Workforce planning and education: Mapping competencies, skills and standards in mental health

Charles B.A. Musselwhite *, Dawn Freshwater

Institute of Health and Community Studies, Bournemouth University, R111, Royal London House, Christchurch Road, Bournemouth, Dorset BH1 3LT, United Kingdom

Accepted 24 October 2005

Summary  This paper aims to identify and critically analyse the provision and commissioning of relevant training for multidisciplinary mental health practitioners in the South West region of England. Data were collected from 45 education and training providers across the region. A total of 132 courses were examined through analysis of a questionnaire and a further 82 courses were studied in more depth through interviews and focus groups, alongside a textual analysis of course documents. Data generated from the analyses were mapped against the competencies and skills outlined in The Capable Practitioner [SCMH, 2001. The Capable Practitioner, Sainsbury Centre for Mental Health, London.] document and National Occupational Standards for Mental Health [Skills for Health, 2004. National Occupational Standards for Mental Health. Available from: <http://195.10.235.25/standards_database/index.htm> (last accessed 17.11.04)]. The findings confirmed that significant gaps exist in training and education. While some aspects of The Capable Practitioner and National Occupational Standards for Mental Health are covered well by courses provided for mental health practitioners in the region, other aspects are missed completely. Recommendations are made for further research, with the suggestion of using an action research and co-operative enquiry method to identify with participants if courses should be developed to cover these areas or if the standards themselves should be adapted. Reflections on the methodological framework and subsequent limitations of the study are outlined.

© 2005 Elsevier Ltd. All rights reserved.

KEYWORDS Workforce; Standards; Skills; Mental health training and education

Introduction  In the UK over the past 30 years, there has been a shift away from psychiatric hospitalisation towards
a community-based provision of mental health services (DoH, 1999). 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, 1999; SCMH, 2001). This, coupled with an increasing emphasis on evidence-based interventions and workforce planning and development, results in the need for an overarching framework to address the skills and knowledge of this diverse workforce.

The purpose of this study was to map current courses provided in the South West region of the United Kingdom (UK) for mental health practitioners, against two documents focusing on workforce planning in the UK, namely The Capable Practitioner (SCMH, 2001) and National Occupational Standards for Mental Health (Skills for Health, 2004).

The capable practitioner

The Workforce Action Team (WAT), set-up by UK Government ministers to consider the implications of the National Service Framework (NSF) (DoH, 1999), 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 document aims to define what is required to deliver effective mental health care rather than focus on a specific profession (SCMH, 2001).

Although The Capable Practitioner is a useful document to begin charting the capabilities required by a workforce and to further develop occupational standards, the document can be criticised in a number of areas. For example, there are various definitions given to 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. However, it is important to have coherent and consistent definitions of these terms because different disciplines use them differently and distinctly; for example, values are seen by some as the affective component of attitudes (Fishbein and Ajzen, 1975; Eagley and Chaiken, 1993). Importantly, there is no definition of mental health staff or mental health itself given in The Capable Practitioner document, making it difficult to identify the conceptual terms of reference, which of course continue to be debated and are contentious (Freshwater, 2003).

The Capable Practitioner framework distinguishes itself from 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' (SCMH, 2001, p. 10), 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 for a capable practitioner; rather that an individual can show a commitment, which is a performance outcome. Some confusion arises between competency frameworks, occupational standards and capability documents, all of which, to a certain extent, seem to address outcomes and performance.

National Occupational Standards for Mental Health

National Occupational Standards were 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, p. 3). As NIMHE (2003, p. 5) points out, they 'provide a systematic approach to establish good practice supported by a clear framework of underpinning knowledge, standards and expected outcomes', which are applicable to the mental health workforce as a whole and are not simply clinical standards.

