners;
- To help commissioners and providers of education and training realise that benchmarking and reflection on their own work is important for developing quality courses for mental health practitioners;
- To further define National Occupational Standards in terms of job role and context of mental health and illness;
- Courses must be developed for the team, team manager and strategic managers with regard to mental health;
- Courses must be developed that match the gaps highlighted above.

To plan and implement the recommendations, the project concludes with the suggestions that a feasibility study should be carried out to chart the development from this project.

This project preceded the publication of the ten Essential Shared Capabilities (ESC) produced by the NIMHE/Sainsbury Centre for Mental Health Joint Workforce Support Unit. The aim of the ten ESC is to set out the minimum capabilities that the mental health workforce requires as part of the Capable Practitioner Framework and NOS. An implementation programme will be undertaken by NIMHE to disseminate and implement the ten ESC linking them to the Capable Practitioner Framework, NOS, and the NHS Knowledge and Skills Framework.

Introduction

Background to Project

In March 2003, staff at the Institute of Health and Community Studies (IHCS) at Bournemouth University were commissioned by Mental Heath South West to undertake an analysis of the commissioning, purchasing and provision of education and training for mental health practitioners of all levels in the South West region of England. It was proposed that education and training could be mapped against established criteria for working effectively in the area of mental health, such as the Capable Practitioner Framework (SCMH, 2001) and National Occupational Standards (NOS) for Mental Health (Skills For Health, 2004). Emerging education and training priorities could then be assessed, and gaps in education and training in the South West of England identified. In addition, local needs, identified through local implementation plans, local delivery plans and strategic service plans, could be analysed and assessed for their relevance against the National Standards Framework (NSF) for Mental Health and the NHS Plan.

Policy framework

The Modernisation Agenda in the National Health Service (NHS) in England highlighted the need for clinical governance, which places Trusts as organisations and individuals as responsible, accountable professionals (DoH, 1997; 2000c). A modern, effective, high-quality service provided by a Trust is linked directly to staff development, in which continuing professional development (CPD) and lifelong learning are integral parts (DoH, 1998a; DoH, 1999a). Trusts functioning as an organisation should have structures in place to facilitate lifelong learning and must provide opportunities for staff to update their skills and knowledge (DoH, 1998a). Specific mental health-based documents follow similar lines, where effective interventions are directly linked to training of staff (see DoH, 1998b; DoH, 1999b). *Working Together* (DoH, 1998c) highlights the importance of planning the quantity and quality of staff required for services provided in the NHS. Thus, consideration must be given to the number of staff needed and the variety and range of skills required.

Emphasis is on addressing training needs of staff within a service. A number of documents have subsequently developed the idea of local workforce planning and development (DoH, 2000a; 2000b). Consequently, Trusts are required to identify the skills and competencies required for modern, effective and high-quality services, and should therefore be able to identify education and training needs of individuals,

teams and organisations. A number of competency, skill and standards frameworks have been developed to aid organisations in workforce planning and development.

Competency, skills and standards in mental health

Over the past 30 years there has been a shift away from psychiatric hospitalisation towards a community-based provision of mental health services (DoH, 1999b). This has created a varied and complex terrain in which services are delivered by multiple agencies, including mental health specialists, primary care, housing, social services, the voluntary sector and family and friends (DoH, 1999b; SCMH, 2001). This, coupled with an increasing emphasis on evidence-based intervention and workforce planning and development, results in the need for an overarching framework to address the skills, knowledge and attitudes required by a capable practitioner in the field.

The Workforce Action Team (WAT), set up by Government ministers to consider the implications of the NSF, commissioned The Sainsbury Centre for Mental Health to identify the key capabilities of the mental health worker. A document, entitled *The Capable Practitioner* (SCMH, 2001), highlights this work by providing a broad unifying framework, encompassing skills, knowledge and attitudes required by the mental health workforce. *The Capable Practitioner* aims to define what is required to deliver effective mental health care rather than focus on a specific profession. However, the parameters of the framework focus on nursing, occupational therapy, psychiatry, psychology, social work and professionally non-affiliated support workers within adult mental health services (SCMH, 2001). The framework is divided into five areas:

- Ethical practice;
- Knowledge of mental health and mental health services;
- The process of care;
- Interventions;
- Applications to specific service settings – which focuses on primary care, community-based co-ordination (community mental health teams), crisis resolution and early intervention, acute inpatient care, assertive outreach, continuing care (including day services, rehabilitation, residential care, vocational and work programmes) and services for people with complex and special needs (including forensics, dual diagnosis and personality disorders).

The five areas are placed in a hierarchical order, in which the capabilities outlined are important for those in increasing specialisation; so all mental health practitioners must have ‘ethical practice’, but fewer must have ‘knowledge’ and fewer again must have ‘process of care’ capabilities, and so on. Each of the five is divided into statements that are listed in *The*

Capable Practitioner document (SCMH, 2001). The framework draws 'the contour lines of a territory, which needs further exploration and the construction of occupational standards' (SCMH, 2001, p6).

Although *The Capable Practitioner* is a useful document to begin charting the capabilities required by a workforce and to further develop occupational standards, it is recognised that a number of areas need to be addressed. Firstly, the content of the framework is too generic but at the same time not generic enough. It seems to be too generic for use by a variety of specialist staff, but in concentrating on certain types of mental health staff, who are not clearly defined, it misses out on a number of people working in mental health. A clear definition is needed of exactly whom the capabilities are for. For example, it seems that a mental health nurse and a psychiatrist should evidently have most of the capabilities defined, but what about a receptionist at a psychiatric outpatient clinic or an unpaid or paid member of the family caring for someone with mental health issues? The introduction to the capability framework mentions how effective care must come from numerous agencies 'and indeed the family' (SCMH, 2001, p4), but it is unclear how this framework helps the multitude of workers in the mental health arena.

No definition of mental health is mentioned throughout *The Capable Practitioner*. For example, should general practitioners (GPs) have these capabilities when as many as 90% of people visiting a GP have psychological or emotional distress (Scott, 2004), or do the capabilities just cover severe or enduring mental distress or those working with diagnosable mental illness? The document should begin with defining the terms of reference.

The Capable Practitioner also varies in its definition of the capabilities. On page 2 it is mentioned that capabilities encompass 'knowledge, skills and attitudes', which changes to 'values, skills and knowledge' on page 5, before altering to 'values, attitudes and knowledge' later on the same page. This is an indication that perhaps the authors see these as interchangeable terms. Definitions of the terms are required because different terminology is used across the disciplines. For example, values are seen as the affective component of attitudes (Eagley and Chaiken, 1993; Fishbein and Ajzen, 1975). The capabilities described in the document often begin with the descriptor 'capable of…' in front of the criteria. However, to be capable may require certain skills, knowledge, attitudes and values that are not described. *The Capable Practitioner* document needs to be clear about what it means by capability and the role that skills, knowledge, attitudes and values have in making up 'capability'.

The Capable Practitioner mentions that it is different to competency frameworks and occupational standards in that it does not provide measurable outcomes or performance. However, many of the capability statements reflect performance and outcome. For example, a capable practitioner must 'demonstrate a commitment to equal opportunities', which is described under 'values and attitudes necessary for modern mental health practice'. Demonstrating a commitment does not mean that attitudes and values towards commitment are appropriate; rather that an individual can show a commitment. A confusion arises in that this is a performance outcome, albeit a not very specific measure but an outcome nonetheless. Thus, confusion arises between competency frameworks, occupational standards and capability documents, all which seem to address outcomes and performance.

National Occupational Standards are developed by Skills for Health 'to raise the standard of practice in a given sector…providing a benchmark against which performance both at individual and organisational level may be assessed and measured' (NIMHE, 2003, p3). As NIMHE (2003) points out, they 'provide a systematic approach to establish good practice supported by a clear framework of underpinning knowledge, standards and expected outcomes' (p5). These are applicable to the mental health workforce as a whole and are not simply clinical standards.

The standards gain credence by appearing thorough and comprehensive. They are UK-wide, cover mental health services for people of all ages, and cover health and social care across both statutory and non-statutory sectors. They are stated to focus on needs of service users and their carers and are based in practical reality, having been subjected to wide consultation and field testing. They have taken account of existing and emerging work on standards, including *The Capable Practitioner* (NIMHE, 2003).

The National Occupational Standards for Mental Health contain 16 key roles, each with a further number of elements that describe the key roles in more depth. These key roles cover a large area of work within the mental health discipline, covering areas such as: mental health promotion; addressing mental health needs of a population; practising in a reflective manner; providing support and services to families and carers; support for planned programmes of care; and support in managing social situations and interactions. Not all practitioners will require competency in every one of the standards within this framework; a number of organisations and job roles have a distinct pattern of competencies assigned to them.

The National Occupational Standards for Mental Health have their roots firmly established in the modernist, positivist paradigm and claim to be 'capable of reliable, objective and consistent assessment across the UK' (NIMHE, 2003, p16). A closer examination, however, suggests some key elements of therapeutic relationships, and indeed interpersonal communication, are missing as a result of adhering to a reliable, objective and consistent framework. In situations involving working with other people, some of the most important aspects of the job will not be objective and do not necessarily yield observable outcomes. This does not mean to say they are any less important than objective outcomes but are largely ignored because they are deemed unreliable (they appear in a different quality each time), subjective (they appear differently to different people and in different relationships) and inconsistent (they appear differently each time). Thus, by ignoring such areas, the resulting occupational standards feel somewhat incomplete. Nevertheless, the document provides a framework against which current training and education can be mapped.

Critique of previous research

This research builds on a previous study conducted by IHCS at Bournemouth University (Fulbrook et al., 2001) in which providers of education in the South West were requested to detail the education and training that they provide for mental health practitioners. This was mapped against *The Capable Practitioner* (SCMH, 2001). The results of the research suggest that gaps exist in the following areas:

- Policy and legislation: education of service users and carers;
- Development and documentation of care plans;
- Monitoring of standards;
- Comprehensive assessment of physical and mental health needs;
- Collaboration with community resources to meet practical and social needs;
- Principles and practice of health promotion.

These results were obtained through questionnaires completed by training providers, who mapped their own courses to the capabilities. This had several limitations:

- No analysis is available as to the level of depth that courses map against criteria;
- No check was made that capabilities really were covered in the courses;
- Differences in interpretation between respondents with regard to definition of capability could have occurred;
- Self-selected return of those who wish to demonstrate how well their course matches capability frameworks could have occurred.

The results were used as part of a national initiative to address gaps and recommendations in education and training with regard to capabilities, commissioned by the WAT (DoH, 2001). As well as the South West, other regional areas completed a similar mapping exercise, including the North West region, Northern and Yorkshire region (Readhead and Briel, 2001), Eastern region, West Midland region, London region, South East region and Trent region. In broad terms, the project was to allow commissioners and providers of education and training to measure themselves to *The Capable Practitioner* and, where appropriate, re-assign their activities. As WAT put it, ‘If some education and training does not match *The Capable Practitioner*, then commissioners should no longer include the course, module, etc. in their contractual arrangements, and providers should consider how best the course, module, etc. should be redesigned to reflect contemporary needs’ (DoH, 2001, p1). This shows the credence and weight placed on *The Capable Practitioner* document. It is such a powerful document it can alter and possibly cease courses. However, this leaves mental health care vulnerable in that there is no evidence to suggest that *The Capable Practitioner* covers every area of mental health care. As with most policy documents, it offers a partial view and needs to be implemented with this in mind. As previously discussed, some ambiguities and problems within the document already serve to suggest it cannot be taken as a definitive and decisive document.

Table 1: Key findings, issues and recommendations adapted from the DoH (2001) report for the future commissioning and provision of education and training for mental health practitioners.

