The Sainsbury Centre
for Mental Health

The Capable Practitioner

A framework and list of the practitioner capabilities required to implement The National Service Framework for Mental Health

A report commissioned by
The National Service Framework Workforce Action Team

by

The Training & Practice Development Section of
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Executive Briefing

1. This Executive Briefing provides a summary of the key points of the document *The Capable Practitioner*, the Sainsbury Centre for Mental Health (SCMH) report to the Competencies Sub-Group of the Workforce Action Team (WAT). It reports on work undertaken by the Practice Development and Training Section of the SCMH since May 2000.

2. The report outlines a Framework of Capabilities that broadly encompasses the skills, knowledge and attitudes required by the workforce of mental health practitioners to implement the National Service Framework (NSF).

3. Within this report the parameters of the Framework of Capabilities is restricted to an examination of the key professional disciplines of nursing, occupational therapy, psychiatry, psychology, social work and professionally non-affiliated support workers within Adult Mental Health Services.

4. For the purpose of this report the term Capability can be defined by the following dimensions:

    - A *performance* component which identifies 'what people need to possess' and 'what they need to achieve' in the workplace;
    - An *ethical* component that is concerned with integrating a knowledge of culture, values and social awareness into professional practice;
    - A component that emphasises *reflective* practice in action;
    - The capability to *effectively implement* evidence-based interventions in the service configurations of a modern mental health system; and
    - A commitment to working with new models of professional practice and responsibility for *Lifelong Learning*.

5. This Capability approach provides an integrative framework, which pulls together the various competency profiles flowing out of the proliferation of core competency research programmes. Practitioners require more than a prescribed set of competencies to perform their role. Capability extends the concept of competence to include the ability to *apply* the necessary knowledge, skills and attitudes to a range of complex and changing settings. The Capability Framework combines the notions of the effective practitioner with that of the reflective practitioner.

6. This Framework provides a foundation on which a national set of competencies can be developed. The Framework maps the terrain across the core and specialist skills of the professional and professionally non-affiliated workforce in relation to the NSF. Capabilities can be viewed as the starting point for defining competencies; that is *levels* of expertise within and across the professional disciplines; and occupational standards; measures of *performance* in the workplace. The concept of Capability provides an organising framework which begins the process of describing the inputs necessary (through curricula development and training) to become capable whereas Occupational Standards are a performance measure of professional competence in the work environment.

7. Previous competency projects emphasised the notion of 'core' or 'common' competencies or skills that were shared by all practitioners. This thinking is continued in this framework but also included, is the recognition that profession specific skills and expertise are needed to implement the NSF in modern service configurations.

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8. The Capability Framework illustrated on page 9 combines the notions of the reflective practitioner with that of the effective practitioner. This Framework divides *capability* for Modern Mental Health Practice into 5 areas:

    - **Ethical Practice** makes assumptions about the values and attitudes needed to practice;
    - **Knowledge** is the foundation of effective practice;
    - **Process of Care** describes the capabilities required to work effectively in partnership with users, carers, families, team members and other agencies.
    - **Interventions** are capabilities specific to evidence-based, bio-psycho-social approaches to mental health care;
    - These areas are then extended to examine their context specific **Application**: Capabilities as they apply to specific service settings or functions, e.g. assertive outreach, crisis resolution.

    Each of these five categories is further subdivided to arrive at specific statements of capability for mental health practice.

9. The empirical foundation for the Capabilities derives from a two-year research programme undertaken by SCMH into the key tasks of mental health practitioners. This research identified a list of key tasks using concept-mapping techniques involving service users, carers and professionals with an expert panel that subsequently refined the list of key tasks. The list of capabilities was then derived from a process of code and match analysis of selected competency research projects and leading competency based curricula that exists currently in Mental Health. These were woven into an inclusive methodology described in detail in Appendix A.

10. This model provides a framework with sufficient detail for sign posting the skill development agenda established by the NSF and to act as a guide to best practice. The capability framework could be used in the following ways:

    - To inform the next phase of the work, which will require the development of performance indicators, related to level of expertise and responsibility (outputs). This will require a functional mapping exercise for the Mental Health Workforce;

    - To involve the professional and regulatory bodies in mapping competence-based exit profiles for the different disciplines using this framework and list of capabilities;

    - To assess workforce needs in relation to further training;

    - To guide training and education consortia on the kind of education and training that is needed at pre-qualifying and post-qualification levels;

    - To provide higher education providers with a framework for generating post-NSF curricula.

11. Further work will be required to:

    - Validate the Capability Framework with professional and accrediting bodies;
    - Identify specialist capabilities linked to specific care settings (assertive outreach, crisis resolution etc.);
    - Seek further user and carer consultation on the Capability Framework.

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Introduction

1.1. Background

Mental health practitioners who work with people with severe mental illness are facing the greatest and fastest moving set of changes ever encountered in the field. These changes are reflected most clearly in the shifting centre of gravity in the provision of mental health care, away from hospitalisation as the mainstay of psychiatric services towards more comprehensive and integrated community-based services as described in the National Service Framework (NSF). The changing terrain of service provision is now more varied, complex and dispersed than ever before. The requirements for effective care must now come from numerous agencies such as primary care, housing, social services, the voluntary sector and indeed the family, in addition to specialist mental health services, creating problems of co-ordination, accountability and efficiency. These developments, along with the reorientation to service provision based on user and carer need and the increasing development of evidence-based interventions, has created a demand for the ever more capable practitioner.

Increasingly there is recognition that development of the workforce is a critical step towards the successful implementation of the kind of care envisioned in the NSF and more recently the National Plan. Reflecting this, there has been in recent years, an explosion of localised research seeking to identify the common skills required of mental health practitioners to deliver effective care and treatment. Since the publication in 1997 of the SCMH report 'Pulling Together', a national review into the education and training of mental health professionals, there has been a proliferation of core competency research.

