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# Essential shared capabilities for the whole of the mental health workforce: bringing the educators into the frame

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## Abstract

Recent drives to modernise the mental health workforce have been led (in England) by initiatives such as New Ways of Working and informed by the *Ten Essential Shared Capabilities* (10 ESCs) (Department of Health, 2004), reflected elsewhere in the UK. Learning materials have been developed to support these and educators encouraged to embed them within curricula. Yet, little has been said about how such principles could or should apply to the practice of mental health educators themselves. Higher education plays a crucial part in shaping tomorrow's practitioners; yet educators can receive scant mention when workforce initiatives are launched. Here, then, we consider the 10 ESCs, examining how these might be put into practice in a higher education context. The pedagogic rationale for this perspective is discussed in terms of Biggs' (2003) concept of '*constructive alignment*', Ward's (1999) '*matching principle*' and Eraut's (1994) analysis of '*professional education*'. Reconceptualising higher education educators as a part (albeit semi-detached) of the mental health workforce may help us move beyond a 'tick-box' approach – exploring not only whether the 10 ESCs are reflected in the content of curricula, but how they are embodied within teaching teams.

## Key words

mental health; capability; higher education; workforce; professional training

## Introduction

A significant barrier to the creation of coherent services for people experiencing mental distress has been the absence of a shared vision concerning the capabilities needed across all professions at all levels. The development of the *Ten Essential Shared Capabilities* (10 ESCs) (Department of Health, 2004) has sought to address this gap, and extensive work has been undertaken to promote their integration into training and education (Basset *et al*, 2007; NHS Education for Scotland, 2007a; Stickley & Basset, 2008). They have informed developments in acute mental health care (NHS Education for Scotland, 2007b) prison mental health care (Hughes, 2006) and psychiatric education (Bhugra, 2008). The associated training materials have been evaluated (Brabban *et al*, 2006) and mapping exercises are underway to ascertain the extent to which the 10 ESCs have been embedded within higher education. Conceptually, the 10 ESCs have been seen primarily as a framework that educators should 'deliver'. In this article, we explore whether and how mental health educators may themselves exemplify the 10 ESCs in their teaching practice. We begin by considering the nature of the mental health educator workforce and the role of the Mental Health in Higher Education project. We select some key pedagogic principles that support the application of the 10 ESCs in a teaching context and elaborate how they might be demonstrated by educators in their own roles, giving examples of some activities and approaches. We conclude by reflecting on the benefits and challenges of conceiving of mental health educators as a distinctive, yet essential, part of the mental health workforce as a whole.

### Higher education teachers of mental health: inside or outside the mental health workforce?

The nature of the mental health educator 'workforce' in higher education is complex and inherently difficult to define (Anderson & Burgess, 2007). Mental health is taught as part of the curriculum of many qualifying professional programmes (among these are medicine, social work, nursing and allied health professions). It may feature in youth and community work programmes and initial and continuing teacher education (Rothi *et al*, 2007). It is also central to many post-registration/qualifying programmes, such as psychology or psychiatry. While some academics define themselves as 'mental health educators' or researchers, others may teach mental health as part of another specialism (eg. gerontology) or include it in a broader sequence covering, for example, human growth and development or health promotion. Clinical or practice educators also play an important part in teaching about mental health, and the contribution of service users and carers as educators ('experts by experience' or 'expert patients') has recently grown significantly (Repper & Breeze, 2004), particularly in the field of mental health (Tew *et al*, 2004; Fadden *et al*, 2005).

The Mental Health in Higher Education project (MHHE), launched in 2003, aims to enhance learning and teaching about mental health through increasing networking and the sharing of approaches across the disciplines in UK higher education (Anderson & Burgess, 2007). A continuing challenge is that of identifying the amorphous group of mental health educators referred to above. At the time of writing, some 1,300 educators are in touch with MHHE, receiving e-bulletins, accessing the website, attending workshops and contributing to discussion groups. They are drawn from across the disciplines and include academics, practice educators and service users and carers with involvement in teaching. Disseminating information about new developments such as the 10 ESCs, and promoting dialogue about their use in the higher education context, have been key aspects of the project's role.

University-based mental health educators, responsible for curriculum design and delivery, are charged with familiarising students with the ESC framework prior to their entry into the workforce – as well as refreshing the understanding of those undertaking post-qualifying courses or other continuing professional development.