	Research findings (locality based)	Research findings (generic national messages)	Recommendations based on the research findings	Additional findings from the research not highlighted in the report
Commissioning of education and training	Problem with access to money for establishing new education and training.	Problem in time of commissioning process (i.e. 3-5 years too long to reflect change; 1 year too short to plan ahead).	Regional Action Plan on Education and Training Provision. WDC and LAS to commission education and training together.	Also mentioned that commissioners need to take responsibility for relevance of training.
Development and continual evaluation of education and training	Level of involvement of users and carers to be improved and formalised.	Evaluation and updating of courses along with quality control needed.	Co-ordination of providers to rationalise education and training. Improve level of involvement, through nationally agreed set of criteria, of users and carers. Better communications between providers with networking facilitated by lead mental health WDC.	Also mentioned that the assessment of learning objectives were not measured after training or education finishes. User and carer involvement limited for most respondents except South West.
Information on and perception of education and training		Practitioners show confusion over content and type of education and training and do not understand how they link to other education and training.	Providers should map their course directly to NSF standards and CP domains to achieve better and clearer labelling of course content. Ethics and learning outcomes should be made more explicit.	Also mentioned the need of health and Social Services to better publicise training. There was also very little information on ethics and/or values.
Attendance at education and training events		CPD not the same or held in similar esteem across all professional groups. Mental health training for those working in primary care not always evident for all workers.	Course links to CPD made explicit and links with other courses made clear. WDC should consider extending mapping exercise to include training for A&E staff, practice nurses, GP staff, housing staff and health visitors.	Mentioned by many respondents: there is a definite need for more multidisciplinary training and education, more team-based training (especially in social work) and better access to training including defined training pathways for all staff.

Cont./

Table 1 cont.

	Research findings (locality based)	**Research findings (generic national messages)**	**Recommendations based on the research findings**	**Additional findings from the research not highlighted in the report**
Content of education and training	Need more mental health training and education on underpinning issues such as deafness or learning disabilities. Training and education needs to focus more on cultural issues. Education and training on health promotion issues needs to be increased.	Undergraduate training focuses too much on academic achievement and not enough on practical skills such as social and communication skills. DipSW does not address mental health issues as a core component.	To ensure all education and training directly supports the delivery of the NSF and NHS plan. Education and training should be developed to focus on sensory impairment and learning disabilities. There should be provision of education and training dealing with cultural, religious and spiritual issues and mental health. Consultation with General Social Care Council about content of DipSW course	Most respondents stated courses in the following areas were needed: sensory impairment, learning disabilities, mental health promotion, assertive outreach, users/carers, working with other professions/inter-relationships, mental health legislation. Also needed training in mental health for managers and for GPs. Also mentioned the need for a better structure to qualification for non-associate professionals. Balance between theory and practice must be considered but only London mentioned problem with DipSW. Many mentioned cultural, religious and spiritual training was good in most regions.
Method of delivering education and training	Staff who deliver education and training did not always have much contemporary clinical service experience.	More flexible approaches to method of delivering education and training should be considered.		Most respondents reported that workplace-based training or education would be useful. Also many did mention that delivery of education and training must be by clinicians with up-to-date clinical experience (though this surely must depend on the content).

Table 1 shows the main findings from the DoH (2001) report, highlighting a number of areas of recommendation. The DoH (2001) report concludes with a summary of future work:

- Studying the quality of the courses; specifically, how good is the design and delivery of a course?
- Extending the mapping to include primary care, prison, CJS and housing, for example;
- Including non-accredited education and training;
- Look more in-depth at a selection of education and training provided by the majority or bulk providers to study promise against delivery;
- Study the feasibility or possibility of different methods of delivery.

However, there were limitations in the design of the different pieces of research that amalgamate to produce the WAT document (DoH, 2001), including:

- Too little time was allowed for too important a task;
- Difficulty in identifying providers and getting a good response from such providers;
- The questionnaire survey method did not afford quality issues to be studied;
- An unsophisticated and poorly designed template questionnaire, which was possibly linked to having too little time to trial and develop a better template.

Building on Previous Research: Introducing the Mapping Project Part 2

The current study aimed to address the issues arising from the previous research, while also aiming to map the training and education provided in the South West. Through performing a multi-method approach, it aimed to overcome some of the problems with previous research and:

- Provide a deeper level of research using an in-depth qualitative case study approach to a number of education and training outputs, which allows a greater understanding of mapping the course content and allows quality issues to be addressed;
- Improve the trustworthiness and validity of results by covering a multi-method approach and not relying on self-report methods alone;
- Improve sampling techniques and response rates by building on an established database set up for the original project. Greater use of modern technology, such as databases and internet, to enhance the database. Creating enough space in the project for following up non-respondents and collecting information from a variety of sources, rather than relying on questionnaire templates alone;

- To address not only course content but also the quality of course content. Where possible, evaluative data on the course is collected;
- Collect information from a variety of education and training scenarios not just traditional accredited courses. Therefore, being able to include more primary care, prison, CJS and housing education and training;
- Address methods of delivery for appropriateness.

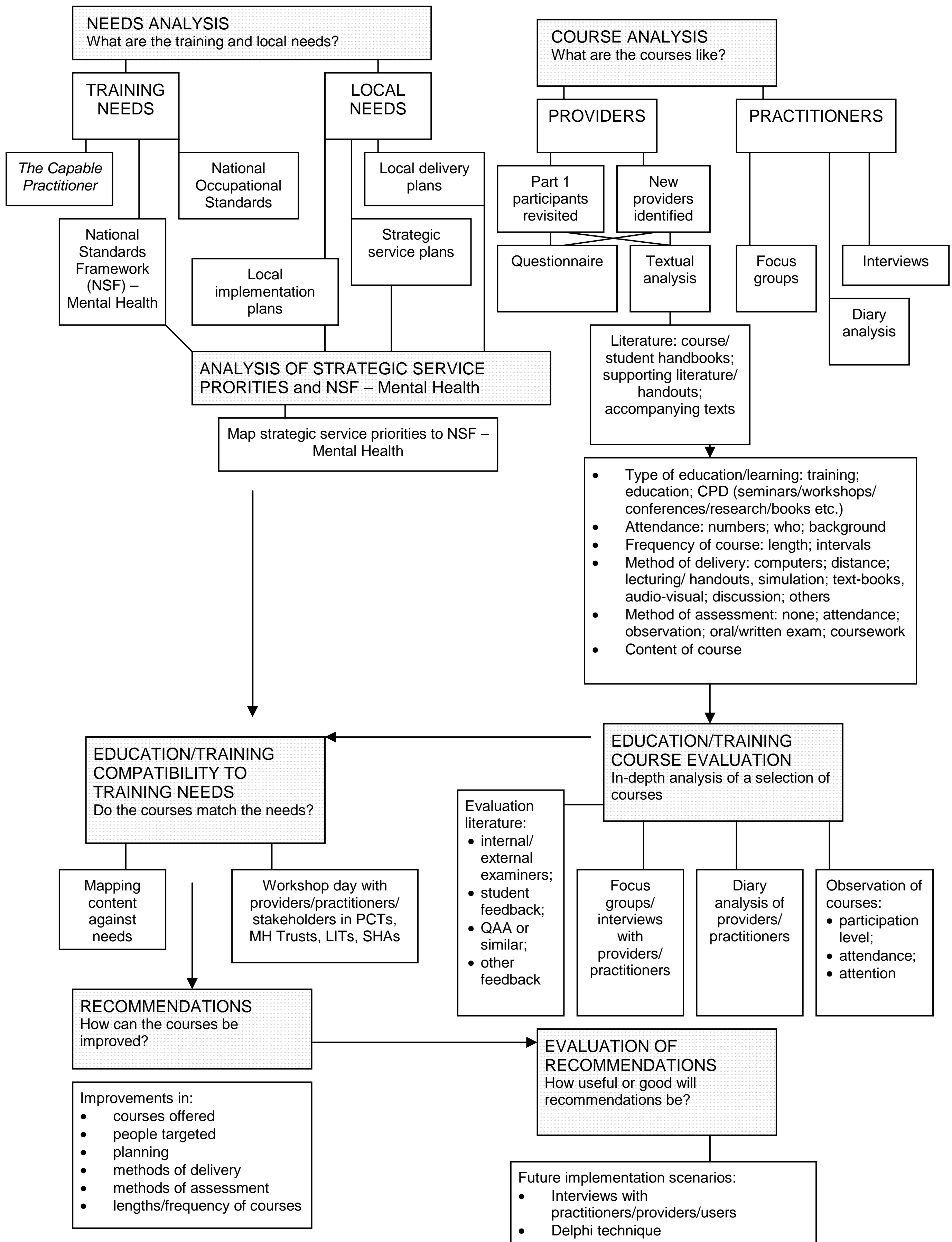
Through a variety of means, including questionnaires, interviews, and document and textual analysis, this project aims to involve interaction with a variety of individuals. These include commissioners, purchasers and providers of education and training, practitioners of a variety of differing levels who are involved with mental health, and users of mental health services and their carers, which will result in a deeper analysis than was found in the original study.

Accordingly, a list of aims and objectives were developed (see Box 1). It was envisaged that these aims and objectives could be met through the processes outlined in Figure 1.

Box 1: Aims and objectives of the Mapping of Education and Training for Mental Health Practitioners in the South West project.

AIM: To identify and critically analyse the provision and commissioning of relevant training for mental health practitioners of all disciplines in the South West region of England.
OBJECTIVES: 1a. To identify the scope and content of education and training being provided, purchased and commissioned in the South West for mental health practitioners. 1b. To critically analyse and evaluate the scope, content and underlying values of a selection of education and training being provided, purchased and commissioned in the South West.
2a. To map local needs, as identified through local implementation plans, local delivery plans and strategic service plans, to the National Standards Framework for Mental Health. 2b. To identify emerging training and education priorities and needs for mental health practitioners in the South West.
3a. To map education and training for mental health practitioners in the South West against *The Capable Practitioner* and National Occupational Standards. 3b. To map education and training for mental health practitioners in the South West against local needs and priorities, with regard for emerging education and training needs for mental health practitioners in the South West.
4a. To identify gaps in education and training provision, purchasing and commissioning for mental health practitioners in the South West. 4b. To recommend improvements in education and training for mental health practitioners in the South West, in terms of commissioning and delivery.
5a. To investigate whether recommendations for improvements in education and training for mental health practitioners in the South West are appropriate, useful and feasible.

Figure 1: Diagram of potential project work for the Mapping of Education and Training for Mental Health Practitioners in the South West project.



Methodology

Scope and Boundaries

The study aims offered a seemingly endless scope for inclusion. Thus, an initial workshop was set-up at IHCS, Bournemouth University, with research staff to address some of the key issues, with the aim of delineating the boundaries around the project. This workshop found the following:

Contextual boundary

The contextual boundary had to be defined. Education and training covers a wide range of possible areas that could be studied, for example, reading a book, attending a workshop or seminar, and interacting with patients or clients. For the purpose of this study, it was decided that, although non-accredited education and training would be studied, the education and training would have to be in the form of a 'course' rather than a stand-alone workshop, conference or seminar and as such should include learning objectives.

Geographical boundary

The geographical boundary of the project was to be based on where the education and training was provided, as opposed to the location of the practitioners. For example, it concentrated on the provision of courses in the South West region, not on where practitioners working in the South West would go on a course.

Procedure

The research process (see Figure 1) offered a great deal of opportunity for a variety of methods to be adopted. However, with further refinement, the following methodology was considered:

Needs analysis

Textual analysis of National Occupational Standards
A comprehensive and critical review of the National Occupational Standards.

Textual analysis of *The Capable Practitioner*
A comprehensive and critical review of *The Capable Practitioner*.

Literature review
A comprehensive literature review addressing research into the training needs of mental health practitioners.

Course analysis

Revisit data from the original Bournemouth University study

The original database contained details of 131 providers of education and training. This was updated with new contact details and was used as a basis to work from. Networking with local stakeholders helped to identify providers of education and training who were not on the original list. A total of 45 new contacts were established, resulting in 176 providers of education and training being contacted in the South West.

Questionnaires administered to providers (see Appendix A)

A questionnaire was sent to each provider asking them to give or update (if they had responded to the previous study) course details. Specifically, the questionnaires asked for:

- Name of provider;
- Name of course;
- Number of taught days on course;
- Type of course (e.g. stand alone or module within a course etc.);
- Level of course;
- How often course runs;
- Approximate average number of people attending course;
- Brief description of basic content of course.

Course evaluation

Criteria for selection

Initially, all providers on the database were asked to respond with the questionnaire and provide a selection of course material to gain a more in-depth view of the courses on offer. Thus, no criterion for selection was adopted. However, not all respondents supplied additional material.

Textual analysis of literature

A textual analysis of the literature provided was made. This literature took many forms, including student feedback, course guides, student handbooks, class handouts, and quality and evaluative documents.

Focus groups and interviews with providers

Three focus groups (two consisting of four participants and one with two participants) and 11 interviews were conducted to gain further information on certain courses.