Much of this research occurred prior to the publication of the NSF and consequently lacked a unifying framework, which clearly described the new service context within which practitioners would provide care and treatment. This proliferation of varying definitions of the key skills and knowledge required for effective practice within the new paradigms of care, has not proved particularly helpful either to practitioners or managers in the field nor to commissioners or providers of education and training.

1.2. Aims

Therefore the overall aim of this project was to identify a broad unifying framework which encompassed the set of skills, knowledge and attitudes required within the workforce of mental health practitioners to effectively implement the National Service Framework. In other words; what would the various multidisciplinary groups of practitioners need in order to be capable of implementing the kind of care and treatment indicated in the NSF?

For the purposes of this report the parameters of this exercise include a focus on the key professional disciplines of psychiatry, nursing, occupational therapy, social work, clinical psychology and those workers described as non-professionally aligned who provide an array of direct care services to people with mental health problems. This analysis of capabilities is also restricted to those who work within specialist adult mental health services.

The Capability Framework will have relevance to those who work in Child and Adolescent Services or Elderly Services; however the extension of the Capability Framework to encompass these areas is beyond the scope of this project. Similarly, this project did not differentiate between those specialist capabilities that may be the domain of any particular profession, nor did it attempt to define the capabilities, which may be common to a number of different disciplines. That piece of work is beyond the scope of this particular project and would need to be undertaken in collaboration with the various professional and accrediting bodies.

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2. The Capable Practitioner

2.1. Capability

As stated earlier, the aim of this report is to provide a broad outline or map of what the workforce requires in order to implement the NSF. Care delivery within comprehensive and integrated community-based mental health services has become increasingly complex. It is a challenge not only for practitioners in the field, but also for service managers to create an optimal environment for best practice and for educators to equip trainees with the requisite values, skills and knowledge. Earlier models of core competencies did not adequately address the comprehensive array of needs of practitioners when working in these new service environments.

Practitioners require more than a prescribed set of competencies. They need to be capable of providing the benefits of both effective and reflective practice. This requires an underpinning framework of values, attitudes and knowledge in addition to competencies along with an ability to apply these in practice, across a range of clinical contexts from acute inpatient care to community-based crisis resolution and assertive outreach teams.

The concept of capability is not new and is discussed in British and Australian Higher Education literature as extending competence to include broader personal characteristics with a particular emphasis on 'reflection-in-action' and 'reflection-about-action' (Schön,1987). Capability is synonymous with terms such as 'transferable skills', 'self-reliance skills' and 'enterprise skills' (Holmes, 1999)

For the purpose of this report the term 'Capability' should be thought of as including:

- A **performance** component which identifies 'what people need to possess' and 'what they need to achieve' in the workplace;
- An **ethical** component that is concerned with integrating a knowledge of culture, values and social awareness into professional practice;
- A component that emphasises **reflective** practice in action;
- The Capability to **effectively implement** evidence-based interventions in the service configurations of a modern mental health system; and
- A commitment to working with new models of professional education and responsibility for **lifelong learning**.

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2.2. Relationship to competencies

The exercise of identifying the capabilities is akin to mapping the broad tasks required of practitioners to work within the type of services described in the NSF and NHS Plan. It does not address the levels of expertise required across the various disciples and care settings. The capability framework draws the contour lines of a territory, which needs further exploration through the development of relevant competency based curricula and the construction of occupational standards. This work will support and inform future developments by providing for the first time a unified framework or map upon which to proceed.

A competency framework would describe the level of expertise expected within a particular domain of capability. This is usually expressed through occupational standards and more clearly outlines the boundaries between the core and specialist skills of various professional and professionally non-affiliated groups. This task is not part of the current project but is an exercise that will need to be undertaken at a later date in collaboration with the various professional and accrediting bodies.

While some commentators may see that some similarities exist between the statements of capability presented here and other statements of competency, a distinction is made because this capability model does not:

- provide for the measurement of 'output' or performance
- distinguish between the various practitioner groups as to who performs what role
- determine the level of capability at which a role will be performed

2.3. Relationship to occupational standards

There is confusion in the mental health field as to the relationship between competencies and occupational standards. The concept of Capability can help by providing an organising framework which begins the process of describing the inputs necessary (through curricula development) to become competent whereas occupational standards act as a performance measure of competence within the work environment.

'National Occupational Standards define the level of performance required for the successful achievement of work expectations' (Storey, 1998). They are described as benchmarks of workplace performance and can be used to ascertain and to determine fitness for practice.

The move towards National Occupational Standards should not be confused or distracted by a capability approach. Neither does the description of capabilities across the entire mental health workforce seek to promote the rise of the generic mental health worker. The capability framework seeks to broadly define what is required to deliver effective mental health care rather than focus on the profession that does it.

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2.4. Possible applications of the Capability Framework

In summary the Capability Framework is best understood as a conceptual map with sufficient detail to define the skills development agenda established by the NSF. The framework and list of capabilities are not designed to proscribe developments at local level but to act as a guide and to signpost best practice in the context of the NSF and the National Plan.

The Capability Framework could be used, for example, in the following ways:

- To inform the next phase of the work, which will require the development of performance indicators, related to level of expertise and responsibility (outputs). This will require a functional mapping exercise for the mental health workforce;

- To involve the professional bodies and regulatory bodies in mapping competence-based exit profiles for the different disciplines using this framework and list of capabilities;

- To guide education and training consortia on the kind of education and training that is needed at pre-qualification and post-qualification levels;

- To give education providers a framework for generating post-NSF curricula.

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3. The Capability Framework

Figure 1 depicts the Framework for Capable Practice. This Framework divides *Capability* for Modern Mental Health Practice into 5 areas:

A. Ethical Practice
B. Knowledge of Mental Health and Mental Health Services
C. The Process of Care
D. Interventions (and)
E. Applications to Specific Service Settings

In this framework **Ethical Practice** makes assumptions about the values and attitudes needed to practice. **Knowledge** is the foundation of effective practice. **Process of Care** describes the capabilities required to work effectively in partnership with users, carers, families, team members and other agencies. **Interventions** are capabilities specific to evidence-based, bio-psycho-social approaches to mental health care.

