



**HSE Legal Activity Project**  
Enhancing Organisational Learning  
in response to the Mental Health Acts  
2001-2009



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

**HSE Legal Activity Project**  
Organisational Learning Strategy  
in response to the  
Mental Health Acts 2001-2009

Meeting the Determinants of a  
Quality Mental Health Service



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive



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## Foreword

*A Vision for Change; Report of the Expert Group on Mental Health Policy* (DoH&C, 2006) signalled the development of mental health services that place users at their centre and facilitates active partnerships between stakeholders. A well educated and skilled professional workforce is crucial to the delivery of safe and effective care. Increasingly, there is an emphasis on capable practice which recognises the need to focus on the competencies which all mental health staff require, irrespective of discipline in order to deliver safe, 'capable' care at the point of delivery. This presents a major challenge to mental health services in ensuring that mental health professionals are equipped with the right knowledge, skills and expertise to deliver high-quality mental health care.

Legal activity in relation to the Mental Health Acts 2001-2009 (MHA) indicates the high exposure of our mental health services to potential breaches of patient human rights in the context of involuntary admission and detention. In the first full year of operation of the MHA, there were 34 Article 40 enquiries to the High Court (Habeus Corpus), 3 judicial review to the High Court, 2 appeals to the Supreme Court and 39 Circuit Court appeals of Mental Health Tribunal decisions. Failure to operate strictly in accordance with the provisions of the legislation in respect of involuntary admission and detention can lead to significant consequences for service users and staff in terms of distress, and to considerable costs to the service in terms of staff time and legal costs.

This strategy is primarily driven by the strategic and quality agenda at a national level, reflective of international standards and norms in respect of mental health legislation and its impact on service delivery. Not only has the practice context continued to change irrevocably since the introduction of the MHA, but the pace and demands for responsive organisational and professional learning into the future will require mental health personnel to engage in an ongoing process of learning.

It is clearly in the interests of the Health Service Executive (HSE) to ensure that its governance within mental health services is fully compliant with the requirements of the legislation to the greatest possible extent. A sound working knowledge of the legislation and the obligations placed on mental health services by legislation, regulation and rules is an essential tool for all those working in mental health services. The acquisition of the required knowledge and competencies in order to meet the requirements of a capable workforce in terms of professional and organisational practice will be heavily dependant on delivery systems that can fit as seamlessly as possible into the workplace and integrate within existing professional curricula.

## Purpose Of Learning Strategy

The purpose of this Learning Strategy is to outline recommended training requirements relating to the full implementation of the Mental Health Act, 2001 with a view to informing the commissioning and sustainability of appropriate training resources and materials. The need for training is clearly stated within the Mental Health Act 2001 (Approved Centres) Regulations 2006 (S.I. No. 551 of 2006).

*“the registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice” (Part 5, 26(4) –Staffing)*

*“registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made there under, commensurate with their role” (Part 5, 26(5) –Staffing).*

This Strategy is intended to provide a structure for the Health Service Executive and allied organisations to assist with the planning and commissioning of training in meeting the requirements of the MHA 2001-2009 and beyond.

This Strategy is targeted at all professional groups, education and training providers and seeks to provide direction to mental health staff in planning and designing training to meet the needs of a modern mental health service. The initial consultation process required engaging with professional bodies, academic experts, and service users on the validity of the methodologies best suited to the acquisition of professional knowledge and skills. Further extensive consultation will be required with operational managers - Heads of Services, Local Health Managers, Heads of Disciplines, Service Users and Clinical Leads to develop plans to support the implementation of the strategy.

## Structure Of Learning Strategy

The Strategy falls into two parts. The first seeks to contextualise the changes taking place in mental health service delivery, the impact and influence of mental health legislation and regulation on practice and the emerging changes in undergraduate and ongoing professional education with a shift towards a ‘*capability*’ model of professional role and performance.

The second part of the strategy seeks to outline the scope of learning required (*what we need to know*) and proposes organisational learning methodologies that support the process of learning and skill acquisition (*how you might learn what you need to know*). Examples are offered for illustrative purpose in the appendices that support the operationalisation of the learning methodologies.

In developing the strategy the project team sought to take account of the significant work that has taken place and is emerging with regard to professional education and training, such as the Medical Education Training and Research Report (HSE, 2007), Report of Post - Registration Nursing and Midwifery Review Group (HSE, 2008), The Education and Development of Health and Social Care Professionals in the Health Services (2009), the anticipated report on the education/training provision of mental health professionals working in Ireland (MHC) and the HSE National Service Plan (2009, 2010).

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## PART 1

### Staff Training & Development

Key training needs are emerging from the implications of mental health legislation in addition to strategic policy reports that have indicated an assortment of training needs for mental health professionals: *Vision For Change* (VfC), (DoH&C, 2006) *Quality Framework for Mental Health Services* (MHC, 2007) (QF), HSE national health strategies and service plans. Other key indicators of training needs emerge from professional bodies such as An Bord Altranais, Irish Medical Council and HSE Human Resources Directorate. In addition, training needs emerge from practice based critical incident analysis reviews, personal development planning, team development needs, audit findings as well as inquiry reports such as the Lourdes Hospital inquiry, the Clonmel inquiry and Central Mental Hospital inquiry.

In consideration of the above, the key emerging themes influencing mental health education and training within Ireland include:

- development of a quality focused workforce
- development of a flexible workforce, competent and fit for purpose
- development of a national quality service
- promotion of inter-disciplinary working and learning
- promotion of accountable professional practice
- promotion of transparency and partnership in terms of interventions, care-planning and systems delivery
- promotion of ethical values that respect the worth, rights and integrity of service users

These are all within the context of the development of more integrated structures and revised clinical care directorates with clinicians more directly involved in the delivery of care and services, management and planning.