Mapping

Mapping by analysis

Mapping was carried out, taking into account data from the course analysis and evaluation, along with the National Occupational Standards and *The Capable Practitioner* documents.

Statistical treatment of mapping

Initially, each standard or capability was mapped in one of three areas:

0 = Standard/capability does not map on the course.

1 = Indirect mapping of standard/capability (i.e. standard or capability is covered as a by-product of looking at an additional area).

2 = Direct mapping of standard/capability.

In addition, for the courses achieving 1 or 2, a Likert scale was adopted for the depth of mapping. The scoring was achieved as follows:

1 = Minimal focus on standard/capability is found.

2 = Small focus on standard/capability is found.

3 = Some focus on standard/capability is found.

4 = Detailed focus on standard/capability is found.

5 = Very detailed focus on standard/capability is found.

6 = Focus exceeds standard/capability.

A final number was added to address whether the standard or capability is generic across mental health (1), or specific to a certain area such as a particular illness or a particular client group (2). Thus, each capability or standard was given a three-digit code.

Mapping reliability

A sample of courses that had been matched were fed back to providers to seek concordance. Interviews took place to discuss differences. In addition, a sample of courses was mapped by different co-researchers and inter-researcher reliability addressed. In all cases high consensus was found.

Generating recommendations

The mapping process resulted in a number of recommendations, specifically addressing the courses offered, attendees, planning, delivery methods, assessment methods, and length and frequency of courses.

Limitations

Local needs have not been addressed nor compared with the National Service Framework for Mental Health as was originally hoped. This is because it was not possible to collect local delivery plans, strategic service plans and local implementation plans from all the groups. It was also not possible to address the commissioning aspect of training, since very little data was obtained from commissioners.

Results

Response

A total of 176 providers of education and training in the South West were contacted. Most of these were from differing organisations. However, different departments were sometimes contacted from the same organisation. Table 2 identifies the respondents and level of response.

An overall response rate of just under 26% is to be expected from a questionnaire sent as such. A second wave of reminders to fill in the questionnaire was sent six months after the original, which increased the returns from 24%. Only around 10% returned anything in addition to the questionnaire or took part in an interview. Nevertheless, this increased from only 5% after the reminders were sent. Thus, in-depth analysis can only occur on education and training in around 10% of the organisations. The response rate for extra full information is similar throughout. Notable absences are from the police and probation services. Acute and Primary Care Trusts also have a low level of full return given the number contacted. Higher education establishments were most likely to reply.

Table 2: Number of respondents by type of organisation.

	Total contacted	Full level response	Basic level response	No response
Higher education	24	7 (29.17%)	3 (12.5%)	14 (58.33%)
Further education	9	0 (0%)	4 (44.44%)	5 (55.56%)
NHS Trust	91	8 (8.79%)	13 (14.29%)	70 (76.92%)
Private	5	1 (20%)	0 (0%)	4 (80%)
Voluntary	24	0 (0%)	5 (20.83%)	19 (79.17%)
Social Services	16	1 (6.25%)	2 (12.5%)	13 (81.25%)
Police/probation	4	0 (0%)	0 (0%)	4 (100%)
WDC/HA	3	0 (0%)	1 (33.33%)	2 (66.67%)
TOTAL	**176**	**17 (9.66%)**	**28 (15.91%)**	**131 (74.43%)**

The 45 responses generated information on 214 courses (average of 4.76 courses per respondent). Modular courses have been separated into modules where they can be taken separately, otherwise they appear as one course.

The 214 courses consisted of a variety of levels:

Continuing professional development courses	31
Level 1 courses	3
Level 2 courses	17
Level 2 and 3 courses	9
Level 3 courses	15
Foundation level courses	14
Pre-qualifying courses	6
Degree level courses	5
Cert/Dip/Masters level courses	5
Newly qualified courses	5
Advanced/specialist courses	19
Courses for service users and their carers	3

Other courses did not specify a specific level.

The courses ranged from two hours long to three academic years, with most courses lasting around one day (average across all courses: 1.09 days per course). The number of attendees per course varied between 5 and 40, with an average of 15. Various methods were used in teaching the content and most courses used more than one method.

Mapping to *The Capable Practitioner* and National Occupational Standards

The 17 full level responses generated 82 courses (see Appendix B; again 4.82 courses per respondent) to carry out full mapping to *The Capable Practitioner* and National Occupational Standards documents. (See Boxes 2 and 3 for specific examples of courses mapped against *The Capable Practitioner* and the National Occupational Standards.)

Box 2 shows a Behavioural Principles course run by an NHS and Social Care Trust. The course is run over six half days and addresses operant modelling, behavioural analysis and techniques. These are delivered through lectures, group exercises, role-plays and video with no formal assessment. It is open to ten people once a year and attendees come from a mental health or social care background. The course specifically maps to three National Occupational Standards – E7, F2 and F5. It maps to E7 with some focus, and to F2 and F5 with a small focus. It maps to these generically rather than to a specific version. It maps specifically to Capable Practitioner 12, 13, and 18 and indirectly to 27. With regards to 12, it only maps with minimal focus, and 13, 18 and 27 with a small focus. The course maps generically to these capabilities.

Box 2: Example 1 – Behavioural Principles course.

Sector provider: NHS Trust **Ref:** 37d

Number of taught days on course: 3 (6 half days)

Type of course: Stand-alone

Content:

Operant model; behavioural analysis; ABC records; behavioural techniques; behavioural planning; negotiation of plan; ethical issues.

Maps to National Occupational Standards:

E7: ‘Contribute to the planning, implementation and evaluation of therapeutic programmes to enable individuals to manage their behaviour’. (Statistical code: 2, 3, 1)

F2: ‘Plan, implement and evaluate therapeutic interventions with people with mental health needs’. (Statistical code: 2, 2, 1)

F5: ‘Reinforce positive behavioural goals during relationships with individuals'. (Statistical code: 2, 2, 1)

Maps to *The Capable Practitioner*:

12: ‘Knowledge of mental health and mental illness, causation, incidence, prevalence, description of disorders and the impact on individuals, families and communities’. (Statistical code: 2, 1, 1)

13: ‘Knowledge of the various explanatory models of mental health and the evidence which underpins them’. (Statistical code: 1, 2, 1)

18 (specifically part 1): ‘Facilitating the participation of users, carers and families in the development, delivery and evaluation of individual care plans’. (Statistical code: 2, 2, 1)

27: ‘Capable of facilitating concordance with effective treatment’. (Statistical code: 1, 2, 1)

Methods of delivery: Lectures, group exercises, role-play and video

Assessment: No formal assessment

Group aimed at: Mental health and social care professionals

Frequency: Once a year

Approx. number of participants: 10

Funding: Somerset Partnership NHS and Social Care Trust

Overall mapping:

National Occupational Standards

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
0	0	0	0	7 (231)	2 (221) 5 (221)	0	0	0	0	0	0	0	0	0

The Capable Practitioner

1	2	3	4	5	6	7	8	9	10	11	12	13	14
											211	221	
15	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**
			221									121	
29	**30**	**31**	**32**	**33**	**34**	**35**	**36**	**37**	**38**	**39**	**40**	**41**	**42**
43	**44**	**45**	**46**	**47**	**48**	**49**	**50**	**51**	**52**	**53**	**54**	**55**	**56**
57	**58**	**59**	**60**	**61**	**62**	**63**	**64**	**65**	**66**	**67**			

Box 3: Example 2 – An Introduction to the Management of Suicide and Self-Harm course.

Sector provider: Higher education **Ref:** 504

Number of taught days on course: 5

Type of course: Stand-alone or part of a BSc (Hons) Health Studies

Unit credit: 20

Content:

Provide a theoretical background and effective practical approaches to the prevention and management of suicide and self-harm in health and social care settings. Evaluation of current practice and development of strategies for managing suicidal and self-harm behaviours.

Maps to National Occupational Standards:

A1: Develop your own knowledge and practice. (Statistical code: 1, 5, 2)

A2: Reflect upon and develop own practice using supervision and support systems. (Statistical code: 1, 5, 2)

J3: Enable people who are at risk to themselves and others to develop control. (Statistical code 2, 5, 2)

Maps to *The Capable Practitioner*:

49: The ability to intervene and provide effective strategies to reduce suicide. (Statistical code 2, 5, 2)

Methods of delivery: Video, lectures, group work

Assessment: Project/dissertation

Group aimed at: Those working with people at risk of suicide or self-harm, or who have attempted suicide.

Frequency: Once a year

Approx. number of participants: 15

Funding: Private/trusts

Cost: £305

Overall mapping:

National Occupational Standards

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1 (152), 2 (152)									3 (252)					

The Capable Practitioner

1	2	3	4	5	6	7	8	9	10	11	12	13	14
15	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**
29	**30**	**31**	**32**	**33**	**34**	**35**	**36**	**37**	**38**	**39**	**40**	**41**	**42**
43	**44**	**45**	**46**	**47**	**48**	**49**	**50**	**51**	**52**	**53**	**54**	**55**	**56**
						252							
57	**58**	**59**	**60**	**61**	**62**	**63**	**64**	**65**	**66**	**67**			

Box 3 shows An Introduction to the Management of Suicide and Self-Harm course run at a higher education establishment. It can be a module within a BSc (Hons) Health Studies course or can be taken alone, and is worth 20 credits. It is run over five taught days and addresses a theoretical background to practical approaches in preventing and managing suicide and self-harm. It is run once a year and around 15 people attend. It is aimed at those working with people who self-harm or attempt suicide. It uses video, lectures and group work and is assessed through project or dissertation. It maps to National Occupational Standards A1 and A2 indirectly with a detailed focus, specifically focusing this area on suicide and self-harm. It also maps directly to J3 with a detailed focus, specifically focusing on self-harm and suicide. It maps to *The Capable Practitioner* area 49 directly with a detailed focus, again specifically focusing on self-harm and suicide.

Table 3 shows the mapping against the National Occupational Standards for the courses combined as a whole. As can be seen, some areas are covered well while others are largely absent. The top five most covered subjects overall are:

A1: Develop your own knowledge and practice (74 courses or 90.24%, of which 30 or 36.6% of all courses directly relate).

J2: Support individuals when they are distressed (69 courses or 84.15%, of which 28 or 34.15% of all courses directly relate).

A5: Promote effective communication and relationships with people who are troubled or distressed (64 courses or 78.05%, of which 18 or 21.95% of all courses directly relate).

D1: Identify potential mental health needs and refer individuals to services (60 courses or 73.17%, of which 19 or 23.17% of all courses directly relate).

G1: Establish, sustain and disengage from relationships with clients (57 courses or 69.51%, of which 21 or 25.61% of all courses directly relate).

There are six standards not covered by any of the courses analysed:

G4: Enable individuals to maintain their personal hygiene and appearance.

M7: Negotiate with employers and others and support them in offering opportunities to individuals with mental health needs.

N7: Lead the development, implementation and improvement of inter-agency services for addressing mental health needs.

O8: Support and challenge workers on specific aspects of their practice.

O10: Represent the agency in courts and formal hearings.

O11: Provide and obtain information at courts and formal hearings.

Table 3: Mapping of mental health courses in the South West against National Occupational Standards (n=82).

			Indirect	Direct	Average focus (1=little to 6=exceeds)
A	A1	Develop your own knowledge and practice	44	30	3
A	A2	Reflect upon and develop own practice using supervision and support systems	20	11	2
A	A3	Promote the values and principles underpinning best practice	26	9	2
A	A4	Promote effective communication and relationships	34	13	3
A	A5	Promote effective communication and relationships with people who are troubled or distressed	46	18	3
A	A6	Promote effective communication with individuals where there are communication differences	41	9	2
A	A7	Maintain and manage records and reports	14	10	2
B	B1	Provide advice and information to those who enquire about mental health needs and related services	22	6	2
B	B2	Enable people with mental health needs to access and use services effectively and in ways which promote their rights	11	5	3
B	B3	Contribute to establishing and running mutual support networks	4	0	2
B	B4	Enable individuals to represent their own needs and interests	17	2	2
C	C1	Assess the needs of carers and families of individuals with mental health needs	26	10	3
C	C2	Develop, implement and review programmes of support for carers and families	27	13	3
C	C3	Establish, sustain and disengage from relationships with families of children and young people (YJU B301)	16	13	3
C	C4	Support individuals in developing their parenting skills	5	0	1
C	C5	Visit and support the families of children and young people in their own homes (YJU B303)	21	3	3
C	C6	Empower families, carers and others to support individuals with mental health needs	15	4	2
C	C7	Establish, sustain and disengage from relationships with the families of older people with mental health needs	3	1	2
C	C8	Enable families to address issues with individuals' behaviour	28	11	3
C	C9	Support families in maintaining relationships in their wider social structures and environments	14	5	3
C	C10	Work with families, carers and individuals during time of crisis	27	2	2
D	D1	Identify potential mental health needs and refer individuals to services	41	19	4
D	D2	Recognise indications of substance misuse and refer individuals to specialists	22	15	4

Cont./

Table 3 cont.