These capabilities are then used in **Application** to specific service settings, each requiring specialist capabilities. The specialist mental health settings are:

1. **Primary Care**
2. **Community-based Care Co-ordination (CMHTs)**
3. **Crisis Resolution and Early Intervention**
4. **Acute Inpatient Care**
5. **Assertive Outreach**
6. **Continuing Care, Day Services, Rehabilitation and Residential Care, Vocational and Work Programmes**
7. **Services for people with complex and special needs: Forensic, Dual Diagnosis and people with Personality Disorders.**

Each of the 5 areas of the framework is divided into broad domains of capability (e.g. Effective Communication, Mental Health Promotion) which are then further subdivided to arrive at distinct statements of capability for mental health practice. These statements are listed in the following section.

The reader will recognise that while these subdivisions are essential to the ordering of this information, they are in many ways artificial. A capable mental health practitioner will deliver care in such a manner that the output of their accumulated values, knowledge, process and interventions in application to/in a particular setting will appear as a seamless activity.

This framework thus attempts to map out the range of capabilities required of the various groups of mental health practitioners. These are constantly changing and developing in the practice of delivering mental health care. When reading the capability statements this should be kept in mind.

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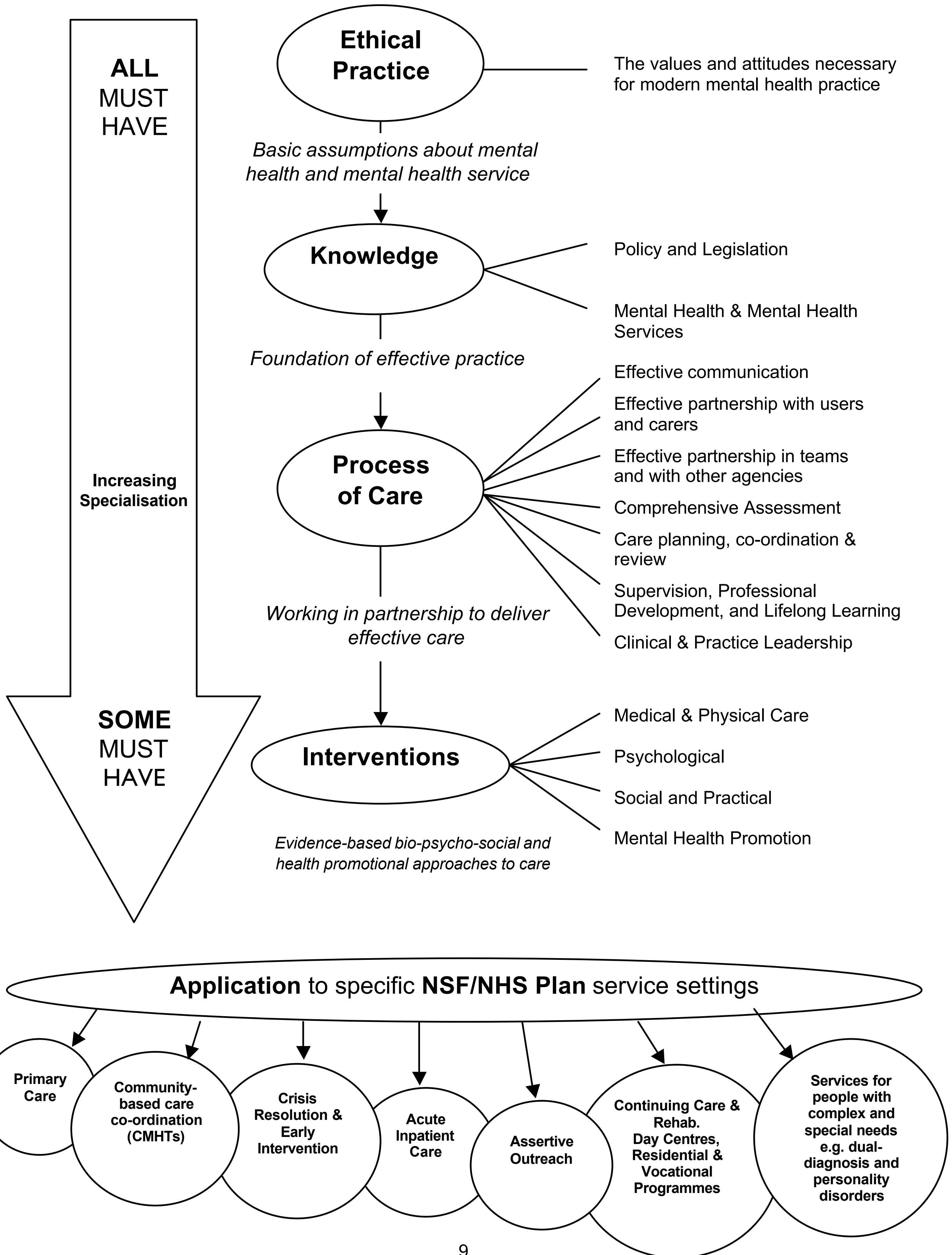
Figure 1: A Framework for Capable Practice



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A List of the Capabilities

3.1. Ethical Practice

This Framework of Capabilities for modern mental health work makes basic assumptions about underlying principles of care. These assumptions come from the conviction that all those who work in mental health services, regardless of the setting, or discipline should respect the dignity of those they provide care for.

Service users, families and carers should expect to be treated in a manner, which preserves their rights as citizens (as described by the law) and that they should be entitled to live as full and rewarding a life as their mental health allows. Whatever their age, background, gender or disability, service users have a fundamental right to receive services in the least restrictive manner conducive to their safety and the safety of their families and their communities.

