Prepared by Health Education England

NATIONAL CURRICULUM FOR MENTAL HEALTH AND WELLBEING PRACTITIONERS

SPECIALIST ADULT MENTAL HEALTH

Second Edition (November 2021)

Published December 2021

National Curriculum for Mental Health and Wellbeing Practitioners – Specialist Adult Mental Health

Introduction

The NHS Long Term Plan[1] sets out a commitment to new and integrated models of primary and community mental health care. A new community-based offer will include access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance use. This includes maintaining and developing new services for people who have the most complex needs and proactive work to address racial disparities. As part of this development, there is a need to expand the adult community workforce by over 10,000 staff[2]. Transformation and expansion will include increasing access to evidence-based psychological therapies – which will mean extended training for existing and new staff across a range of NICE-recommended modalities. To complement this, Mental Health and Wellbeing Practitioners will work alongside multi-disciplinary team members to co-ordinate care, supporting collaborative decision-making about care and treatment. They will also deliver a set of wellbeing-focused psychologically-informed interventions, aligned to cognitive-behavioural principles, based on the best evidence available, that address problems often experienced by people with severe mental health problems. Their work will include carers and families as appropriate to enable connectedness and informal support. Shared decision-making and the interventions will be underpinned by generic therapeutic competences within the NICE-recommended interventions for severe mental health problems[3].

Entry Requirements

The curriculum is designed so that it can be available at both undergraduate (level 6) and postgraduate certificate level (level 7). Entrants do not need to possess previous clinical or professional expertise in mental health, but should have demonstrable interpersonal skills and values consistent with providing hopeful, person-centred care. They should show a commitment to working with people with complex mental health needs. They should hold evidence of academic credit or equivalence allowing entry to either the Level 6

[1] https://www.longtermplan.nhs.uk/

[2] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf

[3] https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks

Published December 2021

or the Level 7 programme. A degree at 2:2 or above in any relevant subject, or equivalent, should be considered the minimum requirement for entry to the Level 7 programme.

Learning and Teaching Strategy

The curriculum is based on three components (see below) delivered over 45 days in total. This number of days is essential to meet the learning objectives specified within the curriculum. Although each component has a specific set of foci and learning outcomes, the clinical competencies build on each other and courses are expected to focus the majority of their teaching activity on clinical competence development through clinical simulation/role play. Assessment focuses primarily on trainees' practical demonstration of competencies. Skills based competency assessments are independent of academic level and must be passed. Students can undertake academic assessments at either undergraduate or postgraduate level, depending on their prior academic attainment.

The curriculum includes both theoretical learning and skills practice within the Higher Education Institute and practice-based learning directed by the education provider that extends learning into practice. Over the 3 components of 45 days, 33 days are delivered as theoretical learning and skills practice and 12 days as directed practice-based learning. Directed practice-based learning tasks include shadowing/observation, role play/practice with peers/colleagues of assessment and
interventions, self-practice of interventions with reflection (i.e. applying techniques to issues from own life), and directed problem-based learning. Beyond the year's training the practitioners should have opportunities to embed competences through a period of preceptorship. They should also have access to opportunities to progress within the MHWP role, and beyond it into psychological therapy or clinical psychology training, after a required period of qualified practice.

Supervised and Assessed Practice

The training programme requires trainees to learn from observation and skills practice under supervision while working in fully functioning adult community mental health / integrated primary care services, as well as through the theoretical teaching, skills practice and practice-based learning directed by the Higher Education Institute. Trainees should complete a minimum of 80 clinical contact hours with patients within an adult community mental health service as a requirement of their training (of which 40 hours should be specifically delivering psychologically-informed interventions). Trainees should undertake a minimum of 40 hours of clinical supervision of which at least 20 hours should be case management supervision and at least 20 hours should be clinical skills supervision. These 80 clinical contact hours and 40 supervision hours are in addition to the 15 practice-based learning days directed by education providers. There should be weekly individual case management supervision (where the entire caseload is reviewed and action agreed if there is current high risk, an increase in risk or a regular monthly review of the care plan is due). Case management supervision can be provided by any suitably qualified professional in the team. In addition, there should be fortnightly individual or group-based clinical skills supervision. Clinical skills development supervision should be provided by a practitioner with competence in the interventions MHWPs will offer, drawn from one of the following occupations: an HCPC registered Clinical Psychologist, a BABCP accredited CBT Therapist or a MHWP with at

least two years of post-qualification practice experience. Supervision (case management and clinical skills) of MHWPs should be by practitioners who have undertaken specific training on MHWP supervision.

Equality, Diversity and Inclusion

Courses must align their programmes to statutory duties under the Equality Act 2010, requiring public authorities who exercise public functions, and organisations carrying out public functions on behalf of a public authority, to advance equality of opportunity, eliminate unlawful discrimination and foster good relations between people of all protected characteristics.

Courses should include equality, diversity and inclusion issues within all teaching, with a specific focus on:

1) Reducing inequity of access and outcome among those from minoritized groups accessing mental health services
2) Seeking to eliminate all forms of discrimination from the experience of the mental health service users and staff.