While a proportion of this mental health educator workforce combine their teaching with practice roles, research has raised concerns about those who are '*clinically inactive*' (Ferguson *et al*, 2003). The difficulties and tensions mental health educators themselves experience in keeping in touch with developments in policy and practice were identified by Anderson (2003), who also points out that educators lack opportunities to contribute actively to such developments themselves.

Thus, reconceptualising higher education mental health educators as part of the mental health workforce – albeit 'long-arm', given that they are employed by universities – enables discussion about how they too may be part of, and help to shape, emergent policy and practice. Considering the application of the 10 ESCs to higher education practice is one way in which this perspective may be developed.

### Alignment, matching and professional learning – supporting educational theories and constructs

The case for considering how and why mental health educators in higher education should themselves embody the 10 ESCs is supported by three (related) pedagogic notions: alignment, matching and professional learning.

The first, '*constructive alignment*,' was developed by Biggs (2003). The key concept – that '*a good teaching system aligns teaching method and assessment to the learning activities stated in the objectives, so that all aspects of this system are in accord in supporting appropriate student learning*' (p11), will be familiar to many. This can be interpreted (or practised) in a narrow sense – that is, ensuring that specific learning objectives are taught and assessed in ways that are congruent. For example, approaches to teaching and assessment will differ radically depending on whether skills development or factual knowledge is the end in sight. While role-play would be likely to align well with the learning objectives for skills work, this would be unlikely to be appropriate for instilling factual knowledge. However, Biggs also asserts that the teaching context (eg. institutional procedures, physical setting and climate or ethos) should be considered. The climate created by educators in their interactions with students is identified as key to constructive alignment. We therefore propose that, if mental health educators are to be effective in preparing students for practice in a context where the 10 ESCs are foregrounded, then they should be guided by this framework in approaching their own task.

Our second construct is that of the *'matching principle'* described by Ward (1999). Developed originally in a residential child care teaching context, this states that *'in all professional training the mode of training should reflect the mode of practice,'* since *'what students gain from professional training may be derived at least as much from the experience of the learning process and its context as it is from the academic content of the learning'* (p161). Thus, a student may learn more about working in partnership from a mental health module co-facilitated with a service user trainer than from a formal lecture on joint working. Conversely, if there is no *'match'*, students may experience the *'cognitive dissonance'* between theory and practice described, in a social work context, by Lymbery and Butler (2004) – both within the higher education setting and on entering practice.

Finally, writing about the nature of *'professional education'*, Eraut (1994) specifies the need to focus on process knowledge, defined as *'knowing how to conduct the various processes that contribute to professional action'* (p107). As such, the educator can be described as a role-model for professional process learning. To the extent that the 10 ESCs can be exemplified in learning and teaching contexts, their centrality will be reinforced.

## Essential shared capabilities for educators

*'The psychiatrist of the future will need a range of competencies in clinical, management, teaching, research and other areas. The impact of documents such as The Ten Essential Shared Capabilities cannot be overestimated.'* (Bhugra, 2008)

*The Ten Essential Shared Capabilities* have been endorsed by all professional groups and their representative bodies. How, then, might the 10 ESCs be relevant to educators, not only as a curriculum framework, but as a set of capabilities that they too can model for their students?

The examples described below may be considered by mental health educators to be nothing more than good teaching practice. Our contribution here is not to identify new methods, but to set effective teaching practice within the framework of the 10 ESCs for the whole of the mental health workforce. In claiming a place within that workforce for educators, we are not

suggesting that they can or should engage in therapeutic interventions with students, the dangers of which have been rehearsed elsewhere (Baker *et al*, 2006). We are suggesting that they have an essential part to play – through the shaping of future practitioners – in the creation of user- and carer-centred services.

In the case study that follows overleaf, we consider the example of a lecturer, Ayesha, newly appointed from a practice setting and convenor of a mental health module on a qualifying programme (for our purposes this could relate to any professional discipline). She is asked to reflect not only on the extent to which the 10 ESCs are embedded in her module, but also on how she embodies them in her own role. The example chosen here is of a lecturer employed within a higher education setting. Practice educators have ample opportunities for such modelling too but, since such opportunities are less readily recognised in the higher education context, that setting has been chosen here.