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, p. 16). A closer examination, however, suggests that some key elements of therapeutic relationships and indeed interpersonal communications are missing as a result of adhering to a reliable, objective and consistent framework. These aspects have been 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). However, by ignoring such areas, the resulting occupational standards feel somewhat incomplete.
Critique of previous mapping research

The current study builds on previous research conducted to address training and education in the South West of England by Fulbrook et al. (2001) where providers of education and training in the South West were requested to detail education and training made available for mental health practitioners. This was subsequently mapped against The Capable Practitioner (SCMH, 2001). The results of the research suggest that gaps in education were found in developing and documenting care plans, monitoring standards, assessing physical and mental health needs, collaborating with community and multi-agency working, principles and practice of health promotion, and educating service users about policy and legislation. These results were obtained through questionnaires completed by training providers, who mapped their own courses to capabilities. The findings of the previous study have several limitations; for example, the depth that courses map against the criteria cannot be assessed, there is no validity check that capabilities really were covered in the course and there could be differences in interpretation between respondents with regard to definition of the capability. It must also be remembered that there was a self-selected return, meaning that those who wished to demonstrate how well their course matched the capability framework were more likely to return the questionnaire, this was also an interesting feature of the current data set.

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, Northern and Yorkshire (Readhead and Briel, 2001), Eastern, West Midlands, London, South East and Trent regions (DoH, 2001).

DoH (2001) noted that practitioners showed confusion over content and type of education and training and it was suggested that providers should map their courses directly to National Service Framework standards (DoH, 1999) and The Capable Practitioner (SCMH, 2001) to achieve better and clearer labelling of course content. At the time, the National Occupational Standards for Mental Health had not been developed, but it is clear that this document should also aid this process. In addition, it was found that Continual Professional Development (CPD) is not held in similar esteem across all professional groups. In particular, mental health training for those working in primary care was not always evident. Finally, the DoH (2001) report concluded that there is a need for more mental health training and education on underpinning issues such as deafness, learning disabilities, cultural issues and health promotion, and that undergraduate training focuses too much on academic achievement and not enough on practical skills such as social and communication skills.

The report also discusses the need for future research to study the quality of an in-depth selection of education and training courses and include more response from primary care, prisons, criminal justice system and housing and address both accredited and non-accredited training (DoH, 2001). Accordingly, the current study conducted a multi-method process analysis of mental health courses mapped to The Capable Practitioner (SCMH, 2001) and National Occupational Standards for Mental Health (Skills for Health, 2004).

Methodology

Inclusion

The aim of the study was far reaching and offered a seemingly endless scope for inclusion. Thus, an initial workshop was set-up at key stakeholders to address some of the main issues, with the purpose of delineating the boundaries around the project. Two key points were focused on:

(i) The Contextual Boundary: Education and training covers a wide range of possible areas that could be studied. For the purpose of this study, it was decided that non-accredited education and training would be included, but that it would have to be in the form of a ‘course’, rather than a stand-alone workshop, conference or seminar, and as such must include learning objectives.

(ii) The Geographical Boundary: It was decided that the geographical scope of the project was the area 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 project adopted the following procedure:

(i) Revisit data: The database from the original study (Fulbrook et al., 2001) was updated by
networking with local stakeholders, with
details from 45 new contacts, which resulted
in 176 providers of education and training in
the South West being contacted.

(ii) Questionnaires administered to providers: A
questionnaire was sent to each provider asking
them to give or update their 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; and a brief description of basic
content of course. In addition, respondents
were asked to provide extra literature for
the courses that they provide.

(iii) Textual analysis of literature: The additional
information supplied included student feedback,
course guides, student handbooks, class
handouts and quality and evaluative docu-
ments, and a documentary analysis using a
thematic approach to identify categories
and themes was undertaken.

(iv) Focus groups and interviews with providers:
The questionnaire asked providers if they
would be prepared to be interviewed or take
part in a focus group. A total of 14 providers
agreed and interviews and focus groups were
conducted to gain further information on cer-
tain courses. A further detailed account of
the interview and focus group analysis can
be found in Musselwhite et al. (2005).

(v) Mapping by analysis: Mapping was carried out
by cross-referencing course content with the
National Occupational Standards for Mental
Health and The Capable Practitioner docu-
ments, taking into account data from the
course analysis and evaluation.