			Indirect	Direct	Average focus (1=little to 6=exceeds)
D	D3	Assess individuals' mental health and related needs	39	16	4
D	D4	Work with individuals to identify their needs, assess related risks and the need for intervention	33	6	4
D	D5	Identify the physical health needs of individuals with mental health needs	16	4	3
E	E1	Contribute to the development, provision and review of care programmes	26	15	3
E	E2	Contribute to the assessment of individuals' needs and the planning of packages of care	22	14	3
E	E3	Contribute to the monitoring and review of care packages (CSC SC3)	22	13	3
E	E4	Plan and agree service responses that meet individuals' identified needs and circumstances (CSC SC18)	30	12	3
E	E5	Co-ordinate, monitor and review service responses to meet individuals' needs and circumstances (CSC SC19)	26	10	3
E	E6	Work with individuals with mental health needs to negotiate and agree plans for addressing those needs	20	8	2
E	E7	Contribute to the planning, implementation and evaluation of therapeutic programmes to enable individuals to manage their behaviour (CSC NC11)	28	11	3
E	E8	Respond to crisis situations	19	4	3
E	E9	Maintain active continuing contact with individuals and work with them to monitor their mental health needs	29	10	3
F	F1	Prepare, implement and evaluate agreed therapeutic group activities (CSC X16)	8	2	1
F	F2	Plan, implement and evaluate therapeutic interventions with people with mental health needs	22	4	2
F	F3	Prepare and provide agreed individual development activities (CSC X2)	25	3	3
F	F4	Work as a member of an inter-disciplinary team to provide individualised programmes of care for people with mental health needs	28	6	2
F	F5	Reinforce positive behavioural goals during relationships with individuals	15	21	1
F	F6	Administer and monitor medication for individuals, consistent with protocols, standards and legislation (Custodial Healthcare Unit CC049)	7	3	4
F	F7	Support people with mental health needs to improve their physical health and well-being	15	2	1
G	G1	Establish, sustain and disengage from relationships with clients (CSC SC14)	36	21	2
G	G2	Enable individuals to maintain their domestic and personal resources	12	0	1
G	G3	Enable individuals to administer their financial affairs (CSC Y3)	2	0	0

Cont./

Table 3 cont.

			Indirect	Direct	Average focus (1=little to 6=exceeds)
G	G4	Enable individuals to maintain their personal hygiene and appearance (CSC Z9)	0	0	0
G	G5	Enable individuals with mental health needs to maximise their employment opportunities	1	0	1
G	G6	Enable people with mental health needs to access housing and accommodation	6	2	1
G	G7	Enable people with mental health needs to undertake their own health care	9	0	1
G	G8	Enable people to identify and address their personal spiritual needs	2	0	1
G	G9	Enable people to choose and participate in activities that are meaningful to them	9	1	1
G	G10	Enable individuals and families to address issues that affect mental health and social well-being	16	2	2
G	G11	Promote the social inclusion of people with mental health needs	4	1	2
G	G12	Represent individuals' interests when they are not able to do so themselves	9	0	2
G	G13	Promote individuals' rights and encourage them to recognise their responsibilities	6	0	1
H	H1	Enable individuals to maintain contacts in potentially isolating situations (CSC W8)	2	1	2
H	H2	Support clients with difficult or potentially difficult relationships (CSC W5)	7	0	1
H	H3	Enable people with mental health needs to explore their behaviour and opportunities for change, and to develop coping strategies	19	6	3
H	H4	Support people in relation to personal and social interactions and environmental factors	17	5	2
I	I1	Enable individuals, and their family and friends to explore and manage change (CSC NC2)	8	1	1
I	I2	Support individuals experiencing a change in their care requirements and provision (CSC W3)	21	4	1
I	I3	Assist individuals to move from a supportive to a more independent living environment (CSC Y5)	6	1	1
I	I4	Support people who are transferring into new environments	7	0	1
J	J1	Work with people to identify their needs for safety, support and engagement and how these needs can best be addressed	16	10	2
J	J2	Support individuals when they are distressed (CSC Z8)	41	28	2
J	J3	Enable people who are a risk to themselves and others to develop control	29	16	2
J	J4	Contribute to the protection of individuals from abuse (based on CSC Z1)	11	7	3
J	J5	Contribute to the protection of children from abuse (Community Justice Unit E202)	2	2	4

Cont./

Table 3 cont.

			Indirect	Direct	Average focus (1=little to 6=exceeds)
J	J6	Support individuals where abuse has been disclosed (CSC Z18)	3	3	3
J	J7	Assess the risk of violence to workers (Employment NTO Work-Related Violence Unit W1)	10	8	1
J	J8	Implement policy and procedures to minimise the risk of violence at work	9	0	1
J	J9	Ensure your actions contribute to a positive and safe working environment	25	4	2
J	J10	Protect yourself from the risk of violence at work (Employment NTO Work-Related Violence Unit W7)	7	0	1
J	J11	Respond to work-related violent incidents (Employment NTO Work-Related Violence Unit W8)	5	0	0
K	K1	Identify trends and changes in the mental health and mental health needs of a population and the effectiveness of different means of meeting their needs	15	0	1
K	K2	Develop and agree priorities and objectives for meeting the mental health needs of a population	2	0	1
K	K3	Develop, implement and improve strategies to meet the mental health needs of a population	1	0	1
K	K4	Develop, monitor, evaluate and review services for addressing mental health needs	20	9	2
L	L1	Determine the concerns and priorities of communities about mental health and mental health needs	1	0	1
L	L2	Work with groups and communities to develop policies, strategies and services to improve mental health and address mental health needs	4	0	2
L	L3	Enable groups, communities and organisations to address mental health issues	8	0	2
L	L4	Determine the concerns and priorities of individuals and families about mental health and mental health needs	22	9	2
L	L5	Work with individuals and families to develop services to improve their mental health and address their mental health needs	6	0	1
L	L6	Enable the views of groups, communities and organisations to be heard by advocating on their behalf	3	1	2
M	M1	Assess how environments and practices can be maintained and improved to promote mental health	1	1	4
M	M2	Facilitate collaborative action by stakeholders to improve environments and practices to promote mental health	1	1	3
M	M3	Contribute to developing and maintaining cultures and strategies in which people are respected and valued as individuals (CSC NC10)	4	2	2
M	M4	Develop, maintain and evaluate systems and structures to promote the rights, responsibilities and diversity of people	4	2	2
M	M5	Monitor and review changes in environments and practices to promote mental health	2	0	2
M	M6	Promote employment, training and education opportunities for people with mental health needs	3	1	2

Cont./

Table 3 cont.

			Indirect	**Direct**	**Average focus (1=little to 6=exceeds)**
M	M7	Negotiate with employers and others and support them in offering opportunities to individuals with mental health needs	0	0	0
M	M8	Promote housing opportunities for people with mental health needs	4	2	3
M	M9	Promote leisure opportunities for people with mental health needs	6	0	1
N	N1	Enable workers and agencies to work collaboratively	18	2	1
N	N2	Develop, sustain and evaluate collaborative work with others	26	2	1
N	N3	Develop and sustain effective working relationships with staff in other agencies (Community Justice Unit F403)	29	9	2
N	N4	Work with others to facilitate the transfer of individuals between agencies or services	21	4	2
N	N5	Assist in the transfer of individuals between agencies and services	17	4	1
N	N6	Represent your own agency at other agencies' meetings (Community Justice F408)	8	1	1
N	N7	Lead the development, implementation and improvement of inter-agency services for addressing mental health needs	0	0	0
O	O1	Contribute to raising awareness of health issues (CSC NC7)	2	0	3
O	O2	Co-ordinate awareness raising about mental health issues	2	0	3
O	O3	Project manage action targeted at addressing mental health issues	15	0	1
O	O4	Contribute to the development of the knowledge and practice of others (CSC CU8)	12	4	2
O	O5	Support others in understanding people's mental health needs and how these can be addressed in their work	6	0	2
O	O6	Work with teams and agencies to review progress and performance and identify next steps	18	4	4
O	O7	Support and challenge workers on specific aspects of their practice	19	0	2
O	O8	Support and challenge workers on specific aspects of their practice (Community Justice F309)	0	0	0
O	O9	Promote people's equality and respect for diversity	14	0	2
O	O10	Represent the agency in courts and formal hearings	0	0	0
O	O11	Provide and obtain information at courts and formal hearings	0	0	0

Table 4 (below) shows the professional group the course is aimed at (defined in the National Occupational Standards) by the type of provider. Trusts have responded with the largest number of courses run for mental health practitioners (48), followed by higher education (HE) with 19 courses run for mental health practitioners. HE and Social Services are likely to provide courses broadly across the range, whereas Trusts are much more likely to concentrate on 'all' or 'qualified' practitioners. As can be seen, most courses are for 'qualified' or 'all' practitioners working in mental health. There were none returned from 'team', 'team managers' or 'strategic managers', possibly reflecting the lack of courses available for these work groups.

Table 4: Number of education and training courses run, by mental health employee and type of provider.

	Shared by all (SBA)	All practitioners (AP)	Qualified practitioners (QP)	Nurses/ medical staff (NM)	Team (T)	Advanced /specialist role (ASR)	Team managers (TM)	Strategic managers (SM)
Trust/ WDC (n=48)	3	18	17	3	0	7	0	0
HE (n=19)	2	4	6	4	0	3	0	0
Private (n=1)	0	0	0	1	0	0	0	0
Social Services (n=14)	4	1	3	1	0	5	0	0
Total (n=82)	**9**	**23**	**26**	**9**	**0**	**15**	**0**	**0**

It is possible to further break down the five main employee 'types' and map their courses to the National Occupational Standards. Table 5 shows a corrected table taking into account the employee the course is aimed at and the appropriate National Occupational Standard.

Table 5: Mapping of mental health courses in the South West against National Occupational Standards, taking into account the professional group that the course and standard are aimed at (n=82).

				Total expected	Maps indirectly to the course (at/above appropriate level)	Maps directly to the course (at/above appropriate level)	Average focus (1=little to 6=exceeds)
A	A1	SBA	Develop your own knowledge and practice	82	44/0	30/0	3
A	A2	SBA	Reflect upon and develop own practice using supervision and support systems	82	20/0	11/0	2
A	A3	SBA	Promote the values and principles underpinning best practice	82	26/0	9/0	2
A	A4	SBA	Promote effective communication and relationships	82	34/0	13/0	3
A	A5	SBA	Promote effective communication and relationships with people who are troubled or distressed	82	46/0	18/0	3
A	A6	SBA	Promote effective communication with individuals where there are communication differences	82	41/0	9/0	2
A	A7	SBA	Maintain and manage records and reports	82	14/0	10/0	2
B	B1	QP	Provide advice and information to those who enquire about mental health needs and related services	49	17/5	5/1	2
B	B2	AP	Enable people with mental health needs to access and use services effectively and in ways that promote their rights	72	10/1	5/0	3
B	B3	QP	Contribute to establishing and running mutual support networks	49	4/0	0/0	2
B	B4	AP	Enable individuals to represent their own needs and interests	72	12/5	2/0	2
C	C1	QP	Assess the needs of carers and families of individuals with mental health needs	49	22/4	10/0	3
C	C2	QP	Develop, implement and review programmes of support for carers and families	49	22/5	10/3	3
C	C3	QP	Establish, sustain and disengage from relationships with families of children and young people (YJU B301)	49	16/0	10/3	3
C	C4	QP	Support individuals in developing their parenting skills	49	3/2	0/0	1
C	C5	QP	Visit and support the families of children and young people in their own homes (YJU B303)	49	11/10	1/2	3
C	C6	QP	Empower families, carers and others to support individuals with mental health needs	49	14/1	4/0	2
C	C7	QP	Establish, sustain and disengage from relationships with the families of older people with mental health needs	49	3/0	1/0	2

Cont./

Table 5 cont.