Professionally qualified workers have their own ethical codes of practice, developed primarily for the protection and benefit of the patient. Locally developed codes of practice should govern the practice of non-professional staff.

Values are easy to articulate but more difficult to demonstrate. One of the more difficult tasks for mental health services will be to find ways to measure how values translate into practice.

For the purpose of this model it is assumed that as a starting point, **all** mental health workers will base their practice on these values:

ETHICAL PRACTICE	Values and attitudes necessary for modern mental health practice	NSF Standard
The ethical practitioner will: 1. Respond to the needs of people in an honest, non-judgemental and open manner which respects the rights of individuals and groups.		*NSF (1 – 7)*
2. Provide holistic, needs-led services that take account of the physical psychological, emotional, social and spiritual needs of individuals and groups.		*NSF (1 – 7)*
3. Conduct a legal, ethical and accountable practice and remain open to the scrutiny of peers.		*NSF (1 – 7)*
4. Demonstrate a commitment to equal opportunities for all persons.		*NSF (1 – 7)*
5. Respond to the needs of people sensitively with regard for age, culture, race, gender, ethnicity, social class and disability and modify behaviour to optimise the helping relationship.		*NSF (1 – 7)*
6. Encourage self-determination and freedom of choice.		*NSF (1 – 7)*
7. Adhere to local and professionally prescribed codes of ethical conduct and practice (e.g. confidentiality).		*NSF (1 – 7)*

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3.2. Knowledge

Knowledge is the foundation of effective practice. The capability of a single practitioner would involve constant interplay between knowledge and the practical application of mental health skills. Recognising the difficulty of separating knowledge from practice an attempt has been made here to outline the fundamental knowledge required for capability as a mental health worker. This knowledge has been divided into two categories:

1. **Knowledge of policy and legislation**
2. **Knowledge of Mental Health and Mental Health Service Delivery**

The knowledge statements in these categories denote the knowledge required by **most** of the mental health workforce.

KNOWLEDGE **1. Knowledge of policy and legislation**	**NSF Standard**
8. Knowledge of the legislation and policy that currently provides the framework within which modern mental health care is delivered in the statutory, independent and voluntary sectors including: • The National Service Framework, The National Plan for the NHS, Partnership in Action, A Quality Strategy for Social Care, Best Value and other relevant policy documents; • The arrangements for effective commissioning, leadership and delivery of mental health services including: ▪ Current priorities, systems and structures for mental health care; ▪ CPA and care co-ordination; ▪ Community care and care management procedures; ▪ Functions and organisation of primary care; ▪ The criminal justice system; ▪ Joint and collaborative working.	*NSF (1 – 7)*
9. Knowledge of mental health law and related legislation on Equal Opportunities, Disability and Human Rights and the legal principles involved in consent, restraint and protection of vulnerable people specifically: ▪ The Mental Health Act 1983; ▪ NHS and Community Care Act 1990; ▪ The Carers Recognition and Services Act 1996; ▪ The Police and Criminal Evidence Act 1984; ▪ The Crime and Disorder Act 1999.	*NSF (1 – 7)*
10. Ability to educate service users and carers, communicating appropriate levels of this knowledge, informing them of their rights and empowering their participation as informed users of the mental health system.	*NSF (1 – 7)*

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KNOWLEDGE	2. Knowledge of mental health & mental health services	NSF Standard
11. Knowledge of the individual in society and the impact of biological, social and psychological processes on: • The development of mental and physical health; • Citizenship roles and responsibilities; • Culture, religion, language, disability, gender, age, sexual orientation and social class and how these factors effect individual experience.		*NSF (1 – 7)*
12. Knowledge of mental health and mental illness, causation, incidence, prevalence, description of disorders and the impact on individuals, families and communities		*NSF (1 – 7)*
13. Knowledge of the various explanatory models of mental health and the evidence which underpins them (e.g. Bio-psycho-social, Stress-Vulnerability, Medical), the strengths and limitations of each and how to make best use out of all available approaches to: • the experience of mental distress/illness and the personal and social consequences • the common/shared and additional special needs of people experiencing mental health problems • the application of the best model of care for the needs of individuals with mental health problems and their families • the impact of all aspects of social and cultural diversity on the mental health of individuals and groups		*NSF (1 – 7)*

3.3. The Process of Care

Mental Illness places demands on services that no one discipline or agency can meet alone…a system of effective care-co-ordination is required if all services are to work in harmony to the benefit of the service user (DoH 1999, p1)

Effective care co-ordination describes the capabilities needed to practice in comprehensive integrated mental health services.

The process of delivering mental health care involves working within a legal system (such as the Mental Health Act), a social system (the NHS, Social Services), with policy frameworks (the Care Programme Approach and clinical governance) and with the range of services available in the community and resources and expertise that exist within teams of multidisciplinary practitioners.

As the lens moves from a wide-angle to close focus, capabilities are required to optimise the relationship with carers and families and the network of care available to the service user. Finally, the relationship with the service user must encourage user participation and utilise the understanding of each individual's experience.