### Ethos Underpinning Mental Health Act Organisational Learning Strategy

An organisational culture is emerging in healthcare that seeks to reduce risk and promote quality standards. In striving towards this, health organisations are recognising the value of governance arrangements that include the utilisation of learning or striving to become 'learning organisations'. In order to fulfil its obligations to promote patient standards, the HSE recognises the need to invest in training and education and has to date, committed significant resources to achieve this

at undergraduate level, postgraduate level and through in-service training and development. In addition, professionals are now more aware of the need to practice within ethical and legal frameworks, coupled with emerging standards of care driven by regulatory bodies such as the Mental Health Commission arising from implementation of the MHA.

The philosophy of lifelong learning is now accepted by health care professionals as a requirement to maintain clinical competency. This not only serves to enhance professional judgement, knowledge and skills but more importantly offers patients the highest possible standard of care. The ethos of this training strategy seeks to strike a balance between the obligations placed on professionals working within mental health services to fulfil their professional requirements, and to maintain competencies and the obligation placed on the HSE to put structures in place to facilitate this. It does not seek to put undue emphasis on either party but seeks to recognise that all have a part to play in supporting the need for lifelong learning which in turn is reflected in an evidence based, safer and more effective Mental Health Service (MHS).

A central element of the training strategy is to harness and maximise the value inherent in the intellectual capital available within MHS. This has built up through clinician experience combined with the investment in further education and professional development over the past number of years. This potential is not sufficiently maximised to create and sustain a learning organisation and offers the opportunity to create the conditions to build capacity within the system through the development of an interdisciplinary blended learning culture. This harnesses latent knowledge in the system in a more complete but different manner.

In the main, the education and training needs of mental health staff can be grouped into 6 key areas, namely leadership, management, professional development, specialist practice, non-specialist role development and development of mental health support workers. The impact of mental health legislation places an obligation on all members of staff to apply the legislation within the letter of the law, as sanctions apply if the MHA is not complied with. The spirit of the law however places a professional obligation on staff to operate to key human rights principles such as working to meet the best interests of the Person; respect, privacy, bodily integrity, quality services and best practice; right to information and representation; least restrictive care environment, ensuring a process of natural justice is available and facilitated.

In meeting these obligations, the MHA requires all mental health care staff to be fully informed and competent to perform their individual responsibilities. Therefore this should be reflected within the competencies and job descriptions for all grades of staff within MHS. Within this process, there is also a need to balance the independence and autonomy of each professional group and body along with the need for all staff to “work together to the benefit of the professions collectively, the employers and most importantly to the public”, (Education & Development of Health and Social care Professionals in the Health Services, 2009).

It is proposed therefore that the focus of this Strategy – mental health legislation, should be part of the training programme for mental health clinical staff, non-clinical staff, students, mental health managers, administrators, heads of service, whether it relates to professional or non-professional roles (Table 1).

**Table 1: Scope Of Mental Health Legislation On Organisational Roles**



## Providing Education & Training Within The Mental Health Service

Learning, in practical terms can be described as both a process and in its outcomes. A narrow definition of training is a process through which individuals are helped to learn a skill or technique where the acquisition of knowledge is often an end-point. Development, in contrast places emphasis on the growth of the individual. There is no fixed point to development because individuals can continually improve. Methodologies include participation in a broad range of planned activities and experience, some of which are described later.

Concepts of Continuing Professional Education, Continuing Professional Development and Life Long Learning all offer the potential for education, training and development to deliver a range of benefits which can help to:

- Improve patient and client care;
- Reduce risks to patients and staff;
- Have a positive effect on recruitment and retention.

The key themes influencing mental health education and training include:

- concepts around lifelong learning – individuals being able to take greater responsibility for their own continuous development
- development of processes which embed education and training in the workplace - moving from over-emphasis on academic achievement to one where learning in and from practice is equally valued
- development of relationships between quality education and quality services-clinical governance
- facilitating a constant dynamic of improvement

Styles of learning and motivation vary greatly, especially in adult learners.

Key points in mental health professionals learning include:

- Individuals are likely to learn more effectively when the learning tasks are seen to be relevant, meaningful, interesting and useful.
- Individuals have wide experience and knowledge, but often lack confidence in themselves as learners
- Individuals expect to be treated with respect and equality
- Achieving some learning success is likely to increase motivation for further learning

(Knowles *et al*, 1998)

## Focus Of Strategy

Whilst legislative changes form the context of this proposal, there are strategic imperatives (VfC, 2006) regulatory requirements and standards (MHC, 2007) and emerging concepts in terms of roles and professional competencies which influence and impact on this Strategy. Recent reports such as *Building a Culture of Patient Safety* (DoHC, 2008) and the *Integrated Quality, Safety & Risk Framework* (HSE, 2009) all point to a more user focused, standards driven service that require a consistency of approach and commonality of service experience that places new demands on services. Local practices both at organisational and professional level, are coming under greater scrutiny to identify more homogenous service delivery standards across all service areas, with clearer, positive and more consistent service user experiences and outcomes.

## Mental Health Training Requirements

Integrated care that effectively blends the expertise of professionals is key to the success of modern MHS and therefore, multi-disciplinary education and training is seen as an intrinsic factor in such a culture change (Action Plan for Health Care People Management, 2002). The VfC (DoH&C, 2006) report reinforces this approach, stating:

*'Consideration should also be given to the option of providing joint training modules across the various disciplines to facilitate collective training in fundamental values and principles, to promote understanding of the unique role that each professional specialty plays in mental health, and to encourage a recognition of the value of multidisciplinary teamwork', (Vision for Change, DoH&C, 2006)*

This strategy explores both themes and needs identified through the mental health policy document *VfC* (DoH&C, 2006) and the *QF* (MHC, 2007) and the enactment of the MHA coupled with operational experience derived from the implementation of the MHA.

The *VfC* devotes a chapter reviewing the education and training required to produce competent professional personnel, capable of delivering quality mental health services.