				Total expected	Maps indirectly to the course (at/above appropriate level)	Maps directly to the course (at/above appropriate level)	Average focus (1=little to 6=exceeds)
C	C8	QP	Enable families to address issues with individuals' behaviour	49	22/6	10/1	3
C	C9	QP	Support families in maintaining relationships in their wider social structures and environments	49	8/6	3/2	3
C	C10	QP	Work with families, carers and individuals during time of crisis	49	22/5	2/0	2
D	D1	QP	Identify potential mental health needs and refer individuals to services	49	22/19	10/9	4
D	D2	QP	Recognise indications of substance misuse and refer individuals to specialists	49	19/3	12/3	4
D	D3	T	Assess individuals’ mental health and related needs	15	6/33	8/8	4
D	D4	QP	Work with individuals to identify their needs, assess related risks and the need for intervention	49	20/13	4/2	4
D	D5	QP	Identify the physical health needs of individuals with mental health needs	49	9/7	4/0	3
E	E1		Contribute to the development, provision and review of care programmes	?	26	15	3
E	E2	AP	Contribute to the assessment of individuals’ needs and the planning of packages of care	72	22/0	14/0	3
E	E3	AP	Contribute to the monitoring and review of care packages (CSC SC3)	72	22/0	13/0	3
E	E4	T	Plan and agree service responses which meet individuals’ identified needs and circumstances (CSC SC18)	15	9/21	4/8	3
E	E5	QP	Co-ordinate, monitor and review service responses to meet individuals’ needs and circumstances (CSC SC19)	49	13/13	4/6	3
E	E6	QP	Work with individuals with mental health needs to negotiate and agree plans for addressing those needs	49	10/10	4/4	2
E	E7	AP	Contribute to the planning, implementation and evaluation of therapeutic programmes to enable individuals to manage their behaviour (CSC NC11)	72	24/4	10/1	3
E	E8	QP	Respond to crisis situations	49	19/0	4/0	3
E	E9	AP	Maintain active continuing contact with individuals and work with them to monitor their mental health needs	72	28/1	9/1	3

Cont./

Table 5 cont.

				Total expected	Maps indirectly to the course (at/above appropriate level)	Maps directly to the course (at/above appropriate level)	Average focus (1=little to 6=exceeds)
F	F1	QP	Prepare, implement and evaluate agreed therapeutic group activities (CSC X16)	49	8/0	2/0	1
F	F2	QP	Plan, implement and evaluate therapeutic interventions with people with mental health needs	49	20/2	4/0	2
F	F3	AP	Prepare and provide agreed individual development activities (CSC X2)	72	25/0	3/0	3
F	F4	T	Work as a member of an inter-disciplinary team to provide individualised programmes of care for people with mental health needs	15	10/18	3/3	2
F	F5	AP	Reinforce positive behavioural goals during relationships with individuals	72	15/0	21/0	1
F	F6	NM	Administer and monitor medication for individuals consistent with protocols, standards and legislation (Custodial Healthcare Unit CC049)	24	7/0	3/0	4
F	F7	AP	Support people with mental health needs to improve their physical health and well-being	72	15/0	2/0	1
G	G1	SBA	Establish, sustain and disengage from relationships with clients (CSC SC14)	82	36/0	21/0	2
G	G2	AP	Enable individuals to maintain their domestic and personal resources	72	12/0	0/0	1
G	G3	AP	Enable individuals to administer their financial affairs (CSC Y3)	72	2/0	0/0	0
G	G4	AP	Enable individuals to maintain their personal hygiene and appearance (CSC Z9)	72	0/0	0/0	0
G	G5	AP	Enable individuals with mental health needs to maximise their employment opportunities	72	1/0	0/0	1
G	G6	AP	Enable people with mental health needs to access housing and accommodation	72	6/0	2/0	1
G	G7	AP	Enable people with mental health needs to undertake their own health care	72	9/0	0/0	1
G	G8	AP	Enable people to identify and address their personal spiritual needs	72	2/0	0/0	1
G	G9	AP	Enable people to choose and participate in activities that are meaningful to them	72	9/0	1/0	1
G	G10	AP	Enable individuals and families to address issues that affect mental health and social well-being	72	15/1	2/0	2
G	G11	SBA	Promote the social inclusion of people with mental health needs	82	4/0	1/0	2
G	G12	AP	Represent individuals' interests when they are not able to do so themselves	72	9/0	0/0	2
G	G13	SBA	Promote peoples' rights and encourage them to recognise their responsibilities	82	6/0	0/0	1

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Table 5 cont.

				Total expected	Maps indirectly to the course (at/above appropriate level)	Maps directly to the course (at/above appropriate level)	Average focus (1=little to 6=exceeds)
H	H1	AP	Enable individuals to maintain contacts in potentially isolating situations (CSC W8)	72	2/0	1/0	2
H	H2	AP	Support clients with difficult or potentially difficult relationships (CSC W5)	72	7/0	0/0	1
H	H3	AP	Enable people with mental health needs to explore their behaviour and opportunities for change and develop coping strategies	72	19/0	6/0	3
H	H4	SBA/TM	Support people in relation to personal and social interactions and environmental factors	82	17/0	5/0	2
I	I1	AP	Enable individuals, their family and friends to explore and manage change (CSC NC2)	72	8/0	1/0	1
I	I2	AP	Support individuals experiencing a change in their care requirements and provision (CSC W3)	72	20/1	4/0	1
I	I3	AP	Assist individuals to move from a supportive to a more independent living environment (CSC Y5)	72	5/1	1/0	1
I	I4	AP	Support people who are transferring into new environments	72	6/1	0/0	1
J	J1	SBA	Work with people to identify their needs for safety, support and engagement and how these needs can best be addressed	82	16/0	10/0	2
J	J2	AP	Support individuals when they are distressed (CSC Z8)	72	37/4	26/2	2
J	J3	AP	Enable people who are a risk to themselves and others to develop control	72	26/3	16/0	2
J	J4	SBA	Contribute to the protection of individuals from abuse (based on CSC Z1)	82	11/0	7/0	3
J	J5	SBA	Contribute to the protection of children from abuse (Community Justice Unit E202)	82	2/0	2/0	4
J	J6		Support individuals where abuse has been disclosed (CSC Z18)	?	3/0	3/0	3
J	J7	SBA	Assess the risk of violence to workers (Employment NTO Work-Related Violence Unit W1)	82	10/0	8/0	1
J	J8	TM	Implement policy and procedures to minimise the risk of violence at work	0	0/9	0/0	1
J	J9	SBA	Ensure your actions contribute to a positive and safe working environment	82	25/0	4/0	2
J	J10	SBA	Protect yourself from the risk of violence at work (Employment NTO Work-Related Violence Unit W7)	82	7/0	0/0	1
J	J11	SBA	Respond to work-related violent incidents (Employment NTO Work-Related Violence Unit W8)	82	5/0	0/0	0

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Table 5 cont.

				Total expected	Maps indirectly to the course (at/above appropriate level)	Maps directly to the course (at/above appropriate level)	Average focus (1=little to 6=exceeds)
K	K1	SM	Identify trends and changes in the mental health and mental health needs of a population and the effectiveness of different means of meeting their needs	0	0/15	0/0	1
K	K2	SM	Develop and agree priorities and objectives for meeting the mental health needs of a population	0	0/2	0/0	1
K	K3	SM	Develop, implement and improve strategies to meet the mental health needs of a population	0	0/1	0/0	1
K	K4	SM	Develop, monitor, evaluate and review services for addressing mental health needs	0	0/20	0/9	2
L	L1	SM	Determine the concerns and priorities of communities about mental health and mental health needs	0	0/1	0/0	1
L	L2	SM	Work with groups and communities to develop policies, strategies and services to improve mental health and address mental health needs	0	0/4	0/0	2
L	L3	SM	Enable groups, communities and organisations to address mental health issues	0	0/8	0/0	2
L	L4	SM	Determine the concerns and priorities of individuals and families about mental health and mental health needs	0	0/22	0/9	2
L	L5	SM	Work with individuals and families to develop services to improve their mental health and address their mental health needs	0	0/6	0/0	1
L	L6	SM	Enable the views of groups, communities and organisations to be heard by advocating on their behalf	0	0/3	0/1	2
M	M1	TM	Assess how environments and practices can be maintained and improved to promote mental health	0	0/1	0/1	4
M	M2	TM	Facilitate collaborative action by stakeholders to improve environments and practices to promote mental health	0	0/1	0/1	3
M	M3	SBA	Contribute to developing and maintaining cultures and strategies in which people are respected and valued as individuals (CSC NC10)	82	4/0	2/0	2
M	M4	TM	Develop, maintain and evaluate systems and structures to promote the rights, responsibilities and diversity of people	0	0/4	0/2	2
M	M5	TM	Monitor and review changes in environments and practices to promote mental health	0	0/2	0/0	2
M	M6	TM	Promote employment, training and education opportunities for people with mental health needs	0	0/3	0/1	2

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Table 5 cont.

				Total expected	Maps indirectly to the course (at/above appropriate level)	Maps directly to the course (at/above appropriate level)	Average focus (1=little to 6=exceeds)
M	M7	TM	Negotiate with employers and others and support them in offering opportunities to individuals with mental health needs	0	0/0	0/0	0
M	M8	TM	Promote housing opportunities for people with mental health needs	0	0/4	0/2	3
M	M9	TM	Promote leisure opportunities for people with mental health needs	0	0/6	0/0	1
N	N1	TM	Enable workers and agencies to work collaboratively	0	0/18	0/2	1
N	N2	TM	Develop, sustain and evaluate collaborative work with others	0	0/26	0/2	1
N	N3	QP	Develop and sustain effective working relationships with staff in other agencies (Community Justice Unit F403)	49	19/10	8/1	2
N	N4	TM	Work with others to facilitate the transfer of individuals between agencies or services	0	0/21	0/4	2
N	N5	QP	Assist in the transfer of individuals between agencies and services	49	10/7	2/2	1
N	N6	SBA	Represent your own agency at other agencies' meetings (Community Justice F408)	82	8/0	1/0	1
N	N7	SM	Lead the development, implementation and improvement of inter-agency services for addressing mental health needs	0	0/0	0/0	0
O	O1	QP	Contribute to raising awareness of health issues (CSC NC7)	49	2/0	0/0	3
O	O2	ASP	Co-ordinate awareness raising about mental health issues	15	2/0	0/0	3
O	O3	ASP	Project manage action targeted at addressing mental health issues	15	9/6	0/0	1
O	O4	SBA	Contribute to the development of the knowledge and practice of others (CSC CU8)	82	12/0	4/0	2
O	O5	?	Support others in understanding people's mental health needs and how these can be addressed in their work	?	6	0	2
O	O6	SM	Work with teams and agencies to review progress and performance and identify next steps	0	0/18	0/4	4
O	O7	SM	Support and challenge workers on specific aspects of their practice	0	0/19	0/0	2
O	O8	TM	Support and challenge workers on specific aspects of their practice (Community Justice F309)	0	0/0	0/0	0

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Table 5 cont.

				Total expected	Maps indirectly to the course (at/above appropriate level)	Maps directly to the course (at/above appropriate level)	Average focus (1=little to 6=exceeds)
O	O9	SBA/TM	Promote people's equality and respect for diversity	82	14/0	0/0	2
O	O10	ASP	Represent the agency in courts and formal hearings	15	0/0	0/0	0
					0	0	0

Key to third column representing the group that the standard is for:

SBA = Shared by all working in mental health
AP = All mental health practitioners
QP = Qualified mental health practitioners
NM = Nurses/medical staff
T = Team
ASR = Advanced/specialist role
TM = Team managers
SM = Strategic Managers

The following National Occupational Standards are mapped most appropriately in the courses surveyed:

A1: Develop your own knowledge and practice (SBA) (87.62% of courses that are supposed to map against this standard do so).

J2: Support individuals when they are distressed (AP) (87.5% of courses that are supposed to map against this standard do so).

E4: Plan and agree service responses that meet individuals' identified needs and circumstances (T) (86.67% of courses that are supposed to map against this standard do so).

F4: Work as a member of an inter-disciplinary team to provide individualised programmes of care for people with mental health needs (T) (86.67% of courses that are supposed to map against this standard do so).

A5: Promote effective communication and relationships with people who are troubled or distressed (SBA) (79.01% of courses that are supposed to map against this standard do so).