The capabilities for effective care-co-ordination in this model are divided as follows:

1. **Effective communication**
2. **Effective partnership with users and carers**
3. **Effective partnership in teams and with external agencies**
4. **Comprehensive assessment**
5. **Care planning, co-ordination & review**
6. **Supervision, Professional Development and Lifelong Learning**
7. **Clinical & Practice Leadership**

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PROCESS OF CARE	1. Effective communication	NSF Standard
14. Capable of communicating effectively with services users, their carers and families and with other members of the therapeutic team.		*NSF (1 – 7)*
15. Capable of listening to service users and maximising opportunities for users, carers and families to be heard; including the use of specialist assistance where required (e.g. sensory aids, sign language, Braille, translation services and advocacy).		*NSF (1 – 7)*
16. Capable of educating users and carers about the role, function and limitations of mental health services.		*NSF (1 – 7)*

PROCESS OF CARE	2. Effective partnership with users and carers	NSF Standard
17. Capable of developing effective working relationships with service users, families and carers including people who are disengaged from services through: • Understanding the fundamental importance of relationships to social and psychological wellbeing; • Facilitating engagement and therapeutic co-operation through the use of flexible and responsive engagement strategies with users; • Establishing safe and consistent mechanisms for continuing communication with service users when they disengage from the service; • Maintaining a respectful, non-judgemental and empathic approach to service users and carers at all times.		*NSF (6)*
18. Capable of supporting the development of opportunities for users, carers and families to participate in all aspects of care through: • Facilitating the participation of users, carers and families in the development, delivery & evaluation of individual care plans; • Encouraging and supporting individual, peer and citizen advocacy; • Encouraging and supporting user forums; • Encouraging and supporting carers groups; • Encouraging and supporting Patients Councils and other advisory and monitoring groups.		*NSF (6)* *NSF (4,5)*

PROCESS OF CARE	3. Effective partnership in teams and with external agencies	NSF Standard
19. Capable of leading or participating effectively in multi-disciplinary, multi-agency team-working across the statutory, independent and voluntary sectors through collaboration and a critical understanding of: • The role & function of the team (generic or specialist), the clinical work it will do, the services that it will provide and the outcomes that it will seek to achieve for service users, their families and carers; • The roles, tasks, systems, structures and processes essential for multidisciplinary, multi-agency team working; • The issues and key tasks involved in the implementation of effective teamwork into routine care for service users and their families; • The skills involved in multi-disciplinary and multi-agency team working; • Professional boundaries and the willingness to flexibly negotiate these to provide care.		*NSF (1 – 7)*

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PROCESS OF CARE	4. Comprehensive Assessment	NSF Standard
20. Capable of recognising various mental health problems and undertaking, or participating in comprehensive, collaborative, holistic needs-based assessment (including the use of standardised assessment measures e.g. HONOS). Key areas for such assessment include: • Individual history; • Strengths, individual goals and resources; • Mental state, signs and symptoms; • Health and social care needs including factors relating to the impact of culture, race, gender, social class and lifestyle; • Risk: the evaluation and treatment of service users at risk of self harm, self neglect, harm to others or suicidal behaviour; • Functional needs; • Family: the impact on children and the social system; • Complex needs such as drug/alcohol abuse and personality disorder; • Mental Health Act assessments.	*NSF (4, 5, 7)*

PROCESS OF CARE	5. Care planning, co-ordination & review	NSF Standard
21. Capable of participating in the development and documentation of written care plans (either as the main case manager and co-ordinator or as a member of the therapeutic team) which include: • The documentation of aspirations and goals for improved quality of life; • The identification of problems, needs and required interventions; • The active involvement of users, carers and families where appropriate; • The comprehensive assessment of health and social care needs (including carers and families support needs); • The health and social care required to meet these needs, the development of positive risk management strategies and the action to be taken in a crisis; • The regular monitoring, review and systematic evaluation of outcome and health gain.	*NSF (4, 5,)*

PROCESS OF CARE	6. Supervision, Professional Development, and Lifelong Learning	NSF Standard
22. Capable of sustaining and enhancing personal and/or professional development through the use of organisational support systems including: • Peer review; • Casework and clinical supervision; • Mentorship; and • Appraisal;	*NSF (1 – 7)*
23. Capable of self-reflection, development and maintenance and development of skills and knowledge through continuous professional development activities such as: • Reflecting on practice; • Training & education; • Audit; and • Maintenance of professional portfolio's.	*NSF (1 – 7)*
24. Capable of critically appraising contemporary and emerging research and evidence-based practice.	*NSF (1 – 7)*

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PROCESS OF CARE	7. Clinical & Practice Leadership	NSF Standard
25. Capable of developing and promoting the evidence-based practice of other team members to ensure the development, implementation and monitoring of quality assured standards of care and treatment in line with the National Service Framework Standards by: • Developing and maintaining the role and capacity of the therapeutic team to provide evidence based practice; • Initiating, implementing and directing the practice of effective staff appraisals, clinical supervision, staff development and other strategies for enhancing staff support and preventing individual and team burnout; • Initiating, implementing and supervising clinical & practice research, quality assurance, clinical governance and evaluation including the use of user-focused monitoring; • Developing local systems for suicide and critical incident audit; • Ensuring the safety of users, carers and staff.		*NSF (1 – 7)*

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3.4. Interventions

Part of effective care co-ordination is the capability to deliver evidence based interventions that facilitate recovery and meet the needs of mental health service users, their carers and families.

Historically this has been the domain of professional specialists, where specific interventions were linked to professional groups. This model outlines a range of interventions that need to be delivered, but does not specify which group of practitioners should deliver them.

The capabilities described here are those not covered in process of care and these relate specifically to the delivery of the following bio-psycho-social and health promotional interventions:

1. **Medical and Physical Health Care**
2. **Psychological interventions**
3. **Social and Practical interventions**
4. **Mental Health Promotion**

INTERVENTIONS	1. Medical and Physical Health Care	NSF Standard
26. Capable of leading or participating in the diagnosis, treatment or care of mental & physical illness including: • The comprehensive assessment of mental and physical health needs, and appropriate action to meet these needs in hospital or in the community including referral to specialist services or to primary care; • Prescribing and administering medications and other treatments, monitoring adverse effects and managing these appropriately.		*NSF (1 – 7)*
27. Capable of facilitating concordance with effective treatment through the use of: • Negotiation skills; • Psycho education, provision of information and giving people choices; • Assessment, management and systematic monitoring of side effects; • Motivational interviewing and promoting therapeutic alliance.		*NSF (1 – 7)*
28. Capable of leading or participating in the safe and effective delivery of electro-convulsive therapy and other physical treatments.		*NSF (1 – 7)*
29. Capable of implementing strategies to safely and effectively manage anger, violence and aggression, including: • de escalation and conflict avoidance; • negotiation and crisis resolution; • physical restraint.		*NSF (1 – 7)*
30. Capable of leading or participating in arrangements to address the physical health needs of service users by appropriate joint working with primary care.		*NSF (1 – 7)*