## Challenges and opportunities

We illustrate in the case study how mental health educators may demonstrate the 10 ESCs in teaching; drawing parallels for students between issues encountered in a learning and teaching context and those they may face in future practice. While constraints on teaching in a student-centred way (for example, high student numbers, restricted resources) may be experienced as far from ideal, they arguably provide examples from which to learn about the challenges of practice. Clearly, it can be inappropriate for a lecturer to share with students the constraints that they are subject to – just as it may be inappropriate for a worker to share constraints with service users in a practice setting. Yet, drawn-on with care, much can be learned from such examples of reflection.

Situations in which students and service users meet to explore their commonalities can be powerful. Co-operative enquiry (Tee *et al*, 2007) has potential as a methodology. Service users might be encouraged to reflect on their experience of the 10 ESCs in practice; students to consider the extent to which each capability was (a) covered as an element of their curriculum and (b) embodied in the process. And educators should themselves reflect on how coherently from their perspective the 10 ESCs have been exemplified.

**Case study: The Ten Essential Shared Capabilities**

<p><b>... for the whole of the mental health workforce</b></p> <p><b>1. Working in partnership</b> Developing and maintaining constructive working relationships with service users, carers, families, colleagues, lay people and wider community networks. Working positively with any tensions created by conflicts of interest or aspiration that may arise between the partners in care.</p> <p><b>Examples</b></p> <ul style="list-style-type: none"><li>• Ayesha maintains relationships with colleagues in the community mental health team where she used to work – strengthening bridges between the university and practice setting. She reflects with students on her own learning as she moved from practice to academia, examining tensions between the two.</li><li>• In planning the module, she takes care to include a variety of perspectives on mental health, involving academic colleagues from other disciplines.</li><li>• Faced with criticism from students of her emphasis on self-directed learning, Ayesha explores with students their desire for information to be handed to them, rather than sought out, explaining how this runs counter to her perception of her role. She draws out parallels with tensions that students may encounter in future relationships with service users.</li></ul>	<p><b>Questions for mental health educators</b></p> <p>How do I develop and maintain constructive working relationships with students, colleagues and wider community networks? How can I work positively with any tensions created by conflicts of interest or aspiration that may arise between the partners in education?</p>
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<p><b>2. Respecting diversity</b> Working in partnership with service users, carers, families and colleagues to provide care and interventions that not only make a positive difference but also do so in ways that respect and value diversity including age, race, culture, disability, gender, spirituality and sexuality.</p> <p><b>Examples</b></p> <ul style="list-style-type: none"><li>• The student cohort is diverse in terms of age, culture and sexuality. Ayesha provides opportunities for exploration of differences within the group, through:<ol style="list-style-type: none"><li>1) articulating how her own age, sex, ethnicity and background impact on her perceptions of mental distress, encouraging students to do likewise</li><li>2) asking students to describe a period of stress in their families of origin and to consider what coping strategies were used.</li></ol></li><li>• When constructing seminar groups, Ayesha is mindful of overt differences in age, sex and ethnicity – ensuring that students are not placed in isolated situations, potentially detrimental to their mental health.</li><li>• Ayesha avoids stereotyping colleagues introduced from other disciplines – encouraging students to examine their preconceptions about other professionals and the origins of these.</li></ul>	<p>How do I work in partnership with students, service users, carers and colleagues to provide educational interventions that not only make a positive difference but also do so in ways that respect and value diversity including age, race, culture, disability, gender, spirituality and sexuality?</p>
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**Case study: The Ten Essential Shared Capabilities (continued)**

... for the whole of the mental health workforce      **Questions for mental health educators**

**3. Practising ethically**

Recognising the rights and aspirations of service users and their families, acknowledging power differentials and minimising them whenever possible.

Providing treatment and care that is accountable to service users and carers within the boundaries prescribed by national (professional), legal and local codes of ethical practice.

How do I ensure that I recognise the rights and aspirations of students, acknowledging power differentials and minimising them whenever possible?

How do I provide educational interventions that are accountable to students and service users and carers within the boundaries prescribed by national (professional), legal and local codes of ethics?