G1: Establish, sustain and disengage from relationships with clients (SBA) (70.37% of courses that are supposed to map against this standard do so).

D3: Assess individuals' mental health and related needs (T) (65.57% of courses that are supposed to map against this standard do so).

C1: Assess the needs of carers and families of individuals with mental health needs (QP) (65.31% of courses that are supposed to map against this standard do so).

C2: Develop, implement and review programmes of support for carers and families (QP) (65.31% of courses that are supposed to map against this standard do so).

C8: Enable families to address issues with individuals' behaviour (QP) (65.31% of courses that are supposed to map against this standard do so).

In addition to the six standards that have no course mapped against them (G4, M7, N7, O8, O10 and O11 – see Table 3), the following standards have no appropriate courses mapped against them: J8, K1, K2, K3, K4, L1, L2, L3, L4, L5, L6, M1, M2, M4, M5, M6, M7, M8, M9, N1, N2, N4, N7, O6 O7 and O9 (see Table 5).

Some courses map to National Occupational Standards that are for a higher level of employee than the course is aimed at. The following National Occupational Standards have a high number of courses that map to them where the courses are for a lower level of employee and therefore do not need to map against this standard:

D1: Identify potential mental health needs and refer individuals to services (QP) (87.51% of courses not required to map to this standard do so).

J2: Support individuals when they are distressed (AP) (66.67% of courses not required to map to this standard do so).

D3: Assess individuals' mental health and related needs (T) (62.12% of courses not required to map to this standard do so).

E5: Co-ordinate, monitor and review service responses to meet individuals' needs and circumstances (QP) (59.33% of courses not required to map to this standard do so).

E7: Contribute to the planning, implementation and evaluation of therapeutic programmes to enable individuals to manage their behaviour (AP) (55.56% of courses not required to map to this standard do so).

B4: Enable individuals to represent their own needs and interests (AP) (55.56% of courses not required to map to this standard do so).

Table 6 shows the overall average percentage of courses mapped to National Occupational Standards by type of employee. As can be seen, team-based courses map well against team-based occupational standards (79.64%). Other groups map fairly poorly, with only 24.44% of courses for advanced/specialist roles mapping against appropriate occupational standards. On average, the higher the specialised group, the better the course maps against all appropriate occupational standards (as shown in brackets), until it reaches team roles – courses aimed at advanced/specialist roles, team and social care mangers and strategic managers map poorly against all occupational standards.

Table 6: Mapping appropriate National Occupational Standards, by group of employee.

	Number of standards for employee group (number of standards for current and lower groups)	Mean % of National Occupational Standards mapping to courses aimed at this group (% across current and lower groups)
Shared by everyone	21	30.5%
All practitioners	28 (49)	25.15% (27.44%)
Qualified practitioners	23 (72)	39.69% (31.36%)
Nurses/medical Staff	1 (73)	41.67% (31.55%)
Team	3 (76)	79.64% (33.4%)
Advanced/specialist roles	3 (79)	24.44% (33.06%)
Team managers/social care managers	13 (92)	0% (28.39%)
Strategic managers	13 (105)	0% (24.87%)
TOTAL	**105**	**24.87%**

Table 7 shows the mapping, both directly and indirectly, of the courses surveyed to *The Capable Practitioner* document. As with the occupational standards, there is great variation in the amount of mapping. The top 10 areas of capability that map to courses are:

1: Respond to needs of people in an honest, non-judgemental and open manner (54 courses or 65.85%).

12: Knowledge of mental health and mental illness, causation incidence, prevalence, description and impact (43 courses or 52.44%).

5: Respond to the needs of people sensitively (34 courses or 41.46%).

14: Capable of communicating effectively with service users, their carers and families and other members of the team (34 courses or 41.46%).

7: Adhere to local and professionally prescribed codes of ethical conduct and practice (31 courses or 37.48%).

11: Knowledge of the individual in society and the impact of biological, social and psychological processes (30 courses or 36.59%).

31: Capable of leading or participating in the provision of psychological interventions (28 courses or 34.15%).

2. Provide holistic, needs-led services (25 courses or 30.49%).

8: Knowledge of legislation and policy that currently provides framework for modern mental health care (25 courses or 30.49%).

13: Knowledge of the various explanatory models of mental health and underpinning evidence (23 courses or 28.05%).

Excluding the applications (for which not all courses are adapted to map), the bottom ten capabilities that are covered by the least number of courses are as follows:

28: Capable of leading or participating in the safe and effective delivery of electro-convulsive therapy (0 courses or 0%).

34: Capable of providing advice, assistance or training in daily living skills for clients and their carers and families (3 courses or 3.66%).

30: Capable of leading or participating in arrangements to address the physical health needs of service users (5 courses or 6.1%).

27: Capable of facilitating concordance with effective treatment (6 courses or 7.32%).

23: Capable of self-reflection, development and maintenance of skills and knowledge through CPD (6 courses or 7.32%).

26: Capable of leading or participating in the diagnosis, treatment or care of mental and physical illness (7 courses or 8.54%).

22: Capable of sustaining and enhancing personal and/or professional development through the use of support systems (7 courses or 8.54%).

19: Capable of leading or participating effectively in multi-disciplinary, multi-agency team working (8 courses or 9.76%).

15: Capable of listening to service users and maximising opportunities for users, carers and families to be heard (9 courses or 10.98%).

29: Capable of implementing strategies to safely and effectively manage anger, violence and aggression (10 courses or 12.2%).

Table 7: Mapping of mental health courses in the South West against National Occupational Standards (n=82).

		Indirect	Direct	Average focus (1=little to 6=exceeds)
	ETHICAL PRACTICE – Values and attitudes necessary for modern mental health practice			
1	Respond to the needs of people in an honest, non-judgemental and open manner	40	14	3
2	Provide holistic, needs-led services	15	10	2
3	Conduct a legal, ethical and accountable practice	10	6	2
4	Demonstrate a commitment to equal opportunities	12	7	2
5	Respond to the needs of people sensitively	26	8	2
6	Encourage self-determination and freedom of choice	11	9	2
7	Adhere to local and professionally prescribed codes of ethical conduct and practice	21	10	2
	KNOWLEDGE – Policy and legislation			
8	Knowledge of legislation and policy that currently provides framework for modern mental health care	20	5	2
9	Knowledge and mental health law and related legislation	16	6	2
10	Ability to educate service users and carers, communicating appropriate levels of this knowledge	15	5	1
	KNOWLEDGE – Knowledge of mental health and mental health services			
11	Knowledge of the individual in society and the impact of biological, social and psychological processes	23	7	3
12	Knowledge of mental health and mental illness, causation incidence, prevalence, description and impact	35	8	5
13	Knowledge of the various explanatory models of mental health and underpinning evidence	19	4	2
	THE PROCESS OF CARE – Effective communication			
14	Capable of communicating effectively with service users, their carers and families and other members of the team	29	5	3
15	Capable of listening to service users and maximising opportunities for users, carers and families to be heard	8	1	1
16	Capable of educating users and carers about the role, function and limitations of mental health services	12	1	1
	THE PROCESS OF CARE – Effective partnership with users and carers			
17	Capable of developing effective working relationships with service users, families and carers	16	4	2
18	Capable of supporting the development of opportunities for users, carers and families to participate in care	8	3	2

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Table 7 cont.

		Indirect	Direct	Average focus (1=little to 6=exceeds)
	THE PROCESS OF CARE – Effective partnership in teams and with external agencies			
19	Capable of leading or participating effectively in multi-disciplinary, multi-agency team-working	6	2	3
	THE PROCESS OF CARE – Comprehensive assessment			
20	Capable of recognising various mental health problems and undertaking or participating in assessment	10	9	3
	THE PROCESS OF CARE – Care planning, co-ordination and review			
21	Capable of participating in the development and documentation of written care plans	11	10	3
	THE PROCESS OF CARE – Supervision, professional development and lifelong learning			
22	Capable of sustaining and enhancing personal and/or professional development through the use of support systems	6	1	1
23	Capable of self-reflection, development and maintenance of skills and knowledge through CPD	5	1	1
24	Capable of critically appraising contemporary and emerging research and evidence-based practice	8	5	2
	THE PROCESS OF CARE – Clinical and practice leadership			
25	Capable of developing and promoting the evidence-based practice of other team members	6	5	2
	INTERVENTIONS – Medical and physical health care			
26	Capable of leading or participating in the diagnosis, treatment or care of mental and physical illness	5	2	2
27	Capable of facilitating concordance with effective treatment	4	2	2
28	Capable of leading or participating in the safe and effective delivery of electro-convulsive therapy	0	0	0
29	Capable of implementing strategies to safely and effectively manage anger, violence and aggression	8	2	3
30	Capable of leading or participating in arrangements to address the physical health needs of service users	4	1	2
	INTERVENTIONS – Psychological interventions			
31	Capable of leading or participating in the provision of psychological interventions	18	10	3
	INTERVENTIONS – Social and practical			
32	Capable of identifying and collaborating with local community resources	9	3	1
33	Capable of creating, developing or maintaining personal and social networks of service users, carers and families	15	2	1

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Table 7 cont.

		Indirect	Direct	Average focus (1=little to 6=exceeds)
34	Capable of providing advice, assistance or training in daily living skills, for clients and their carers and families	3	0	1
	INTERVENTIONS – Mental health promotion			
35	Capable of understanding and appropriately applying mental health promotion	11	6	2
36	Capable of increasing others' understanding of the wider implications of mental health promotion through practice	11	1	2
	APPLICATIONS – Primary care			
37	Ability to assess the prevalence of mental health problems and needs amongst the population	6	0	2
38	Ability to work in partnership with other agencies to secure wider public health of local population	2	0	1
39	Ability to screen, diagnose and assess people experiencing mental health problems	2	0	1
40	Ability to assess health and social care needs and provide care and treatment to meet mild or moderate needs	8	1	2
41	Ability to refer to and collaborate with the specialist mental health services	11	4	3
	APPLICATIONS – Community-based care co-ordination (CMHTs)			
42	Ensuring seamless delivery of care	8	2	3
	APPLICATIONS – Crisis resolution and early intervention			
43	The ability to recognise the health and social factors that precipitate acute relapse	13	3	3
44	The ability to intervene and resolve crises for individuals in hospital or community settings	19	3	3
45	The ability to identify risk categories and specific risk factors as well as recognise individual strengths	14	2	2
46	The ability to process knowledge into a comprehensive assessment tailored to individual needs	10	1	3
47	The ability to implement a range of risk management strategies	11	2	3
48	The ability to evaluate assessment information	4	0	2
49	The ability to intervene and provide effective strategies to reduce suicide	15	4	3
	APPLICATIONS – Acute inpatient care			
50	The ability to lead or participate in complex care planning processes	2	0	1
51	The ability to carry out a comprehensive assessment of physical health needs	3	0	2

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Table 7 cont.

		Indirect	Direct	Average focus (1=little to 6=exceeds)
52	The ability to safely and effectively administer medications	1	0	1
53	The ability to implement strategies that facilitate adherence to treatment	1	0	1
54	The ability to implement strategies to safely and effectively manage anger, violence and aggression	2	0	1
55	The ability to process knowledge into a comprehensive assessment tailored to individuals' needs	3	0	3
56	The ability to manage the necessary communication required for transfer of service users or discharge from hospital	4	0	1
57	The ability to arrange or provide a range of therapeutic, social, occupational and leisure activities	3	0	1
	APPLICATION – Assertive outreach			
58	Contribute in teams to the care and treatment of people with the most complex needs	13	2	3
	APPLICATION – Continuing care, rehabilitation, day and residential services and vocational programmes			
59	The ability to sustain a respectful, consistent and reliable therapeutic relationship with service users	12	5	2
60	A commitment to providing interventions that promote independence and enhance the autonomy of service users	6	4	2
61	The ability to maximise user strengths and interests and increase their participation in community activities	2	1	2
62	A commitment to support and facilitate service user strengths and interests and increase participation in community	3	0	1
	APPLICATIONS – Services for people with complex and special needs: forensics, dual diagnosis and personality disorders			
63	The ability to apply knowledge of the effects of mental illness as it contributes to psychopathology or criminal behaviour	8	3	3
64	The ability to apply knowledge of the mental health and legal system	9	3	3
65	A commitment to the rehabilitation of people with forensic mental health needs	4	1	2
66	The ability to adapt specific techniques such as boundary setting and escorting to manage risk and resolve conflict	6	1	1
67	The need to expand knowledge and expertise in medical and psychological interventions	5	5	3

Discussion

Sample

The response from providers and commissioners of mental health education and training was disappointing but not surprising. The total of 176 providers and commissioners contacted represents a large number of the local providers and commissioners of education and training in the field. Responses from only 45 of these is around 24.57%, which may seem low, but is to be expected for a questionnaire of this type (see Robson, 2002). The response rate from the initial mapping study (Fulbrook et al., 2001) was 56%. However, due to the aims and objectives of this project, this questionnaire was more in-depth and required a longer time for completion, so a lower response rate is unsurprising.