Participants
A total of 176 providers of education and training in
the South West were contacted, most from differing
organisations. However, different departments
were sometimes contacted within the same organi-
sation. Table 1 identifies the respondents and the
level of response. The response rate (26%) to the
questionnaire was disappointing, although this is
not unusual in this type of research (see Robson,
2002). A second wave of reminders sent six months
after the original increased the questionnaire re-
turns by only 2% from the initial 24%. Only around
10% of providers returned anything other than the
basic questionnaire or offered to supplement this
with an interview, (this was an increase of 5% fol-
lowing reminders). As such, in-depth analysis was
only possible on courses provided by 10% of the
contacted organisations. Notable absences in re-
ponse were from the police and probation ser-
vices; acute and primary care Trusts also had a
low level of full return given the number con-
tacted, with higher education institutions being
the most likely to reply.

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

The 214 courses consist of a variety of levels as
outlined in Table 2. As can be seen, the majority
of courses are considered to be 'Continual
Professional Development' and as such are not
subject to a specific award. In addition, 'Advanced
and Specialist' courses are well represented, which
again have no award. Courses that have an
award, particularly National Vocational Qualifi-
cation (NVQ) Levels 2 and 3, were quite well
represented.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Number of respondents by type of organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total contacted</td>
</tr>
<tr>
<td>Higher education</td>
<td>24</td>
</tr>
<tr>
<td>Further education</td>
<td>9</td>
</tr>
<tr>
<td>NHS trust</td>
<td>91</td>
</tr>
<tr>
<td>Private</td>
<td>5</td>
</tr>
<tr>
<td>Voluntary</td>
<td>24</td>
</tr>
<tr>
<td>Social services</td>
<td>16</td>
</tr>
<tr>
<td>Police/probation</td>
<td>3</td>
</tr>
</tbody>
</table>
| Workforce development
  confederation and
  health authorities | 4 | 0 (0%) | 0 (0%) | 4 (33.33%) |
| Total | 176 | 17 (9.66%) | 28 (15.91%) | 131 (74.43%) |
The courses ranged from two hours to three academic years in length, with most courses lasting around a day (average across all courses: 1.09 days/course per year). The number of attendees per course varied between 5 and 40, with an average of 15. Various methods were used to teach the content, and most courses used more than one method.

Findings

Mapping to *The Capable Practitioner* and the *National Occupational Standards for Mental Health* documents took place for 82 courses, generated from 17 responses (4.76 courses per respondent).

Table 3 shows the National Occupational Standards which are covered most and least often in the courses analysed.

According to the *National Occupational Standards for Mental Health*, some standards are for certain groups of practitioner. This ranges (in a hierarchy based on job role) from standards that should be 'Shared By All Mental Health Workers’ through to standards that are appropriate only for 'Strategic Managers'. Therefore, comparing who the course is aimed at and mapping the appropriate standards creates a more comprehensive mapping exercise. Table 4 shows the *National Occupational Standards for Mental Health* that are mapped most appropriately to the courses surveyed and those that had no appropriate courses mapped to them.

With regard to *The Capable Practitioner*, Table 5 highlights the capabilities that were covered most and least by the courses analysed.

Discussion

Response

Receiving responses from only 45 of the 176 providers of mental health education and training was disappointing but not surprising. It was also disappointing to receive additional material from only 17 respondents, but the generation of 82 courses created enough work in the mapping stages of the study. A variety of means was used to try and raise the number of full responses, including documents,
telephone interviews and face-to-face interviews. Although the 82 courses are not necessarily representative of those found in the South West, they are all different in background and represent a good reflection of the breadth of courses available to mental health practitioners. The rationale for the low return rate is an interesting finding in itself and deserves more attention:

(i) Providers were sceptical about the outcomes of the project. There was unwillingness for many providers to share information on the courses they offer for fear that similar organisations would plagiarise the course, or that funding or commissioning bodies may terminate the course. This is interesting given that most courses invite external feedback through quality assurance processes. We would advocate that future studies addressing education and training should work closely with providers. A co-operative strategy based on action research could be used whereby providers and commissioners become co-researchers and are part of alter-

Table 4 National Occupational Standards for Mental Health mapped most and least appropriately to courses analysed