Expert by Experience Involvement in Training

People with lived experience make a positive contribution to the learning, practice and work of mental health professionals. The involvement of those with lived experience highlights to professionals the importance of placing the goals, needs and strengths of service users, families, carers and the wider community at the centre of all they do.

The inclusion of people with lived experience in training programmes improves trainees understanding of the way in which service users, families and carers experience and understand their situation. Trainees should be equipped to provide compassionate, empathetic and effective care and understand the networks and systems in which service users live.

In addition to the lived experience of members of the public, it is also important that trainees have the opportunity to explore the relevance of their own lived experiences to their clinical practice.

Programmes should incorporate lived experience into the training. Informing, collaborating and co-production are all valuable contributions. Courses should attend to:

- How the involvement of those with lived experience is co-ordinated.
- How lived experience contributors are selected to be representative of all backgrounds, cultures and ethnicities.
- How people with lived experience are rewarded for their contribution.
- Involvement in:
    - Course development
    - Student selection and interview panels.
    - Teaching and learning.
    - Assessment
    - Student mentoring
    - Recruitment of staff
    - Planning of programmes and quality assurance

Course Structure

The curriculum for the education of Mental Health and Wellbeing Practitioner in Specialist Adult Mental Health (MHWP-SAMH) is organised into three components (see below). Components can be organised according to local module structure requirements by training providers to comply with their academic timetable and tailored to suit local needs.

The assessment of academic and clinical skills is detailed below. All clinical skills should be assessed by practical tests of clinical competence. Because of the critical nature of clinical competence, there can be no compensation/condonement for a failed clinical competence assessment. While the assessment strategies for assessing practical clinical skills are set out for each component, the methods of assessing academic skills and knowledge may be varied locally to cover the academic content of all three components.

The curriculum will form the basis of future course accreditation.

Component 1: Engagement and assessment with people with severe mental health problems

Component 1 Aims

This component introduces MHWPs to severe mental health problems and teaches how to engage and form collaborative alliances with service users, carers and families. It teaches how to assess, manage risk, and arrive at a collaborative, simple formulation which can guide the planning of care. It will highlight the value of successful engagement as an end in its own right.

Component 1 Learning Outcomes:

Demonstrate a systematic understanding and critical awareness of, and ability to apply in practice:

1. Engagement with warmth and empathy – active listening and enquiry: developing a collaborative alliance;
2. Supporting the service user to maintain and develop relationships within the community in line with the CHIME factors (Connectedness, Hope, Identity, Meaning and Empowerment)
3. Being with someone in distress – managing affect by listening and validating
4. Professional and ethical practice;
5. Appropriate involvement of families and carers in engagement and assessment
6. Cultural competence and anti-discriminatory practice – addressing inequities of access and outcome;
7. Respect for and the value of individual differences in age, sexuality, disability, gender, spirituality, ethnicity and culture;
8. Responding to peoples' needs sensitively with regard to all aspects of diversity, including working with older people, the use of interpretation services and taking into account any physical and sensory difficulties service users may experience in accessing services.
9. CHIME factors –: understanding their link with wellbeing and recovery;
10. Risk assessment, safety management plans and safeguarding;
11. Confidentiality, consent, and the appropriate involvement of families and carers;

12. The experience and core features of psychosis, bipolar disorder, ‘personality disorder’ and eating disorders, and associated difficulties (including anxiety and depression);
13. Reasonable adjustments to make mental health services autism-friendly, and responsive to service users with substance misuse problems;
14. Understanding the relationship between adversity and presentations of severe mental health problems;
15. Trauma Informed Care principles in practice, including the role of attachment and self-compassion;
16. Collaborative assessment and formulation within the ‘5 Ps’ framework of Presenting problem, Predisposing factors, Precipitating factors, Perpetuating factors and Protective factors;

Component 1 Learning and teaching strategy

Skills based competencies will be learnt through a combination of clinical simulation in small groups working intensively under close supervision with peer and tutor feedback and supervised practice through supervised direct contact with patients in the workplace. Knowledge will be learnt through a combination of lectures, seminars, discussion groups, guided reading and independent study.

Component 1 Assessment Strategy

1) Standardised role-play scenario(s) where trainees are required to demonstrate skills in undertaking problem focused assessment and 5 P formulation. This will be video-recorded and assessed by teaching staff using standardised assessment measures that measure skills in engagement, flexibility and ability to stick to task.
2) Academic assignment: trainees should also provide a reflective commentary on their performance on the above, or an alternative academic assignment could be set e.g. an exam, case report or essay.
3) Successful completion of the following practice outcomes, to be assessed by means of a practice outcomes portfolio:

- Demonstrates the common factor competencies necessary to engage effectively and involve families and carers in line with the service user’s and their family’s needs
- Demonstrates competence in undertaking assessments across a range of presenting problems
- Demonstrates competence in the generation of 5 P formulations with clients

Component 1 Duration

The following structure is suggested for this component:
12 days in total, with a minimum of 9 days of theoretical teaching, skills practice in intensive workshops and clinical simulations and up to 3 days undertaking directed practice-based learning in the service setting.