- Providers and commissioners were sceptical about the outcomes of the project.

There was an unwillingness for many providers to give information on the courses they provide for fear of other places copying or reproducing the course. Also, there was a fear that funding or commissioning bodies may terminate the course due to it being considered ‘unnecessary’ or of ‘poor quality’. Many places were ‘proud’ of their courses and felt the project may highlight negative aspects that do not reflect the hard work put in. This is interesting given that most courses invite external feedback on course processes through external examination or in the case of HE, the QAA process. This has implications for how providers and commissioners view research that needs to be addressed. Perhaps future projects addressing education and training should work closely with providers, perhaps using co-operative enquiry methods or action research frameworks whereby providers and commissioners become co-researchers and are part of altering and changing courses. Despite the qualitative approach that this project adopted, the nature of the data collection still seemed as if the research was being done to them. On reflection, this is probably due to the lack of resources to cover such a large geographical area. It would have been impossible to work with 176 providers and commissioners on a co-operative enquiry or action piece of work with the current level of resources.

- Providers and commissioners of education and training did not have time to complete the piece of research.

Again, perhaps they saw the research as having little added value to their job role. Working more closely with such organisations could have overcome this; so again adopting a co-operative enquiry or action research framework would have helped overcome this. Also, there is a need for education providers and commissioners to look beyond their current workload and reflect on the courses they are responsible for. This research project would have enabled them to do that, providing a benchmark for their reflection. It was therefore disappointing that more did not reply. Maybe this was because there is already a wealth of bureaucratic policy and quality initiatives to which providers and commissioners must work to help in reflective course development. Nevertheless, it is worrying that some major providers and commissioners may well not be taking opportunities to reflect on the courses they are responsible for; not seeing this as part of best practice in course development is problematic.

- The tools used for gathering information were difficult to use.

Appendix A shows the questionnaire template. Although the template is not the easiest to complete, certain measures were introduced to aid the process. For example, if details were previously held by IHCS at Bournemouth University from the original mapping project carried out in 2001, these were re-sent so that details could simply be returned with amendments rather than requiring each establishment to fill out the form again. In addition, different methods were used to distribute and collect the questionnaires. For example, it was possible for respondents to fill in an electronic version, return via stamped addressed envelope or give details over the telephone and the form filled in by the researcher. Future research could consider having a questionnaire that can be completed on a website for ease of filling in. This would also aid respondents in updating their information.

Higher education and further education establishments were most likely to respond, perhaps because they value this kind of research, are less sceptical, or have more resources and hence more time to reply than Trusts, voluntary, private and Social Service sources. Police or probation did not respond at all.

In addition, higher education organisations were more likely to provide a full level of response. This was perhaps because they realise the value of research since they are possibly actively engaged in it themselves.

However, it could be that it was easier for the researcher to target other higher education establishments because the research and the researchers were based in such an establishment.

The difference in responses from different organisations could suggest that reply was based on providers and commissioners who have courses well-grounded in policy and procedure. Both higher education and further education establishments have to follow rigorous quality procedures, meaning close scrutiny of courses takes place. Because of this, such organisations may be more willing to disseminate information for a project. Training carried out in other types of organisation is perhaps not up to the same levels of scrutiny and therefore providers and commissioners may not have the same level of confidence in the courses. This may suggest that the courses studied could have come from a skewed response. Further research could investigate the level of review a course undertakes and the levels of confidence providers and commissioners have with their course. Such results could then be studied along with whether confidence grows among stakeholders involved in courses that map well to *The Capable Practitioner, The Ten Essential Shared Capabilities* or the National Occupational Standards

Further response from only 17 respondents was also a little disappointing, but given the resources on the project, the generation of 82 courses created plenty of work in the mapping stages of the project. Everything was done to try and raise the number of full responses by a variety of means including documents, telephone interviews and face-to-face interviews. Sometimes a variety of these methods was used until data saturation occurred. Although the 82 courses are not necessarily representative of those found in the South West, which must be taken into account when interpreting the results of this project, they have very different backgrounds and are a good reflection of the breadth of courses available to mental health practitioners in the region (see Appendix B).

National Occupational Standards

For almost all the education and training providers, the analysis carried out during this project was the first time the courses had been mapped to either *The Capable Practitioner* or the National Occupational Standards. Commissioners and providers of education and training, on the whole, are not yet using these tools to map the courses they are responsible for. However, it is noted that newly developed courses were being mapped to *The Capable Practitioner* and the National Occupational Standards.

The National Occupational Standards for Mental Health (Skills For Health, 2004) were analysed. Some mistakes were found in the documentation that caused slight difficulty in analysis. For example, different versions of the standards vary on whether standard O11 (provide and obtain information at courts and formal hearings) is included. Also, standards J6 (support individuals where abuse has been disclosed) and O5 (support others in understanding people's mental health needs and how these can be addressed in their work) have not been assigned to a professional grouping that should adhere to that particular standard. These standards were therefore omitted from the analysis. In addition, standards H4 (support people in relation to personal and social interactions and environmental factors) and O9 (promote people's equality and respect for diversity) are placed for both 'Shared by All' and also specifically for 'Team Managers'. For ease of analysis, in both cases it was taken that they were supposed to be 'Shared by All'.

The WAT report (DoH, 2001) mentions the need for service user education and training. The National Occupational Standards for Mental Health, despite being a definitive guide to mental health practice, ignores this. It has standards that are to be 'Shared by All', which is a 'lower' level in their hierarchy than 'All Practitioners'. This presumably means any professional coming into contact with mental health issues. It must be established exactly who this level of standard is for because it could be that they reflect standards for all people who work in mental health and could possibly extend to family, carers and eventually service users, none of whom are mentioned in the National Occupational Standards. These groups need to be reconsidered, especially as courses are now being developed and run for them.

The 82 courses were mapped against National Occupational Standards for Mental Health (Skills For Health, 2004). Courses mapped fairly well against a number of standards, although there were some notable absences. Nearly all courses developed practitioners' knowledge and practice, which maps to standard A1. Similarly, many courses map to J2 (to support individuals when they are distressed) and A5 (to promote effective communication and relationships with people who are troubled and distressed).

Data was collected on who the course was aimed at so this could be mapped to appropriate needs. Most courses were aimed at qualified practitioners or all practitioners. No courses were aimed at team, team manager or strategic manager level specifically. Again, it is not possible to assess whether it represents a dearth of education and training available for these professionals or whether providers of such education

and training did not respond. Since there seems no reason for the latter, it could be assumed that there is not much education and training for these groups. This would agree with previous research (see Table 1 and DoH, 2001).

Nearly three-quarters of all the courses map to D1 (identify potential mental health needs and refer individuals to services). However, on closer inspection, most of these courses are for those who, according to the National Occupational Standards, do not need to know this area. It must be considered, therefore, whether the National Occupational Standards need revising with regard to this standard or whether the courses need revising. Similar results are found with D3 (assess individuals' mental health and related needs) and E5 (co-ordinate, monitor and review service responses to meet individuals' needs and circumstances). J2 (support individuals needs) is mapped against many appropriate courses but also many inappropriate courses, and therefore also needs addressing as to which professional group should have such a standard.

There were six National Occupational Standards that courses did not map to at all, mainly because they were for professional groups not covered in the courses in this analysis. However, one standard, G4 (enables individuals to maintain their personal hygiene and appearance) not being covered by any course is more significant because it is a standard for all practitioners and so should have been covered by 72 courses. This situation should be addressed. Similar standards in unit G were also poorly mapped (except G1). Perhaps new courses should be developed to address unit G, which supports individuals in managing their lives throughout the South West.

Other National Occupational Standards not well covered by the appropriate courses include:

B3: Establishing and running mutual support networks.

C4: Support individuals in developing their parenting skills.

C7: Enable families to address issues with individuals' behaviour.

H1: Enable individuals to maintain contacts in potentially isolating situations.

H2: Support clients with difficult or potentially difficult relationships.

I3: Assist individuals to move from supportive to a more independent living environment.

I4: Support people who are transferring to new environments.

J5: Contribute to the protection of children from abuse.

J10: Protect yourself from risk of violence at work.

J11: Respond to work-related violence.

M3: Contribute to developing and maintaining cultures and strategies in which people are respected and valued as individuals.

O1: Contribute to raising awareness of health issues.

The above standards could be grouped into categories and addressed as follows:

- B3, M3 and O1 could all be described as mental health promotion-based standards (previous research suggests a lack of such courses – see DoH, 2001).
- C4 and C7 could all be described as family issues and could be run as a course.
- H1, H2, I3, I4 and J5 all could be addressed by complex issues and change management-based education and training.
- J10 and J11 deal with assessing and managing risk at work and could be covered by a course addressing such issues.

Relating this to other research, mental health promotion was mentioned in the WAT report (DoH, 2001) as an area that is not well covered by courses. Family issues and managing risk at work are both new areas to be identified as gaps. Previous research has not suggested such a gap was evident. More research should perhaps concentrate on courses in these particular fields to further establish the extent of the gap. Complex issues and change is also mapped as a gap to some extent by *The Capable Practitioner,* which suggests there is a gap in education and training in this area in the South West.

Capable Practitioner

The courses were also mapped against *The Capable Practitioner* document. Nearly two-thirds of courses mapped to capability 1 (to be able to respond to the needs of people in an honest, non-judgemental and open manner). Nine of the top ten capabilities mapped to courses from the first two areas of capability – ethical practice and knowledge. This is to be expected because the document was developed in such a way that each section builds on the last, displaying the capabilities for a less generic and more specialist professional.

The capabilities that map poorly to the courses on offer fall into four main areas:

- Support individuals to manage their own lives (capabilities 15, 27, 28, 29 and 34);
- Physical and mental health aspects of care (capabilities 26 and 30);
- Education and continuing professional development for practitioners (capabilities 22 and 23);

- Effective multi-agency and interprofessional partnerships (capability 19).

There were also few courses covering acute inpatient care and complex needs in the applications section of the capable practitioner.

Mapping these gaps to previous research literature is interesting:

- Support individuals to manage their own lives is also a gap identified by the National Occupational Standards, so clearly there is a gap in courses in this area in the South West.
- Physical and mental health aspects were noted in the previous IHCS studied carried out in 2001 (Fulbrook et al., 2001).
- Effective multi-agency and interprofessional partnerships is also a nationwide gap, noted in the WAT report (DoH, 2001). Therefore, a gap identified here in the South West reflects a national problem.
- Acute inpatient care and complex needs is identified similarly in complex issues and management of change identified through mapping courses to the National Occupational Standards, so can be identified as a gap area.

Closed Gaps in the South West

Some areas identified in previous research have not emerged as gaps in this research. The findings of the previous study (Fulbrook et al., 2001) suggest that there was a lack of education and training in policy and legislation education for service users and carers, no education and training in monitoring of standards, and no education and training in development and documentation of care plans. This study has not identified such areas as problematic, but new programmes may since have been developed and old courses re-vamped to cover such gaps. Both *The Capable Practitioner* and the National Occupational Standards should have highlighted such gaps if they were evident. The WAT report (DoH, 2001) identified a dearth of education and training in learning disabilities, social and communication skills, assertive outreach and legislation, for which this project failed to find a similar gap. Many of these areas were not covered by the courses studied in this research to a great depth. Moreover, many courses merely touched on them. However, they still failed to appear as gaps.

Recommendations

Further research

Recommendation 1:

To carry out an in-depth case study using a co-operative enquiry approach and/or action research to study the purchasing, commissioning and provision of education and training focusing on perhaps one or two local areas or Trusts.

Recommendation 2:

To study in further depth the courses that map to standards not appropriate for the level of practitioner, according to National Occupational Standards. This will enable a study to address whether the courses need to change or whether standards need to be adapted.