(Key recommendations within the report are detailed in Appendix 1)

The *QF* (MHC, 2007) is explicit in identifying education and training needs for mental health professionals. The Quality Framework reflects the shift in culture in service delivery towards choice, person-centeredness, mental health promotion and recovery. It also focuses on respect, privacy and dignity, user empowerment, access to services, advocacy, best practice, holistic and seamless provision, all underpinned by corporate governance. Other requisite needs to deliver on the framework are, care provided by multi-disciplinary teams, record-keeping, adhering to legislative requirements, service user rights, consent, interpretation services, workload management, professional supervision, clinical risk management, continuous quality management, clinical audit, information technology systems, care planning and cultural awareness.

Many training needs have been identified and have emerged since the introduction of the MHA and the Criminal Law (Insanity) Act 2006. Further needs will emerge from the introduction of other planned legislation (e.g. Mental Capacity and Guardianship Bill, 2007).

The MHC rules, codes and guidance documents (2006, 2008, 2009), all have implications for training and education, these include:

- Approved Centre Regulations
- Code of Practice - Guidance for Persons Working in Mental Health Services with People with Intellectual Disabilities
- Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre
- Code of Practice on the Use of Physical Restraint in Approved Centres
- Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients
- Code of Practice Relating to Admission of Children under the Mental Health Act, 2001
- Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting

- Rules Governing the Use of Electro-Convulsive Therapy
- Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint

Mental Health Training, including training on legislation can no longer be confined solely to each professional group, rather there are shared requirements of both knowledge and skills, as well as key shared aspirations of what a modern MHS should reflect and provide. This is clearly an opportunity to focus on the ‘common ground’ that exists within mental health legislation in a number of key areas. Equally, there is a synergy gained from combining a proportion of each disciplines training programmes both in terms of knowledge/skills but also better communication and understanding within working relationships in the workplace.

This requires a response that goes beyond the traditional approach to training, which inevitably struggles to keep up with clinical service delivery and thus requires innovative ways of organisational and professional learning. Methodologies are required to be adopted by organisations and the professionals that practice within them, in order to ensure competence, currency and acceptability from a regulatory, legislative and consumer perspective. In essence this requires a cultural shift whereby learning is regarded as integral to everyday practice, implementation of standards and experience of service delivery rather than an adjunct to the organisations activity. This Strategy will address the logistics of training delivery, increase interprofessional learning and offer potential for service user involvement in learning. Essentially this involves embedding learning into the structures, roles and everyday activity within the organisation. This requires organisational commitment, managerial engagement and insight, team based performance and individual professional accountability.

## Competency Based Approach

The World Health Organisation (WHO) (1988) described competence as:

*“Competence requires knowledge, appropriate attitudes and observable mechanical or intellectual skills which, together account for the ability to deliver a specified professional service (WHO, 1988:68).*

Competence is also a dynamic process that changes as experience, knowledge and skills develop through and in practice. The identified competencies for new roles for mental health professionals can be built upon competencies achieved by the already identified health care professionals eligible to undertake the role.

Table 2 demonstrates an example of a continuing professional development portfolio incorporating competency based learning. (adapted from: *The Ten Essential Shared Capabilities, National Institute for Mental Health in England (NIMHE, 2004)*)

Table 2



**Key Point:** A movement from traditional models of training to professional development which incorporates leadership and management that builds on competencies for all staff is required.

## Developing Capability

Increasingly, the notion of ‘capability’ is appearing in the literature in relation to staff development and training. Two key documents, *The Capable Practitioner Framework* (Sainsbury Centre for Mental Health (SCMH), 2001) and *Mapping of Mental Health Education & Training in England* (NIMHE, 2001) have provided the lead for a fundamental shift in multidisciplinary educational policy in delivering a modern mental health service. These reports recognize the need to focus on the competencies which all mental health staff require, irrespective of discipline in order to deliver safe, ‘capable’ care at the point of delivery.

The SCMH report (UK) (2001) defines Capability 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

This Capability approach provides an integrative framework, which pulls together the various competency elements from numerous frameworks. However, it is acknowledged that 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.

Competency models emphasise the notion of ‘core’ or ‘common’ competencies or skills that were shared by all practitioners, for example, competencies required for authorised officer, (see Appendix 3). The ‘capability’ framework builds on this, but recognises that profession specific skills and expertise are also needed.

The Capable Practitioners 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 specific context:

- **Application:** Capabilities as they apply to specific service settings or functions, e.g. assertive outreach, crisis resolution, assisted admissions, authorised officer. Each of these five categories is further subdivided to arrive at specific statements of capability for mental health practice.

## National Policy For Education And Training Within Mental Health Services

The *VfC* (DoH&C, 2006) defines education as a process by which knowledge is acquired. Training, on the other hand, is a process by which a student is brought to a required standard of competency and proficiency in the practice of professional tasks. The Capability model provides a framework for signposting the skill development agenda identified in *VfC* and can act as a guide to best practice.

The capability model 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. 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 providers 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 developing purposeful curricula for modern mental health practice

## Interprofessional Approaches To Learning

The *VfC* (DoH&C, 2006) identifies the need for greater interdisciplinary co-operation in service provision. Freeth et al. (2005) state that “interprofessional education in health care occurs when two or more professions learn with, from and about each other to improve collaboration and quality of care”. This delivery format encourages joint training modules across various disciplines to facilitate a collective training of values and principles while encouraging recognition of the value of interdisciplinary teamwork. Freeth (2001) recognised that collaboration between mental health care professionals posed particular difficulties which included allegiance to professional cultures and different approaches to care delivery.

One method suggested to overcome these barriers is to engage in regular interdisciplinary case conferences. One member of the team leads out on preparing and presenting a case conference. This presentation in turn is reviewed and evaluated by the team. A further benefit of this approach is the involvement of the service user or their representative to add another dimension to the overall learning. Breaking down barriers and changing cultures within interdisciplinary teams is not without challenge but unless it is undertaken the full potential for education and training will not be ‘tapped into’ for all stakeholders.