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INTERVENTIONS	2. Psychological interventions	NSF Standard
31. Capable of leading or participating in the provision of a range of evidence-based psychological interventions including systematic assessment of needs, negotiation of goals and targets and the evaluation of outcomes. These interventions include: • Early intervention, early signs monitoring and relapse prevention • Psychoeducation • Crisis intervention and resolution • Cognitive behavioural interventions • Psychotherapeutic and other talking treatments • Therapeutic strategies for alcohol or drug misuse • Cognitive and behavioural family interventions		*NSF (2-7)*

INTERVENTIONS	3. Social and Practical	NSF Standard
32. Capable of identifying and collaborating with the range of local specialist and non-specialist community resources available to service users and their families to assist them to maintain quality of life including: • Housing & residential services; • Health care; • Work; • Education; • Leisure; • Social welfare, income and support; • Individual and systemic advocacy.		*NSF (2–7)*
33. Capable of creating, developing or maintaining the personal and social networks of services users and their carers and families.		*NSF (2-7)*
34. Capable of providing advice, assistance or training in daily living skills, for clients and their carers and families in the areas of: • Financial management; • Domestic and household skills; • Social skills; • Food and nutritional management.		*NSF (2-7)*

INTERVENTIONS	4. Mental Health Promotion	NSF Standard
35. Capable of understanding and appropriately applying the principles and practice of evidence based mental health promotion which include; • The continuum of mental health promotion & prevention; • The impact of mental health on physical health; • The benefits of mental health promotion for people with mental health problems.		*NSF (1)*
36. Capable of increasing others understanding of the wider implications of mental health promotion through practice which: • Empowers individuals and facilitates self help; • Recognises the use of complimentary and creative therapies; • Strengthens social networks; • Reduces discrimination & promotes social inclusion; • Builds partnerships with individuals and organisations to address the impact of inequalities on health.		*NSF (1)*

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3.5. Applications

The provision of mental health care in the UK has moved towards the development of comprehensive services. The mental health workforce will need to draw on values, knowledge, process skills and a range of interventions that will enable them to practice effectively. But in reality, this practice **will relate to specific service settings.**

While this model attempts to map a broad brush of capabilities not specific to any setting or to professional level, this final section of the model addresses the specific **applications** required for each of these areas, that are distinct from the essential capabilities described in the previous section. These are:

1. **Primary Care**
2. **Community-based Care Co-ordination (CMHTs)**
3. **Crisis Resolution and Early Intervention**
4. **Acute inpatient care**
5. **Assertive Outreach**
6. **Continuing Care, Day Services, Rehabilitation and Residential Care, Vocational and Work Programmes**
7. **Services for people with complex and special needs: Forensic, Dual Diagnosis and people with personality disorders.**

APPLICATION	**1. Primary Care**	**NSF Standard**
In addition to the ***capabilities*** *described above* the Primary Care practitioner will need to develop their: 37. Ability to assess the prevalence of mental health problems and needs amongst the population served including the use of valid and reliable instruments.		*NSF (2,3)*
38. Ability to work in partnership with other agencies to secure wider public health of the local population and contribute to the health improvement programme that reflects the perspective of the local population		*NSF (2,3)*
39. Ability to screen, diagnose and assess people experiencing mental health problems and those most at risk of mental illness and commonly associated primary health care needs.		*NSF (2,3)*
40. Ability to assess health and social care needs and provide care and treatment to meet the needs of people with transient needs or mild to moderate problems including: • Accessing NHS Direct; • Support or counselling for people with reactions to life events, grief reactions, mild to moderate anxiety, and depression; • Specific evidence based therapy for people experiencing moderate depression and anxiety, anxiety states, panic disorder, phobias.		*NSF (2,3)*
41. Ability to refer to and collaborate with the specialist mental health services to meet the needs of people with severe and enduring mental health problems and their associated physical health problems.		*NSF (2,3,4,5)*

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APPLICATION	2. Community-based Care Co-ordination (CMHTs)	NSF Standard
In addition to the ***capabilities*** *described above the* CMHT practitioner will have a central co-ordinating role essential to the delivery of effective community treatment & support : 42. Ensuring 'seamless' delivery of care by providing the main point of contact for services users, carers and families, making use of specialist services where required (e.g. crisis intervention, home treatment, after-hours services) and responding flexibly and rapidly to changing needs with particular emphasis on: • Developing effective partnerships with service users, carers and families; • Applying knowledge of relevant legislation; • Communication skills; • Care planning, co-ordination and review; • Positive risk taking; • Promoting concordance with medication and other treatment strategies.		*NSF (2,3,4,5)*

APPLICATION	3. Crisis resolution and early intervention	NSF Standard
In addition to the ***capabilities*** *described above* the practitioner in crisis intervention and home treatment will need to develop their expertise in: 43. The ability to recognise the health and social factors that precipitate acute relapse and crises and to monitor early warning signs for individual service users.		*NSF (2 - 7)*
44. The ability to intervene and resolve crises for individuals in hospital or community settings through: • Facilitating therapeutic co-operation • Developing a care plan to resolve the crises in the least restrictive setting consistent with effective treatment and safety. • Involving the users social network of support • Sustaining appropriate involvement with individuals undergoing a crisis and initiating strategies for recovery.		*NSF (2 - 7)*
45. The ability to identify risk categories and specific risk factors as well as recognise individual strengths and opportunities for positive risk taking		*NSF (2 - 7)*
46. The ability to process knowledge into a comprehensive assessment tailored to individual needs, involving the service user and carers which facilitates effective early intervention and relapse prevention, including: • Education regarding early warning signs of illness • the collaborative identification of individual relapse signatures, with users • providing assistance to users and carers in identifying and implementing strategies to prevent relapse- including psychosocial interventions • the development and implementation of agreed crisis management plans		*NSF (2 - 7)*
47. The ability to implement a range of risk management strategies including: • Application of treatment • Supportive counselling • Management of medication • Managing violence & aggression and de-fusing volatile situations • Supporting and monitoring positive risk taking decisions		*NSF (2 - 7)*
48. The ability to evaluate assessment information, in light of service delivery and identified unmet needs		*NSF (2 - 7)*
49. The ability to intervene and provide effective strategies to reduce suicide.		*NSF (7)*