Recommendation 3:

To carry out research into evaluation of education and training. Mapping highlights where gaps may be evident at quite a superficial level. Proper evaluation would highlight where gaps were in quality courses. Evaluation data will need to be collected in a variety of ways including observing courses, documentation and evidence of training or education transfer into practice. To this end, it would probably be beneficial for an in-depth case study approach using a co-operative enquiry method or action research framework to be adopted. Such a project could therefore form part of the research mentioned in Recommendation 1.

Recommendation 4:

To research the link between confidence in commissioning, providing and delivering a course and the quality framework used to develop such a course. This could then link confidence in commissioning, providing and delivering a course that has been mapped against National Occupational Standards or *The Capable Practitioner*.

Recommendation 5:

The recently developed National Continuous Quality Improvement Tool (Brooker et al., 2003) highlights the importance of real service user involvement in the development, delivery and evaluation of mental health education and training. A future research project could investigate the extent to which service user involvement works in education and training and the usefulness this has on the quality of such courses. It is proposed that service users should be involved in a research project charting their involvement (and non-involvement through addressing barriers to involvement) in education and training in the South West. Interviews, focus groups and questionnaires with service users could be used to gain

an in-depth analysis of involvement and results that could be generalised to the area.

Further projects

Recommendation 6:

To provide a website for such a project. This could provide:

- Information about the project;
- A searchable database of courses by content, level, geographical area, etc;
- The ability for commissioners and providers of education and training to update/complete information online;
- Contact details for providers and commissioners to enable contact between them;
- Examples of good practice.

The database could be used for students and employees looking for a certain education or training course and could be part of continual professional development. It could be used by providers to develop new courses in areas not covered in the locality, and has the potential for commissioners of education and training to commission new courses not covered. It could also be the basis for sharing best practice between similar courses delivered. For such a database to 'go live', permission would have to be sought from the providers of such courses. The database would also have to be continually updated. Taking this into account, and the fact that not all courses may be covered by this project, it would be useful for the database to be completed by providers themselves, perhaps on-line, thus ensuring updated information, consent and a wider sample of providers. This could link in with or draw on work carried out by the Mental Health in Higher Education (MHHE) (http://www.mhhe.ltsn.ac.uk) project and go further to develop conferences, workshops and seminars. It could also link into initiatives of university and Trust collaboration, such as Bournemouth University's Academic Centres in Practice. It may be possible to have different levels of access based on differing levels of membership. A pilot study could look into the needs and scope of such a database.

Strategic Health Authority and Workforce Development Agencies

Recommendation 7:

To help commissioners and providers of education and training realise that the quality of their work should involve reflection on their courses, and so involvement with research projects such as this, which aid benchmarking and reflection, are important to quality development and delivery of courses.

Course development in Trusts

Recommendation 8:
To ensure that Trusts provide education and training for a variety of levels of practitioner across all professional disciplines.

Further development of National Occupational Standards

Recommendation 9:
Further work is needed to refine the National Occupational Standards to the differing job roles, organisations and sectors within the mental health arena. The guidelines set out by NIMHE (2003) are being used by many commissioners as a definitive guide against which to map standards and it is unclear as to whether these guidelines have any evidence base.

Recommendation 10:
National Occupational Standards should be used in conjunction with workers in the mental health domain. However, since mental health, by its own definition, spans a wide context, it is unclear as to when the National Occupational Standards apply or do not apply. For example, it needs to be addressed whether to have standards for courses aimed at service users, carers and families of carers, as they are no less engaged with mental health than mental health practitioners are.

Reducing gaps

Recommendation 11:
Courses must be developed for teams, team managers and strategic managers with regard to mental health. This is a nationwide issue (see DoH, 2001) as well as a South-West regional one.

Recommendation 12:
Courses in the South West must be developed in the following areas:

- Supporting individuals in managing their lives;
- Mental health promotion;
- Family issues and mental health;
- Complex issues and management of change (including acute inpatient workers);
- Assessing and managing risk at work;
- Physical and mental health relationships;
- Supporting clinical supervision, enabling professional development and developing research skills;
- Interdisciplinary and multi-agency working in mental health.

The way forward

It is suggested that the next stage of work is to develop a test of these recommendations through use of a Delphi technique involving stakeholders in mental health education and training in the South West. This technique would highlight what recommendations are feasible and

desirable and outline barriers and costs for following some of the methods. A resulting plan and matrix could then be developed to map the way forward for commissioning and providing quality, timely education and training for mental health practitioners in the South West.

Conclusion

Overall, the study has identified a reflection of some of the provision and commissioning of relevant training for mental health practitioners of all disciplines in the South West region of England. It has also critically analysed a selection of these, which has shown that training is lacking for professionals based at team, team manager and strategic manager levels. In addition, education and training are lacking in the following key areas for all practitioners:

- Supporting individuals in managing their lives;
- Mental health promotion;
- Family issues and mental health;
- Complex issues and management of change (including acute inpatient workers);
- Assessing and managing risk at work;
- Physical and mental health relationships;
- Supporting clinical supervision, enabling professional development and developing research skills;
- Interdisciplinary and multi-agency working in mental health.

Accordingly, a number of recommendations have been made and it is suggested that a feasibility project is carried out with key stakeholders to identify the procedure for taking the recommendations forward.

Although the project had a number of limitations, it has nonetheless been a valuable exercise and is the first in the country to map course content to National Occupational Standards, placing the National Institute of Mental Health for England's South West office at the forefront of new initiatives. Such mapping exercises should continue as new documents are developed; for example, NIMHE are developing a 'Ten Essential Shared Capabilities Framework'. Such research is vital for establishing standards and frameworks such as these and is vital to providers and commissioners in benchmarking their courses and assessing for relevance and quality.

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Appendix A

Questionnaire

1. Please could you complete the following table, highlighting any changes that have been made to the education and training provided in the space below.

	Name of education provider	Ref	Name of education and training course	Number of taught days on course	Type of course	Main group course is aimed at	Level of course	How often course runs	Approx. average no. of people attend
Details you provided us with March 2001	Dept of Social & Housing Services	356a	Groupwork Skills and Dementia	3.0	Stand alone	Social workers	Skills/knowledge for health and social care assistants	Twice a year	16
Please indicate any changes to the above course									
Details you provided us with March 2001	Dept of Social & Housing Services	356b	Mental Health Specialist: Older People	2.0	Stand alone	Social workers	Advanced/ specialist staff	Once a year	16
Please indicate any changes to the above course									
Details you provided us with March 2001	Dept of Social & Housing Services	356c	Mental Health Awareness	2.0	Stand alone	Social workers	Skills/knowledge for health and social care assistants	Four or more times a year	16

Please indicate any changes to the above course									
Details you provided us with March 2001	Social & Housing Plymouth City	356d	Mental Health Awareness - Older People	2.0	Stand alone	Multi-disciplinary	Skills/knowledge for health and social care assistants	Twice a year	16
Please indicate any changes to the above course									
Details you provided us with March 2001	Social & Housing Plymouth City	356e	Carers Awareness Training	1.0	Stand alone	Multi-disciplinary	Continual professional development	Four or more times a year	14
Please indicate any changes to the above course									

2. Please complete the following table for any education or training that you offer that may have relevance to mental health practitioners or workers and has not been included in Question 1 (continue on a separate sheet if necessary).

Name of education provider	**Name of education and training course**	**Number of taught days on course**	**Type of course (i.e. stand alone, part of a broader course or a module within a course)**	**Main group of workers the course is aimed at**	**Level of course**	**How often course runs**	**Approx. average no. of people attend**	**Basic content of course**

3. Please indicate whether you would be interested in taking part in any of the following aspects of the research project

Area of research	***Interested in taking part (please circle)***
Taking part in focus groups	Yes / No
Filling in further questionnaires	Yes / No
Being involved in an interview	Yes / No
Supplying further course information	Yes / No
Having your courses observed by a researcher	Yes / No
Obtaining results of this research project	Yes / No
Steering or advising the research project	Yes / No

4. Do you think that a website with details of all education and training provided for mental health practitioners and workers would be a useful resource? (Please circle) Yes / No Please explain your answer further:

5. Please feel free to add any other comments about education or training for mental health practitioners or workers in the South West region of the UK.

Thanks for your time and please return the form to: Charles Musselwhite, Researcher, Institute of Health and Community Studies, Bournemouth University, R111, Royal London House, Christchurch Road, Bournemouth, Dorset BH1 3LT.

Appendix B

List of courses

Name of Course (yellow = Trusts; green = Higher Education; pink = private; red = Social Services)	**Professional group aimed at**
Family interventions in psychosis	Shared by everyone
Working with families and systems	Qualified practitioners
CBT principles	Qualified practitioners
Behavioural principles	Qualified practitioners
EAB A12 Cognitive behaviour therapy	Shared by everyone
Collaborative community mental health care	Nurses/medical
Working with people experiencing severe enduring mental illness	Nurses/medical
Medication management	Qualified practitioners
Psychosocial interventions	Qualified practitioners
Mental health awareness	Nurses/medical
Ethical and legal principles	Nurses/medical
EN conversion	Nurses/medical
Teaching skills: Staff and consultants grades	Advanced/specialist
Personal development skills for specialist registrars	Advanced/specialist
Critical appraisal and research methods	Advanced/specialist
Effective leadership and team working	Advanced/specialist
Appraisal and supervision day	Advanced/specialist
Litigation, courts and enquiries	Advanced/specialist
Practical introduction to team leadership	Advanced/specialist
Certificate in professional studies – mental health in primary care	Nurses/medical
Assessment and management of personality disorder	Advanced/specialist
Suicide prevention	Shared by everyone
Certificate in community mental health care	Nurses/medical
Working with families on the interface childcare/mental health	Advanced/specialist
Vulnerable adults – mental health	Advanced/specialist
Issues – working with parental mental ill health	Qualified practitioners
Dementia awareness	Qualified practitioners
Approved social worker's updates	Advanced/specialist
ASW course	Advanced/specialist
Integrated care programme approach	All practitioners
Risk assessment and management	Shared by everyone
Mental health act and code of practice training	Shared by everyone
Race, equality and customer care	Shared by everyone
Self advocacy and user involvement	Shared by everyone

Awareness of psychosocial interventions – in-patient care	Qualified practitioner
Mental health in primary care	All practitioners
Certificate in professional studies – child and adolescent mental health services	Qualified practitioner
Integrated approaches to serious mental illness	Qualified practitioner
Diploma in mental health studies	All practitioners
MRCPsych Part 1	Advanced/specialist
MRCPsych Part 2	Advanced/specialist
Critical appraisal for psychiatrists	Advanced/specialist
Risk assessment and management in clinical mental health	All practitioners
Clinical risk management in mental health	All practitioners
Introduction to ICPA	All practitioners
Care management and planning	All practitioners
Mental Health Act updates	All practitioners
Carers education	Qualified practitioners
CBT introduction	Qualified practitioners
CBT + depression	Qualified practitioners
CBT + anxiety	Qualified practitioners
Introduction to motivational intervening	Nurses/medical
Introduction to medication management	Nurses/medical
Dual diagnosis	Qualified practitioners
HONOS	Qualified practitioners
CBT in psychosis	Qualified practitioners
Certificate in mental health	All practitioners
BSc Psychosocial interventions	Qualified practitioners
MA Psychotherapy and counselling	All practitioners
MSc Inter-professional mental health	All practitioners
Psychosocial care	All practitioners
Mental health aware	Qualified practitioners
Introduction of care pathways	All practitioners
Alcohol awareness	All practitioners
Dementia/Alzheimer's awareness	All practitioners
Depression	All practitioners
Drug awareness	All practitioners
Dual diagnosis workshop 1	Qualified practitioners
Eating disorders in adults and young people	All practitioners
Enhanced therapeutic skills for in-patient mental health practitioners	Qualified practitioners
Forensic education and training – rolling programme	Qualified practitioners
Mental Health Act and code of practice training	Shared by everyone
Motivational interviewing skills course – dual diagnosis	All practitioners
Motivational interviewing update skills – dual diagnosis	All practitioners

Psychosis – the cognitive behavioural approach	Qualified practitioners
Psychosis – dealing with delusions and hallucinations	Qualified practitioners
Certificate in community mental health	All practitioners
Mental health needs of the older person	All practitioners
Introduction to mental health	All practitioners
Mental health awareness for prison officers	Shared by everyone
Rehabilitation, assertive outreach and early intervention	All practitioners
Using care pathways and planning	Qualified practitioners