Additionally, outcome evaluations in education and training are needed to ensure that healthcare professionals’ education programmes are designed so that patients, not just students or staff, benefit from the resources expended (Jordan, 1998). However, linking educational input to clinical outcomes is notoriously difficult (Priest, 2008). Studies have attempted to determine skills acquisition through self-report (Brooker et al., 2003; Bailey, 2003). However, with few exceptions courses have been introduced without evaluation of their impact on patients (Jordan, 2000). Yet it is clear that there are numerous benefits to both the organisation and the service user, from interdisciplinary education. Oxley (2002) found that a greater understanding of other professional’s roles and skills lead to individual professional identities being strengthened.

In terms of undergraduate interprofessional education, many benefits have been reported in the international literature (McFarlane, 2006). There is evidence that it provides students with new knowledge and skills for team-working and information about the prospective roles and remits of various health professionals (Pryce and Reeves, 1997). It has also been found to reduce negative stereotypes and attitudes which students may have towards students of other health professions (Carpenter, 1995).

This fact was borne out in the national MHA training (2005), the training for 'Authorised Officer' (2008) and the planned 'Assisted Admission' training programme (2010). These national training programmes have adopted an interprofessional approach to training delivery with positive feedback through evaluations received.

**Key Point:** Increase in regulations and standards driven practice requires an interdisciplinary approach to professional development.

## Continuing Professional Development (CPD)

Considerable variation exists in the interpretation and use of these terms. It is widely accepted that both terms are used interchangeably (Lawton and Wimpenny, 2003). Friedman et al. (2001) describes CPD as;

*"a systematic maintenance, improvement and broadening of knowledge and skills, and the development of personal qualities necessary for execution of professional and technical duties throughout the individual's working life".*

The purpose of CPD is to bring about improvements in clinical practice with the teacher acting as an agent for change (Francke et al., 1995; Jordan, 1998) but it can be viewed as having a range of functions.

Sadler-Smith et al. (2000) identify three key types of CPD:

- the 'maintenance role' that fosters the notion of lifelong learning
- the 'survival role' that requires practitioners to demonstrate their ongoing competence
- the 'mobility role' that aims to increase a person's employability

*A Mental Health Workforce for the Future – A Planners Guide* (SCMH, 2003) identified the centrality of service users and carers in shaping the curricula, as well as the teaching and assessment of learners in mental health settings. The HSE recognises the importance of service users and carer involvement in developing local MHS and this approach is enshrined in *VfC* (DoH&C, 2006). This approach is already well reflected in an innovative course developed through an ongoing partnership between the HSE and Dublin City University.

The purpose of the course is threefold:

- to bring service users, carers/family members and service providers together in a joint learning environment
- for participants to understand the nature and practice of a cooperative approach to leading change in healthcare organisations
- and for teams (service user, service provider and carer) to instigate and lead a service improvement in their local mental health service

## Professional Development Portfolios (PDPs)

A portfolio is described as a collection of evidence, usually in written form, of both the products and the processes of learning and attests to professional achievement (Anderson et al, 2008) and is recommended in *VfC* (DoH&C, 2006) as a means for managers addressing common learning requirements and organising staff release. The primary purpose of the portfolio of learning is to demonstrate that a student of a particular discipline has mastered the knowledge, skill, attitude and competence to work effectively within that particular discipline (Berlach, 1997). CPD and engagement in personal development planning is advocated by the National Council for the Professional Development of Nursing and Midwifery and is proposed to become a requirement for all employees in the health care sector (DoHC, 2002; Office for Health Management, 2003).

However, to date the use of portfolios tend to be restricted to academic courses or personal professional preparation for promotional opportunities rather than an aid to ensuring fitness for practice in the workforce. This issue of a 'capable' workforce is gaining currency through publications such as the ten essential shared capabilities (DOH,UK, 2004) and the need to have a good fit between service user requirements and workforce skills. The Action Plan for People Management (DoHC, 2002) proposed the roll out of personal development planning across the health service. A Professional Development Plan is a continuous development process that enables an individual to make the best use of their current knowledge and skills. It is suggested that it helps focus and advance an individual's career plans and the strategic goals of the organisation for which they work and is described as a working strategy which helps identify development needs.

**Key Point:** Increase in regulations and standards driven practice requires an interdisciplinary approach to professional development.

## Whole Systems Approach To Organisational Learning

This approach to learning is defined by Epstein & Hundert (2002) as the '*habitual and judicious use*' of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served.

This translates into reviewing roles and functions, agreeing on a common sense of what constitutes success, meeting agreed standards of practice, identifying opportunities for practice enhancement and deliberately promoting a culture that expects, facilitates, values and rewards staff input.

This approach is dependant on the values expressed by the service being pervasive (Barrett, 2006) driving all aspects of decision making and processes and reflected in individuals job descriptions.

Barrett (2006) suggests that whole system change begins with a personal shift followed by the groups' actions, in other words organisations don't change, people do. This in turn is dependant on the leaders in the organisation not only modelling the way but monitoring performance to ensure everyone is pulling in the direction of best practice. The construct of 'appreciative enquiry' (Cooperrider et al, 2000) is linked with the intention to take a whole systems approach. Appreciative enquiry seeks to take elements of the system that work well and maximise the value to be gained from it.

If we regard the knowledge, expertise and skills already in the system as an asset, 'appreciative enquiry' seeks to build on what is already in place. This approach consequently involves engaging with our roles and the way we might approach our work differently. Therefore, it is not simply about attending training or meeting core professional clinical competence but applying the doctrine of individual lifelong learning to the workplace.