<table>
<thead>
<tr>
<th>National Occupational Standards mapped most appropriately to the courses</th>
<th>National Occupational Standards not mapped at all to the courses</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1. Develop your own knowledge and practice shared by all mental health workers (87.62% of courses that are supposed to map against this standard)</td>
<td>J8. Implement policy and procedures to minimise the risk of violence at work</td>
</tr>
<tr>
<td>J2. Support individuals when they are distressed for all practitioners (87.5% of courses that are supposed to map against this standard)</td>
<td>All of Unit K: address mental health need</td>
</tr>
<tr>
<td>E4. Plan and agree service responses that meet individuals’ identified needs and circumstances for team based roles (86.67% of courses that are supposed to map against this standard)</td>
<td>All of Unit L: work with groups and communities to address the mental health needs</td>
</tr>
<tr>
<td>F4. Work as a member of an inter disciplinary team to provide individualised programmes of care for people with mental health needs for team based roles (86.67% of courses that are supposed to map against this standard)</td>
<td>All of Unit M (except minimum mapping of M3): Influence organisation behaviour and service so as to promote mental health</td>
</tr>
<tr>
<td>A5. Promote effective communication and relationships with people who are troubled or distressed shared by all mental health workers (79.01% of courses that are supposed to map against this standard)</td>
<td></td>
</tr>
</tbody>
</table>

Table 5 Capabilities covered most and least by the courses analysed

<table>
<thead>
<tr>
<th>Sainsbury Capable practitioner capabilities covered most by the courses</th>
<th>Sainsbury Capable practitioner capabilities covered least by the courses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Respond to the needs of people in an honest, non-judgemental and open manner (54 courses or 65.85%)</td>
<td>28. Capable of leading or participating in the safe and effective delivery of electro-convulsive therapy (0 courses)</td>
</tr>
<tr>
<td>12. Knowledge of mental health and mental illness, causation, incidence, prevalence, description and impact (43 courses or 52.44%)</td>
<td>34. Capable of providing advice, assistance or training in daily living skills, for clients and their carers and families (3 courses or 3.66%)</td>
</tr>
<tr>
<td>5. Respond to the needs of people sensitively (34 courses or 41.46%)</td>
<td>30. Capable of leading or participating in arrangements to address the physical health needs of service users (5 courses or 6.1%)</td>
</tr>
<tr>
<td>14. Capable of communicating effectively with service users, their carers and families and other members of the team (34 courses or 41.46%)</td>
<td>27. Capable of facilitating concordance with effective treatment (6 courses or 7.32%)</td>
</tr>
<tr>
<td>7. Adhere to local and professionally prescribed codes of ethical conduct and practice (31 courses or 37.48%)</td>
<td>23. Capable of self-reflection, development and maintenance of skills and knowledge through CPD (6 courses or 7.32%)</td>
</tr>
</tbody>
</table>
ing and changing courses. Despite the approach this project adopted, the nature of data collection still seemed as if the research was 'being done' to the providers, and indeed it mainly was. This makes it difficult for providers of courses to achieve ownership of the outcomes and processes.

(ii) Providers of education and training did not have time to engage fully in the research. The providers saw the research as giving little added value to their job role. Working more closely with such organisations, perhaps through adopting a co-operative enquiry method or action research framework, could have overcome this. There is a need for education providers to reflect on the courses for which they are responsible. However, it is recognised that there is already a wealth of bureaucratic policy and quality initiatives with similar aims to which providers and commissioners must work and that this research was perceived as being an unnecessary addition to their workload.

(iii) The data collection tools were difficult to use. Although the questionnaire was not the easiest to complete, certain measures were introduced to aid completion. For example, if details were previously held by the researchers from the original mapping project (Fulbrook et al., 2001), these were resent so that details could simply be returned with amendments rather than requiring each establishment to complete the form again. In addition, different methods were used in distributing and collecting the questionnaire. It was possible for respondents to fill in an electronic version, return via stamped addressed envelope or give their details via telephone to be filled in by the researcher.