Component 2: Care Planning in Partnership

Component 2 Aims
This component enables MHWPs to mobilise resources in collaboration with service users, carers and families – including information, resources within the multi-disciplinary team and beyond in the wider community. It also enables MHWPs to make effective use of clinical supervision and to look after their own wellbeing.

Component 2 Learning outcomes:
Demonstrate a systematic understanding and critical awareness of, and ability to apply in practice:

1. Helpful information giving to service users, families and carers
2. Shared decision making in practice
3. Appropriate involvement of families and carers in care planning
4. The range of resources available to support wellbeing and recovery in the locality served
5. Understanding the roles in multi-disciplinary teams (within primary care teams and mental health community teams)
6. Understanding the role of employment support in the team;
7. Symptom focused and personal recovery/wellbeing models of mental health;
8. Diagnosis and formulation, how they differ, limitations and benefits;
9. Demonstrate awareness and understanding of the power issues in professional /service user and family and carer relationships.
10. Demonstrate competence in managing a caseload of people with severe mental health problems efficiently and safely.
11. Collaborative care planning within the multi-disciplinary team, with active management of risk and safeguarding and with understanding of the impact of this on service user, family and carers;
12. Use of clinical information systems and correspondence
13. Reflexive practice and using clinical supervision
14. Self-care and wellbeing for staff and teams

Component 2 Learning and teaching strategy
Skills based competencies will be learnt through a combination of clinical simulation and role plays in small groups working intensively under close supervision with peer and tutor feedback and supervised practice through supervised direct contact with patients in the workplace. Knowledge will be learnt through a combination of lectures, seminars, discussion groups, guided reading and independent study.

Component 2 Assessment Strategy
1) A portfolio of collaborative care plans developed with service users, demonstrating effective use of available resources of information, team members, and wider community/networks.

2) Academic assignment: A Case Report detailing care planning with a service user, linked to relevant theories of mental health and intervention. There must be evidence of appropriate consideration of / engagement with carers and families.
3) Successful completion of the following practice outcomes, to be assessed by means of a practice outcomes portfolio:

- Demonstrates competence in the mobilisation of appropriate resources with service users
- Demonstrates high quality use of clinical information systems and effective correspondence.
- Demonstrates effective use of clinical supervision and self-care

Component 2 Duration
The following structure is suggested for this component:
12 days in total, with a minimum of 9 days of theoretical teaching, skills practice and clinical simulations and up to 3 days undertaking directed practice-based learning

Component 3: Wellbeing-focused Psychologically-informed Interventions for Severe Mental Health Problems

Component 3 Aims
This component enables MHWPs to deliver wellbeing-focused psychologically-informed interventions that support connectedness, hope, identity, meaning and empowerment (CHIME). MHWPs will learn to set collaborative goals with people with severe mental health problems and to deliver seven interventions according to an intervention manual. The interventions will be applied with appropriate flexibility within the context of a positive collaborative working relationship, whilst maintaining fidelity to the interventions. It will also embed the routine use of patient-reported outcome measures to support collaborative evaluation of progress.

Component 3 Learning outcomes:
Demonstrate a systematic understanding and critical awareness of, and ability to apply in practice:

1. Collaborative construction of a 5-areas formulation to inform psychologically-informed interventions;
2. Collaborative goal setting for wellbeing-focused psychologically-informed interventions
3. When not to intervene, or to pause or end an intervention.
4. Appropriate involvement of families and carers in psychologically-informed intervention
5. Working with motivational difficulties and readiness to change
6. The effective use of routine patient-reported outcome measures
7. Seven specific wellbeing-focused psychologically-informed interventions:
    a. Behavioural Activation and Graded Exposure using the “GOALS” programme
    b. Teaching problem-solving skills
    c. Improving sleep

   d. Recognising and managing emotions
   e. Guided self-help for bulimia and binge-eating
   f. Building confidence
   g. Medication support – based on information-giving.
8. Relapse Prevention/Staying Well
9. Dealing with endings safely and appropriately;
10. Appreciation of the worker's own level of competence and boundaries of competence and role

Component 3 Learning and Teaching Strategy

Skills based competencies will be learnt through a combination of clinical simulation in small groups working intensively under close supervision with peer and tutor feedback and supervised practice through supervised direct contact with patients in the workplace. Knowledge will be learnt through a combination of lectures, seminars, discussion groups, guided reading and independent study.

Component 3 Assessment Strategy

1) A recording of a session with a service user delivering one of the specified interventions, rated according to a standardised rating scale
2) A case report of intervention with a service user using one of the specified interventions, linked to relevant theory and critical evaluation.
3) Successful completion of the following practice outcomes, to be assessed by means of a practice outcomes portfolio:

- Demonstrates the ability to set appropriate goals for intervention collaboratively with service users
- Demonstrates competence to deliver all specified interventions in practice

Component 3 Duration

The following structure is suggested for this component:
21 days in total, with a minimum of 15 days to be spent in class in theoretical teaching and clinical simulation and up to 6 days undertaking directed practice-based learning.