A whole systems approach also touches on roles and functions undertaken by different elements of the internal HSE structure as well as external partner agencies. Although not an exhaustive list this includes:

- IT Departments
- Librarians
- HEI partners
- Professional bodies
- Staff representatives
- Regulatory agencies
- Internal stakeholders (Managers, Clinicians, Practice Developers, Administrators, Clinical Educators, Performance & Development Unit, CNMEs)

## Summary

The need for alignment between training priorities, policy development, educational curricula and strategic plans involve the inputs of all the above in order to ensure that the contribution of all leads to a service that maximises staff potential and is responsive to service users needs. Essential to any methodological approaches adopted to up skill and develop staff within the mental health service, a number of key principles need to be agreed. These are;

1. Commitment; from the top team to develop all staff to achieve its organisational objectives
2. Planning; regular reviews of the needs, clear plans and training for all employees
3. Action; training and developing individuals from recruitment throughout their employment and;
4. Evaluation; ensuring that investment in training and development is evaluated to assess achievement and effectiveness

*(Investors in People, UK, 1998)*

**Key Point:** There needs to be whole systems approach to organisational learning that utilises the resources available e.g. Higher and Continuing Professional Education Institutes, Librarians, I.T. Departments etc.

## Methodological Approach

The proposal to enhance organisational learning in response to the MHA was informed through a multistage process.

### Stage 1

Involved an overview of the literature on strategic policy with reference to the health sector in Ireland, auditing judgements in response to challenges to the MHA and considering the literature both in terms of organisational learning and contemporary frameworks addressing professional competencies in mental health services.

### Stage 2

Involved a preliminary presentation in June, 2009 by the Legal Activity Project (LAP) of initial considerations and proposal findings to senior HSE managers and clinicians. This was intended to determine if the Legal Activity Group proposals were consistent with the experiences of this group and to enable further development of the proposals.

### **Stage 3**

Involved responding to the advice and expertise offered at stage two, firming up the proposal and presenting this to the National Mental Health Steering Group.

### **Stage 4**

Involved consultation (Sept 2009) with professional bodies, academic experts and service user groups. Inputs of stakeholders were refined and integrated before an implementation process was scoped.

### **Stage 5**

Submission of the initial Training Strategy document to the National Mental Health Steering Group.

### **Stage 6**

Further extensive consultation will be required with Operational Managers, Heads of Services, Local Health Managers, Heads of Disciplines, Service Users and Clinical Leads to develop plans to support the implementation of the Training Strategy.

## PART 2

### Mental Health Legislation Training & Education

Because of the evolving nature of mental health case law and the urgent requirement to meet training needs it is not enough for either the MHC or the HSE to rest the training requirements of the MHA (2001-2009) on training given to date for existing personnel. If due regard is not given to an ongoing training process, then the potential for breaches of patient human rights and non compliance with legislative requirements will continue to occur, leaving service providers with an ongoing vulnerability to legal cases. Given the high level of legal activity in relation to the Acts to date, it is in the interest of the HSE to ensure that its MHS remain fully compliant with the requirements of the legislation to the greatest extent possible. Robust training provision has a major role to play in ensuring this compliance.

The MHA has been fully implemented since November 1st 2006. The two main aspects of the MHA are directed towards the establishment of the MHC and its functions, as well as, the statutory process for the involuntary admission of a person to an Approved Centre. Both aspects have introduced new educational and training needs for mental health service providers.

The MHC has laid down a range of Guidelines, Rules and Codes of Practice in pursuance of its mission to promote, encourage and foster the establishment and maintenance of high standards and good practice in the delivery of MHS. Equally the process of involuntary admission has introduced a number of new processes (e.g. Tribunals), roles ( Authorised Officers), and functions ( Approved Centres). In order to address the full implementation of the MHA as well as, new and emerging requirements, a comprehensive training plan is required to address the wide ranging training needs.

#### Aims And Objectives Of Training Proposal

- To ensure mental health service staff are enabled through training to be knowledgeable and skilled in complying with the mental health legislation commensurate with their role
- To offer a framework of legislative training and guidance relevant to all levels of staff within the organisation and identify who is responsible for its' provision
- To provide access to appropriate training and materials in a variety of appropriate formats in respect of the key changes in legislation, and the implications for practice
- To alert service providers (and service users) to changes in service processes or practices that may follow case law decisions and tribunal determinations
- To ensure that any training materials are presented in a practical context that reflects best practice and supports ease of access to all appropriate staff



- To involve service users in the design, development and roll out of the training
- To identify evidence – based training and education methodologies leading to an agreed standardised approach across all mental health services throughout Ireland

## **Scope Of The Mental Health Acts 2001-2009**

Key changes include:

- Definition of Mental Disorder and Criteria for Involuntary Admission
- Mental Health Review Tribunal
- Professional roles
- Mental Health Inspectorate
- Registration of Approved Centres

## **Key Training Needs Emerging From The Introduction Of The Mental Health Acts 2001- 2009 Include:**

**Overview of the Mental Health Acts 2001-2009 including:**

### **Governance in relation to consent for**

- Psycho-surgery
- Medication
- Electroconvulsive Therapy

### **Approved Centre Regulations (S.I. No.551 2006) (DoHC)**

- Preliminary & General
- General care & welfare
  - Identification of residents
  - Food & nutrition
  - Food safety
  - Clothing
  - Residents personal property and possessions
  - Recreational activities
  - Religion
  - Visits
  - Communication
  - Searches
  - Care of the dying

- Care of residents
  - Individual care plan
  - Therapeutic services and programmes
  - Children's education
  - Transfer of residents
  - General health
  - Provision of information to residents
  - Privacy
  
- Premises
  - Premises
  - Ordering , prescribing, storing and administration of medicines
  - Health & safety
  - Use of closed circuit television
  
- Staffing
  - Staffing
  
- Records
  - Maintenance of records
  - Register of residents
  - Operating policies and procedures
  
- Other provisions
  - Mental Health Tribunals
  - Complaints procedure
  - Risk management procedures
  - Insurance
  - Certificate of registration
  - Enforcement of regulations
  - Closure of an approved centre

#### **Mental Health Commission Rules**

- Rules governing the use of Electro-convulsive therapy (R-S59(2)/2009)
- Rules governing the use of seclusion & mechanical means of bodily restraint (R-S69-(2) Oct. 2009)