**National Occupational Standards**

For almost all education and training providers, the analysis carried out was the first time the courses had been mapped to either The Capable Practitioner or the National Occupational Standards for Mental Health. On the whole, providers are not yet using these tools to map existing courses, but some newly-developed courses are being mapped to such documents. Courses mapped fairly well against a number of standards; for example, nearly all courses developed practitioners' knowledge and practice (Standard A1). Similarly, many courses mapped to J2 (to support individuals when they are distressed) and A5 (to promote effective communication and relationships with people who are troubled and distressed).

Most courses were aimed at qualified practitioners or 'All Practitioners'. However, no courses were aimed specifically at 'Team', 'Team Manager' or 'Strategic Manager' level. It is not possible to assess whether this represents a dearth of education and training available for these professionals or whether providers of such education and training did not respond. However, the former is likely as this would concur with previous findings (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 mental health professionals who, according to the National Occupational Standards, do not need to know this area. Perhaps the National Occupational Standards need revising accordingly or maybe the courses need refining. 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 the relevant professional grouping.

It is recommended that new courses need to be developed to support the following areas that were not covered well by current provision in the South West:

- Empowering service users to manage their own lives: a low number of courses mapped to most of Unit G suggesting the need for more courses.
- Mental health promotion: B3, M3 and O1 could be described as mental health promotion-based standards.
- Family issues: C4 and C7 could be described as family issues and so could be run as a course.
- Complex issues and change management: H1, H2, I3, I4 and J5 could all be addressed through education and training in this area.
- Risk at work: J10 and J11 could be covered by a course addressing this issue.

Relating this to other research, mental health promotion was identified in the WAT report (DoH, 2001) as an area that is not well covered by courses. However, family issues and managing risk at work are both new areas to be identified as gaps. Future research might concentrate on courses in these particular fields to further establish the extent of the gap.
The capable practitioner

Nearly two-thirds of the courses mapped to capability 1 (to be able to respond to the needs of people in an honest, non-judgemental and open manner). Ethical practice and knowledge areas of the capabilities are covered well by the courses, as would be expected because they are for generic mental health professionals.

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

- Empowering service users 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. Supporting, enabling and empowering individuals to manage their own lives is also a gap identified by mapping to the National Occupational Standards in this research, so clearly there is a gap in such course provision in the South West. The lack of attention to physical and mental health aspects was noted previously by Fulbrook et al. (2001), and is noted throughout the literature (e.g., Allen et al., 2004; Burns and Cohen, 1998).

In mental health services, often the mental health and social care needs of patients take precedence over basic care and assessment of physical needs, which can result in poor general health and greater risk of premature death (Allen et al., 2004). The NSF for Mental Health (DoH, 1999) emphasised the need for primary care and secondary services to work closely together, but despite some services attempting to do this, it does not happen at a training or educational level. In addition, effective multi-agency and interprofessional partnerships is also a nationwide gap (DoH, 2001). It seems likely that the gaps identified in the South West reflect a national problem.

Conclusion and recommendations

Although many areas of the National Occupational Standards and *The Capable Practitioner* are covered well by courses in the South West, it is recommended that courses need to 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, professional development and developing research skills.
- Interdisciplinary and multi-agency working in mental health.

The gaps highlighted in this research suggest that the NSF (DoH, 1999) has not yet been fully implemented some five years after its inception. The NSF, for example, makes explicit the importance of multi-agency working, and it is still clear from studies such as this one that training and education in mental health occur mainly in a uni-professional context. In addition, Standard 10 of the NSF is to ensure mental health promotion, but this is still not addressed through education and training for practitioners. Furthermore, while many of the services highlighted by the NSF as important are being delivered, the accompanying training and education to support them are not available. As such, the standard and continuity of such services are not ensured. However, the author’s would like to note that the amount of high quality training that is being delivered is done so with great enthusiasm and professional integrity, in a climate of constant change and where staff are engaged in multiple roles and tasks.

References


Fulbrook, P., Galvin, K., Gibson, S., Morgan, O., 2001. South and West Region Mental Health Mapping Exercise. Institute of
Health and Community Studies, Bournemouth University, Bournemouth.

Workforce planning and education

Available online at www.sciencedirect.com