**Examples**

- In the first session of a module, taught interprofessionally, Ayesha facilitates a discussion about power – enabling students to share how they feel or do not feel powerful and to consider how this impacts on their learning. Power differentials between professional groups, and in relation to service users, are explored; and students are helped to understand how similar discussions in a practice context may be helpful.
- Ayesha's programme involves service users and carers in all aspects of its work – from recruitment and programme planning, through teaching, assessment and evaluation. She reflects with students on the strengths and limitations of this work to date; introducing strategic involvement work as one potential aspect of their future role.
- While working collaboratively and openly with students, Ayesha is clear about the power differential that assessment entails. When a student discloses his own mental health problems, Ayesha enables him to access suitable support within the university, careful not to overstep the boundaries of her role.

**4. Challenging inequality**

Addressing the causes and consequences of stigma, discrimination, social inequality and exclusion on service users, carers and mental health services.

Creating, developing or maintaining valued social roles for people in the communities they come from.

How do I address the causes and consequences of stigma, discrimination, social inequality and exclusion for students with mental health problems?

Through education, how do I help create, develop and/or maintain valued social roles for people in the communities from which they come?

**Examples**

- Ayesha supports anti-stigma work – contributing to a panel at a student union meeting on World Mental Health Day and encouraging the active participation of students and her colleagues.
- Ayesha enables students who have prior learning in psychology to unpick some assumptions that underpinned a module on 'abnormal psychology' – helping them to recognise the weight that, as psychology graduates, their views may be seen to carry within the communities from which they come.
- She ensures that a student with mental health problems does not fall behind in class, ensuring that handouts are retained for her.

**Case study: The Ten Essential Shared Capabilities (continued)**

<p><b>... for the whole of the mental health workforce</b></p> <p><b>5. Promoting recovery</b> Working in partnership to provide care and treatment that enables service users and carers to tackle mental health problems with hope and optimism and to work towards a valued lifestyle within and beyond the limits of any mental health problem.</p> <p><b>Examples</b></p> <ul style="list-style-type: none"><li>• Throughout her teaching, Ayesha includes reflective discussion about stress, how this affects us all, how it can be recognised and how it can be lived with.</li><li>• In the classroom, Ayesha makes use of digital resources that illustrate how well-known people are living with mental health problems, including the links these can have with creativity. She is a personal tutor to a student with a diagnosis of bipolar disorder, and introduces her to Kay Redfield Jamieson's account (1997) of her own diagnosis and its impact – positive as well as challenging – on her work as a medical practitioner.</li></ul>	<p><b>Questions for mental health educators</b></p> <p>How do I work in partnership to provide support that enables students to tackle mental health problems with hope and optimism and – through education – to work towards a valued lifestyle within and beyond the limits of any mental health problem?</p>
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<p><b>6. Identifying people's needs and strengths</b> Working in partnership to gather information to agree health and social care needs in the context of the preferred lifestyle and aspirations of service users their families, carers and friends.</p> <p><b>Examples</b></p> <ul style="list-style-type: none"><li>• Keen to enable students to discuss their perceptions of their own needs and strengths, but lacking time to meet with them individually, Ayesha shares the dilemma with her students. They decide to undertake the task in pairs and Ayesha draws out parallels with problem-solving in a practice context.</li><li>• Ayesha takes a strengths-based approach to student assessment, giving generic feedback founded on successful work. She suggests a revision of individual assessment feedback forms to prompt positive comments, along with suggestions for improvement.</li></ul>	<p>How do I work in partnership to gather information to agree educational goals in the context of the preferred lifestyle and aspirations of students?</p>
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<p><b>7. Providing service user centred care</b> Negotiating achievable and meaningful goals; primarily from the perspective of service users and their families. Influencing and seeking the means to achieve these goals and clarifying the responsibilities of the people who will provide any help that is needed, including systematically evaluating outcomes and achievements.</p> <p><b>Examples</b></p> <ul style="list-style-type: none"><li>• Ayesha adopts a problem-based learning approach. Students meet in groups that include two service users to agree their learning goals and, together, investigate and report back on learning outcomes. Ayesha engages colleagues from other disciplines as consultants. She reflects with the students on the process and her own role as facilitator – drawing out parallels with the practice context.</li></ul>	<p>How do I negotiate achievable and meaningful goals; primarily from the perspective of students and informed by service users and their families? How do I influence and seek the means to achieve these goals and clarify the responsibilities of the people who will provide any help that is needed, including systematically evaluating outcomes and achievements?</p>
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**Case study: The Ten Essential Shared Capabilities (continued)**

... for the whole of the mental health workforce      **Questions for mental health educators**

**8. Making a difference**

Facilitating access to and delivering the best quality, evidence-based, values-based health and social care interventions to meet the needs and aspirations of service users and their families and carers.