## **Mental Health Commission Codes of Practice**

- Code of Practice Admission of a child under the MHA 2001 (COP- S33(3)/01/2006, 2009)
- Code of Practice Physical Restraint in Approved Centres (COP – S33(3)(e) /09/2009)
- Code of Practice for Mental Health Services of Notification of Deaths & Incident Reporting (COP – S33 01/2008)
- Code of Practice governing the use of Electro – convulsive therapy for voluntary patients (COP – S33(3)(e)/09/2009)

## **Procedures**

- Section 23/24
- Section 14.2
- Ensuring individual rights are upheld
- Consent to treatment
- Client information
- Tribunals
- Legal representatives
- Authorised Officer( S.I. No. 550, Mental Health Act 2001 (Authorised Officer) Regulations 2006.
- Assisted Admissions
- Involuntary Admission of an Adult

## **Emerging Issues from court proceedings**

### **Inspection Process MH Inspectorate**

- Inquiry
- Inspection

### **Documentation**

- MHC Forms
  - Forms 1-18
  - Patient notification of the making of an order or certificate and renewal order
- Clinical Practice Forms
  - CPF - Power to detain a voluntary patient (Child) in an Approved Centre (S.23(2) & S.23(3))
  - CPF – Detention of a person (Adult) for the purpose of carrying out an examination (S.14(2))

- CPF – Power to prevent voluntary patient (Adult) from leaving an Approved Centre (S.23(1))
- CPF – Notification to MHC of the Admission of a Child to an Approved Centre for Adults
- CPF – Notification to the MHC of the discharge of a child from an Approved Centre for Adults.
- Reports
- Assessments (Local Clinical Practice Forms)
  - Mental Health Assessments
  - Welfare of Dependants
  - Risk Assessment

### **Judicial Reviews**

### **Legal Challenges**

- HSE guidance on completion of Certificate and Renewal Order Dec.2008. (AR v Clinical Director of St. Brendan's Hospital and Mental Health Tribunal case)

### **Central Mental Hospital**

### **Criminal Law (Insanity) Act 2006**

### **Capacity Legislation**

**Key Point:** Mental Health Legislation is a key driver of training and education for everyone in the organisation due to its wide range of complexities, application and implication for service provision.

## **Pre-Registration Delivery Systems**

Familiarity with the MHA and its impact on clinical practice and service users is essential as part of pre-registration undergraduate programme curricula for all healthcare professionals. This includes not only the legal and 'administrative' components of the Act but also considers the professional and ethical implications. In ensuring that such programmes remain relevant Mental Health practitioners need to support curricular review of pre-registration programmes within HEIs. It would also be prudent to link with the educational sections of respective professional bodies to ensure that all training is consistent with this approach.

## **Post-Registration Delivery Systems**

Education and training now forms a significant element of the mental health care standards as identified by 'Approved Centres Regulation' (MHC, 2006) and is recognised as key to the provision of a quality mental health service. The acquisition of the knowledge and competencies required to meet professional and organisational practice that is appropriate, will be heavily dependant on delivery systems that can fit as seamlessly as possible into the workplace and integrate within existing professional curricula.

## **Targeting Training Commensurate With Organisational Role**

This proposal recommends four levels (or Tiers) of training for mental health staff. All managers, professionals and practitioners working in mental health services (including professionally qualified and non-professionally qualified staff) voluntary sector staff, allied health professionals and anyone who may be working in a variety of roles, for example as managers, as team leaders or in front-line services are included.

As services develop further, a robust system of training needs analysis will be required within each catchment area. This exercise will require a multidisciplinary approach, led by the local HSE management team and monitored by the local clinical governance structure. The training needs analysis will need to be inclusive of all disciplines outlined in tiers 1-3 within the service. The clinical governance group will need to consider the need for Tier 4 training, based on data emerging, e.g. from service user surveys.

## Tier 1

Those clinicians and practitioners prioritised for training include those who have specific statutory duties and responsibilities in respect of the current legislation:

- a. **Clinical Directors**
- b. **Authorised Officers**
- c. **Approved Centre Staff**
- d. **Non-Consultant Hospital Doctors**
- e. **General Practitioners**
- f. **Service Managers/ Administrators and Mental Health Act Administrators.**

## Tier 2

This group includes practitioners with an involvement with the MHA but who may not fulfil a statutory obligation

- Mental Health professionals working in community care settings.
- Individuals working in mental health services who need a working knowledge and understanding of the MHA.
- Non-mental health specialist staff working in other care services (Intellectual Disability/Older Persons/Addiction, Accident and Emergency Dept. staff) social workers, nursing staff in certain settings and residential care staff.

## Tier 3

- The wider mental health workforce who provide mental health services to patients subject to involuntary admission (Household staff, Ward Clerks, Catering, Healthcare Assistants)
- The workforce who are not specialist health service providers, but who have inter - related involvement with patients for whom serious mental risk is an issue e.g., Gardai, Voluntary Sector providers etc.
- Primary care teams who may come into contact with service users through other physical health problems.

## Tier 4

- Family Members and Carers
- Service Users
- Public at large

The training should be designed to support competent practice tailored within the relevant legislative domain for each level within mental health service to prepare professionals to discharge their legal responsibilities.

Training resources should be produced in a user friendly format and take into account the realities of delivering training to a wide range of managers and staff across varied service sectors. Training resources should also utilise examples of best practice and case examples that will enhance key competencies and appropriate practice in mental health service delivery within the framework of legislative powers.

**Key Point:** Tiered approach to training where skill and knowledge development are commensurate with role.

## Programmes Currently Developed Or Under Development By The HSE

### **i. Two-Day Mental Health Act 2001 Training Programme**

This training is mandatory for all new front-line staff, in order to prepare this group of professionals to carry out their legal responsibilities.

### **ii. 5-Day Authorised Officer Training Programme**

All AOs must complete the specified 5 day AO training programme. A pre-requisite requirement is the successful completion of the 2 day MHA 2001 training. The 5 day training is designed to complement any training procured by individual professionals from their current professional qualifications and it will provide an ongoing reference for practitioners. Some elements of this programme will be available in an eLearning format.