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APPLICATION	4. Acute Inpatient Care	NSF Standard
In addition to ***capabilities*** *described above* the practitioner in acute inpatient care will need to develop their expertise in: 50. The ability to lead or participate in the complex care planning process surrounding hospital admission and deliver appropriate strategies that optimise the experience for service users, their carers and families, including the provision of written agreed care plans upon discharge.		*NSF (4,5,6,7)*
51. The ability to carry out a comprehensive assessment of physical health needs, and make appropriate referrals to services that will address identified deficits.		*NSF (4,5,6,7)*
52. The ability to safely and effectively administer medications.		*NSF (4,5,6,7)*
53. The ability to implement strategies which facilitate adherence to treatment, including: • Negotiation skills; • Early warning signs monitoring and psycho education; • The monitoring and management of side effects of medication, using systematic measures; • Motivational interviewing.		*NSF (4,5,6,7)*
54. The ability to implement strategies to safely and effectively manage anger, violence and aggression, including: • De escalation and conflict avoidance; • Negotiation and crisis resolution; • Physical restraint.		*NSF (4,5,6,7)*
55. The ability to process knowledge into a comprehensive assessment tailored to individual needs, (involving the service user and carers) which facilitates effective early intervention and relapse prevention, including: • Education regarding early warning signs of illness; • The collaborative identification of individual relapse signatures, with users; • Providing assistance to users and carers in identifying and implementing strategies to prevent relapse- including psychosocial interventions; • The development and implementation of agreed crisis management plans.		*NSF (4,5,6,7)*
56. The ability to manage the necessary communication required for transfer of service users or discharge from hospital.		*NSF (4,5,6,7)*
57. The ability to arrange or provide a range of therapeutic, social, occupational and leisure activities.		*NSF (4,5,6,7)*

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APPLICATION	5. Assertive Outreach	NSF Standard
In addition to the ***capabilities*** *described above* the assertive outreach practitioner will need to develop their practice to: *58.* Contribute in teams, to the care and treatment of people with the most complex needs, who are disabled by their mental distress and who require long term intensive community support including*:* • To carry out or contribute to comprehensive assessment of complex health and social care needs including risk assessment and management • To develop and sustain trusting relationships and constructive partnerships with people with complex needs who unwilling to engage with services • To promote partnerships between the health, social and voluntary sectors, the police and to access the resources of these agencies • To work intensively and develop an individualised approach to the practical and functional needs of the service user. • To contribute to the development of strategies to prevent stress and burn-out in self and amongst colleagues in the team		*NSF (4,5,6,7)*

APPLICATION	6. Continuing Care, Rehabilitation, Day and Residential Services and Vocational programmes	NSF Standard
In addition to the ***capabilities*** *described above practitioners who work in these services will need to further develop their practice to provide long term care and support particularly in social and practical interventions. Capabilities include:* 59. The ability to sustain a respectful, consistent and reliable therapeutic relationship with service users that enhances their ability to build social networks and diminishes their social exclusion.		*NSF (4,5,6,7)*
60. A commitment to providing interventions which promote independence and enhance the autonomy of the service user.		*NSF (4,5,6,7)*
61. The ability to maximise user strengths and interests and increase their participation in meaningful community activities.		*NSF (4,5,6,7)*
62. A commitment to support and facilitate service users opportunities to obtain meaningful and independent work where they can develop skills, receive an income and contribute to the community.		*NSF (4,5,6,7)*

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APPLICATION	7. Services for people with complex and special needs: Forensic needs, Dual Diagnosis and people with Personality Disorders	NSF Standard
The practitioner specialising in work with people with forensic histories will need, in addition to the ***capabilities*** *described in* ***'interventions':*** 63. The ability to apply knowledge of the effects of mental illness as it contributes or results in psychopathology and criminal behaviour.		*NSF (4,5,6,7)*
64. The ability to apply knowledge of the mental health and legal system and to work effectively with agencies such as the: • Police; • Courts; • Parole Office; • Prison Service; • Probation Service; • Home Office.		*NSF (4,5,6,7)*
65. A commitment to the rehabilitation of people with forensic mental health needs through the use of a carefully designed and implemented care plan.		*NSF (4,5,6,7)*
66. The ability to adapt specific techniques such as boundary setting and escorting, to manage risk and resolve conflict which balances safety for others and independence for people with forensic mental health needs.		*NSF (4,5,6,7)*
67. The practitioner specialising in work with people with a dual diagnosis or personality disorder will need to expand their expertise in medical and psychological interventions specific to the client group, their knowledge of the social and cultural context of illicit drug taking and the behavioural issues associated with personality disorder. They will need to be capable of: • Understanding the ethical & legal issues relating to the client group; • Understanding the barriers to care and treatment; • Undertaking the complex assessment and diagnosis of the client group; • Medication management and interactions with illicit drugs and alcohol; • Motivational interviewing; • Applying cognitive and behavioural approaches; • Using strategies to reduce self-harm and other self-destructive behaviour.		*NSF (4,5,6,7)*

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Appendix A:
Developing the Capabilities: An Inclusive Methodology

The capabilities described in this report were developed through a complex methodology, weaving together several strands of enquiry to ensure that the final product reflects a diversity of approaches and innovations in mental health training and curriculum development. Moreover, the capabilities aim to provide an integrative, biopsychosocial framework, which enables a continuing debate about the nature of mental illness and mental health and facilitates a very wide range of interventions and activities to support those with mental illness and their carers. The methodology used to develop and refine the capabilities included the following components:

Researching the key tasks of mental health workers

The empirical foundation for the Capabilities was provided by research undertaken by SCMH into the key tasks of mental health practitioners. In this research, which will be published by SCMH in spring 2001, a list of key tasks was developed using concept-mapping techniques involving service users, carers and professionals. An expert panel subsequently refined the initial list of key tasks. The key tasks were used to develop a national survey tool, which was completed by a representative sample of staff working in both community and acute inpatient settings.