How do I facilitate access to and deliver the best quality, evidence-based, values-based educational interventions to meet the needs and aspirations of students, service users and their families and carers?

**Examples**

- Ayesha attends a workshop on evaluating outcomes in education, and sets up a self-efficacy questionnaire for students to complete at the start and finish of the module. This provides Ayesha with valuable evidence about learning, and her students with experience of a process adaptable to their own future work with service users.
- The head of Ayesha's programme lobbies for appointment of a user lecturer, actively supporting them once in post. Students are encouraged to take a role in arguing for the post and encouraged to learn from this experience of activism, drawing out parallels with practice.

**9. Promoting safety and positive risk-taking**

Empowering the person to decide the level of risk they are prepared to take with their health and safety. This includes working with the tension between promoting safety and positive risk-taking, including assessing and dealing with possible risks for service users, carers, family members, and the wider public.

How do I empower the student to decide the level of risk they are prepared to take with their health and safety? This includes working with the tension between promoting safety and positive risk taking, including assessing and dealing with possible risks for students and the wider public.

**Examples**

- Ayesha helps students explore what they are prepared to reveal within teaching sessions, sharing some of her own dilemmas in that area and considering boundary issues in a practice context. Students are encouraged and supported to set up a mental health support group and meetings are resourced.

**10. Personal development and learning**

Keeping up-to-date with changes in practice and participating in lifelong learning, personal and professional development for one's self and colleagues through supervision, appraisal and reflective practice.

How do I keep up-to-date with changes in practice and education and participate in lifelong learning, personal and professional development for myself and colleagues – through supervision, appraisal and reflective practice?

**Examples**

- Ayesha accesses support on a reciprocal basis from colleagues within the programme team. She ensures that her learning from these discussions is evident to students – modelling for them the need for personal and professional development and support. Where appropriate, she arranges for students to accompany her to conferences and events.



## Conclusion

McGonagle *et al* (2008, p25) argue that the 10 ESCs '*can and should underpin not only interactions with service users and carers, but also interaction with colleagues in mental health and other services*'. We have extended this logic to encompass relationships in higher education settings too. We have identified some key pedagogic principles (constructive alignment, the 'matching' principle and process learning) that lend support to this approach. The examples we have given of how the 10 ESCs might be exemplified by educators themselves are, we believe, applicable across a range of disciplines and in interprofessional learning contexts too. Our approach goes some way to addressing Hope's (2008) warning about the dangers of a 'tick-box' approach to evaluating integration of the 10 ESCs, contrasted with an '*in-depth scrutiny of curricula*' (p18). Such scrutiny implies that the 10 ESCs should be mapped not only against the content of programmes, but also against our own practice as educators and the work of our own teaching teams.

We do not claim that this is easy. While university educators – many of them former if not current practitioners and/or users of services – may welcome recognition as part of the 'mental health workforce', such a definition will bring its challenges too. Independence and academic freedom are highly prized in higher education. There may be a fear that the right to critique emergent policy and practice could be compromised if academics were to be subsumed into the workforce for health and social care. Modularisation and other features of the current academic landscape may militate against the approach we advocate. It can be daunting to recognise that such challenges have their roots not only within individual programmes, but in the academic institution as a whole. Yet, mechanisms to address them will have concomitant gains across this broader field. Taking the approach we have adopted with the 10 ESCs, other practice-related frameworks may be extended to encompass the role of educators too. Is there potential for *Creating Capable Teams* (Department of Health 2007a) in higher education; for *New Ways of Working* (Department of Health, 2007b) for educators? Could recent policy developments in mental health have something to offer academics in professional disciplines – seen as a lever for change, rather than in terms of the potential challenges they pose?

Applied with creativity and sensitivity, we believe that the value base informing the 10 ESCs (and other recent policy initiatives) has much to offer students and teachers in a higher education context – with the potential to enhance not only direct practice with service users, but learning and teaching too. The model that we suggest – reconceptualising educators as a distinct but integral part of the mental health workforce – may be one way forward.

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