### **iii. 2-Day Assisted Admissions Training Programme**

All staff involved in assisted admissions are required to undertake this training. This is to ensure legislative compliance and that standards set out in the Quality Framework (MHC) are adhered to.

### **iv. Refresher Training**

Refresher training will be required as changes take place in legislation, in response to critical incidents or where changes in practice are required. This may be as a result of amendments to the MHA itself or as determined by case law and communicated via MHA alerts by the HSE (see Appendix 5).

## Mental Health Legislation Refresher Training

### Authorised Officers

As an interim arrangement authorised officers (AO) (MHA, Section 9) were introduced by the HSE on a provisional basis on the 1st November 2006 until a full AO service was established. 'Interim' arrangement AO's often lacked any professional mental health expertise which meant that as applicants, they were not best placed to consider alternatives or offer specific advice and support to families and service users. In moving to a 'full' authorised officer service, there is a clear need to ensure through training and education that Authorised Officers are fit for purpose and fit for practice in furthering government policy objectives, meeting service user/family needs and ensuring full compliance with both the letter and spirit of the legislation. This ongoing training need will be necessary in affording Authorised Officers the opportunity to be re-approved for the role every three years as per policy. Once this date is reached they will have to be re-approved as AOs. All existing AOs should access update training and have access to clinical supervision and related mental health training during their period as AOs on an ongoing basis in undertaking their statutory responsibilities as AOs in accordance with the MHA.

### Assisted Admissions Staff

Section 13 of the MHA makes provisions for the removal of a person to an approved centre. The removal of a person or return of a person to an approved centre is a planned intervention informed by the therapeutic skills of mental health professionals where *"due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy"* (section 4(3), MHA 2001). Assisted admission refresher training can be undertaken on a more informal basis led for example by a local assisted admissions co-ordinator. However it would be useful if teams were clear about their need to undertake refresher training in ancillary training e.g. Cardio-Pulmonary Resuscitation, Conflict Resolution Skills etc.

HSE mental health services must also keep abreast of emerging training and educational requirements, as well as constantly reviewing operational and clinical practices in the light of new findings.

### Approved Centre Staff

Similar regular education and training is required, in relation to Approved Centre staff in ensuring compliance with MHC Rules, Regulations, Codes of Practice and the continued registration of Approved Centres. Other 'Tier 1' staff will require refresher training based on their particular needs and role but it is envisaged that this would largely be achieved through information technology and work based formats, taken by the practitioner in their own time.



Standardised Policies for all the above identified staff, in meeting mandated sections of the legislation, need to be integrated into mental health services to ensure that the most appropriate, most sensitive, discreet, safest and least restricted options of care are provided to service users. Training on these and other mandated policies needs to be provided in an efficient and standardised manner to ensure service users access quality person centred care.

## Achieving Organisational Learning

A significant challenge is not just to deliver 'once off' training, but to ensure that training continually supports practitioner fitness for purpose and fitness for practice. There will also be a need to deliver urgent training if immediate changes to practice are required due, for example to high court judgements. (This technical approach is less likely to achieve sustainable learning, but may be necessary in response to outcomes of legal cases.) Significant work has been undertaken in attempting to clarify the effective use of expertise and the knowledge required to deliver a quality service (Royal College of Psychiatrists, 2007; SCMH, 2001; TESC, 2007).

**Key Point:** Choice of pathways to facilitate staff to meet their learning needs e.g. work based learning, mentorship, buddy system, eLearning or a combination of these.

## Sustainability

A major consideration in terms of enabling ongoing training and professional competence is the sustainability of any training strategy. A number of different training methodologies are offered in terms of addressing sustainability. These are designed to take into account the potential for undergraduates to emerge with the basic mandatory knowledge required for practice, enabling workplace learning to take place to its fullest extent while offering more flexible modes of delivery. These factors also take into account the difficulties in feasibility and cost of releasing large numbers of staff for training. Pre-registration healthcare programmes should include core modules on mental health legislation. The application of legislation would then be supplemented through practice placements in acute mental healthcare settings.

## Blended Learning

Blended learning is a blanket term for an approach to learning which incorporates a wide range of teaching methodologies. Blended learning integrates face-to-face delivery with online study; skills workshops; assignments; assessments and workplace coaching and mentoring. This fusion of modes of delivery, addresses not only the preferences of different learners, but also seeks to provide a comprehensive and accessible learning environment for all staff, both on-site and off-site. It also offers the potential for a more economical method of education and training delivery.

eLearning has emerged as an important element in the successful blended learning approach to people development. However, it in itself is not the solution to training needs, but rather as, an additional delivery channel which gives more flexibility.

Given that the nature of healthcare delivery is not primarily technical, but rather interpersonal, similar methodologies in addition to eLearning are required to train and develop healthcare professionals. It is therefore important that there is provision for face to face learning, that is interactive and enables opportunities to learn from each other collaboratively.

This approach coupled with personal development planning (electronic) provides the preferred option to more effectively use the training budget whilst keeping a tight control on who is studying what; when; to what level; whether the manager is involved or not and ultimately how the learning is being applied.

Whilst it is recognised that certain basic training may still require an element of traditional classroom based training, for example 'Authorised Officer' training, it is hoped a significant element of this could be achieved at the point of induction for new staff, perhaps organised or across proposed new mental health catchment areas or teams. Equally familiarity with the MHA is recommended as part of the graduate level for pre-registration/qualification.