Respondents were asked to rate the tasks according to their perception of their importance for their own role and for that of other members of the multi-disciplinary teams. The survey provides valuable information about the shared territory between staff working in mental health services and also about those areas that continue to be professionally specific. It needs to be noted that this research was undertaken prior to the publication of the NSF and the key tasks do not necessarily address all of its requirements.

Mapping innovation in education and training

The framework provided by the Key Tasks was developed and extended into the proposed capabilities through a complex process of mapping onto it a range of ‘competencies’ established by education providers, consortia and others organisations throughout the country. The full list of sources used for this stage of the work is identified in **Table 1**. The aim of this stage of the work was to build up a ‘unified’ set of competencies using ‘code and match’ qualitative analysis discussed briefly below.

Code and match analysis

In the first stage of analysis a template based on the key tasks was developed. The sets of ‘competencies’ were mapped into this template. From this exercise, an initial 12 ‘domains’ of competency were identified. These domains represented broad clusters of activity. Theses clusters were considered by the project Steering Group which identified a number of gaps in relation to the requirements of the NSF, suggesting that current training, however innovative, would need to be developed further to address the skill requirements of the NSF. As a consequence, the number of domains was extended to 16 in discussion with the steering group and a range of national expert advisers.

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Subsequently, statements from 5 multi-disciplinary competency frameworks were mapped into the 16 domains. Details of the source and scope of these competency frameworks are set out below. The 16-domain tool was used, like a net, to catch all the competencies and include them in a common framework.

This process produced 5 separate maps with the 16 common clusters. A second stage of code and match refined these into one unified map in consultation with the Core Competency Network. This process also identified a number of gaps and overlaps. Ultimately a single aggregated map of existing competencies was built up. This summary was then submitted to the Steering Group for comment. Feedback indicated that greater attention should be paid to common or 'foundation' competencies and that greater specificity was required in relation to evidence-based interventions required by the NSF.

Table 1: The Sources of the Capability Statements

	Competency project	Type of project and methodology used
1	*Norfolk and Suffolk Education and Training Consortium, Mental Health Working Party (2000)*	• Uses 4 levels of competency, (1) Awareness, (2) Basic, (3) Comprehensive and (4) Detailed Specialist Knowledge • Professional and non-professional. Includes non clinical support (Administration staff)
2	*North West Demonstration Project: Core Competencies for Mental Health Workers (University of Central Lancashire, 1999)*	• Divides competency into knowledge attitude and skills • Used a qualitative methodology – focus groups and subsequent analysis • Uses the views of carers and users, psychologists and psychiatrists • Outlines competencies for different staff in settings such as: Hospital based, Primary Care, Staff in CMHTs
3	*Mental Health Competencies project, OLEC, (Mullins 1998)*	• Scoping exercise (1997) – leading to competencies project • Focused on the community setting • Utilised both a multi-disciplinary working group and a profession-specific action group to develop competencies.
4	*Shared Skills, The identification of core competencies for mental health professionals who work in Community Mental Health Teams, (Bowe, 1999)*	• Skills based – focused on key-working in CMHTs • Qualitative methodology was focus groups: users, carers and professionals • Utilised skills at 4 levels of care: (1) Assessment of care needs, (2) Planning to meet care needs, (3) Implementing the delivery of care & (4) Evaluation of care needs
5	*STAND, A schedule for assessing the Development needs of mental health staff in North Cumbria, North Cumbria Health Authority (Balogh & Somerville, 1999)*	• Designed as a training schedule to identify the training needs of all mental health care staff: Inpatient and community • Professional and non-professional • Uses rating scales to be completed with line manager to identify areas where training is required to (a) Assess the requirement of your role, and (b) assess your own level of competence

The unified map of competency statements was then checked against a number of

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other prominent core competency curricula such as:

- The Programme in Community Mental Health, Birmingham University
- The Postgraduate Diploma in Psychosocial Intervention, University of Sheffield
- The Certificate in Mental Health, Mental Health Foundation
- The Postgraduate Diploma in Effective Community Care for People with Mental Health Problems at the Sainsbury Centre for Mental Health (O' Halloran et al 1996)
- The Postgraduate Diploma in Acute Inpatient Care (Mental Health) at the Sainsbury Centre for Mental Health

This enabled an identification of gaps and the inclusion of specific statements to complete the unified map of competencies.

The unified map once completed, lacked a coherent structure. The project team developed the Capability Framework to organise and integrate the competencies into a unifying framework of Ethical practice, Knowledge, Process of Care, and Interventions, which could be applied to specific field of mental health practice.

Mapping to NSF Standards

The Capability Framework was then mapped onto the 7 Standards of the NSF to identify both:

- The NSF standards addressed by each capability statement;
- NSF Standards that were not addressed by any capability statements.

This process identified a number of gaps. Particular deficits were identified in relation to the capabilities required to address the fourth level of the model, the new service settings. Subsequently new capabilities were written for these service settings. Advice and support in writing these capabilities was obtained from key stakeholders on the steering group and elsewhere and from documentary analysis.

Consultation

Further to this, a series of consultative events with key educationalists, mental health interest groups and local services were undertaken. Feedback from these events both written and oral was used to further refine the list of capabilities.

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