In as much as is possible, through building capacity within services, it is desirable that the majority of this learning takes place in the workplace during working hours. The delivery systems include real time workplace learning and involves the following ingredients;

- In house 'preceptors'/peer mentoring/supervised practice
- Interdisciplinary learning fora
- The availability of IT systems to facilitate eLearning
- Professional development portfolios
- Provision of staff who are leads and experts in legal affairs
- Supports from practice development co-ordinators, front line managers and heads of department
- Supporting resources e.g. time, audit tools, clinical supervision, action learning sets, Total Quality Management groups, evidence based approaches, further education and training, problem based learning, blended learning strategies
- Adoption of support programmes e.g. Productive Ward, Acute Solutions, Essence of Care

## **Undergraduate Staff**

It is recommended that the MHA and its impact on clinical practice is addressed within the curricula of undergraduate programmes. This includes the legal and 'administrative' components of

the MHA but also considers the professional implications. Mental Health practitioners need to support curricular review within pre-registration programmes in Higher Education Institutes. It would also be prudent to link with the educational sections of respective professional bodies to ensure that all training is consistent with this approach.

## In-House Preceptors

The model of preceptorship as it applies to trainees or undergraduate students is well established in all professional groups in mental health care. The role primarily involves transferring knowledge and or skills in real time, i.e. during the course of a normal working day/week. This is carried out with the deliberate intention to facilitate the acquisition of competencies to ensure all staff can fulfil their role in accordance with legislative, organisational and professional standards.

The advantages of this are multi-fold. It harnesses the knowledge already in the system, increases peoples sense of purpose and professional values and harvests latent knowledge in a way that brings it to the fore in everyday practice. It also creates a learning environment with the potential to increase audit activity, enhance policy and practice as a live issue and improve practice. The mechanism for achieving this could be realised in a number of ways such as through a 'buddy system' or designated leads on certain topics. (See table 3 as an example).

**Table 3**

<p><b>Step 1</b></p> <p>Staff member (Cathy) identifies training need for example undertaking formal risk assessment as identified from recent court case alert issued by MHALAG)</p>
<p><b>Step 2</b></p> <ul style="list-style-type: none"> <li>• Cathy identifies clinical mentor with appropriate expertise</li> <li>• Clinical mentor (CNS/CNM/PSI graduate/SW/ OT/Psychiatrist) takes Cathy through local policy and assessment tool</li> <li>• Joint assessment undertaken with Cathy shadowing</li> <li>• Cathy undertakes 2 supervised assessments and receives feedback from service users and Clinical mentor</li> <li>• Cathy formulates risk management plan and feeds back to Multi-disciplinary Team</li> <li>• Cathy writes up reflective account</li> <li>• Option to submit written assignment for academic credits</li> </ul>

## **Buddy Mentoring**

The mentorship approach could further be enhanced by using a mentor from another discipline. This approach is widely and successfully being used in the Nurse Prescribing Programme where a consultant agrees to mentor a nurse during the practical element of the programme. There is potential for this approach to further enhance learning from a point of view that may not have been experienced before.

## **Supervised Practice**

Many examples exist in post graduate programmes of supervised practice structures. Students are typically involved in tripartite supervisory arrangements between a facilitator (practice developer, lecturer) and a practice mentor (or senior colleague). This model can be extended to the workplace in the delivery of work based learning.

## **Practice Development**

Practice development as an approach to sustainable practice change, has been growing in momentum internationally in recent years. It is clear that developing services that focus on the needs of individuals whilst focusing on clinical and cost effectiveness are at the heart of most government's modernisation programmes. Practice development is defined as a continuous process of improvement towards increased effectiveness in patient-centred care. This is brought about by helping health care teams to develop their knowledge and skills and to transform the culture and context of care. It is enabled and supported by facilitators committed to systematic rigorous continuous processes of emancipatory change that reflect the perspectives of service users. (Garbett & McCormack, 2004).

Practice developers incorporate a range of methodologies, such as clinical supervision, facilitation, change management, training, personal development planning, evaluation methodologies, audit and benchmarking. They also incorporate work-based learning and mentoring as well as supporting professional development through evidenced based approaches to care, education and research utilisation. This group of mental health professionals offer a solid platform through which sustainable learning from mental health legislation and case law can be incorporated into mental health practices.

## **Facilitation**

Facilitation has been used in different fields, inside and outside health care, including education, counselling, psychotherapy, management, health promotion, clinical supervision, practice

development, practitioner-research, quality improvement, audit and evidence-based practice. According to Anderson et al (2008), 'facilitation is achieved by an individual carrying out a specific role (a facilitator) which aims to help others'. Facilitators are individuals with appropriate roles, attributes, knowledge and skills to help individuals, teams and organisations to carry out particular activities.

The HSE to date has provided for a number of training programmes in facilitation. An updated database is currently being compiled within mental health services and this resource should be used as a mechanism to enable the further implementation of this practice based learning approach.

## **Facilitating Learning Through ICT**

The World Health Organisation (WHO) advocates the use of technology to disseminate medical information to improve the accessibility of healthcare services particularly for people in rural areas through teleconsultation and teleducation, *WHO, Health Information and Evidence Policy* (1998). The provision of Information Communication Technology (ICT), allowing internet and e-mail access would offer opportunities to be exploited in terms of e-learning. Estabrooks (2003) reported that whilst practitioners are slow to utilise the internet at work they tend to make use of the facility when material relevant to their everyday work is available to them.

The provision of I.C.T. in rural service locations in particular would have a number of benefits. Releasing staff to attend seminars, conferences and in-service training is costly in terms of travel, loss of time, replacement cost and indeed demands on individuals. Having ready access to ICT offers the possibility of being able to access that information from their base and offers different possibilities i.e. more staff can avail of the information rather than the 'lucky few' who get to attend a training event.

## **eLearning**

The following are some well-recognised benefits of eLearning:

- You can study at your own pace, any time, any place, anywhere you have access to a Personal Computer
- Quality of content and learning experience is assured - information is delivered in a consistent manner
- eLearning is learner-centric rather than teacher-centric, like many adult classroom-based courses
- The connectivity of your PC and Internet encourages peer-based learning. Instead of learning from just one source - the trainer, you learn from the comments, experiences and perceptions of other like-minded professionals

- If developed in conjunction with sound instructional design, eLearning provides a powerful and effective way to convey knowledge, promote learning and retention, and increase performance
- eLearning can be closely matched to individual learning styles  
(*HSE Performance & Development, 2009*)

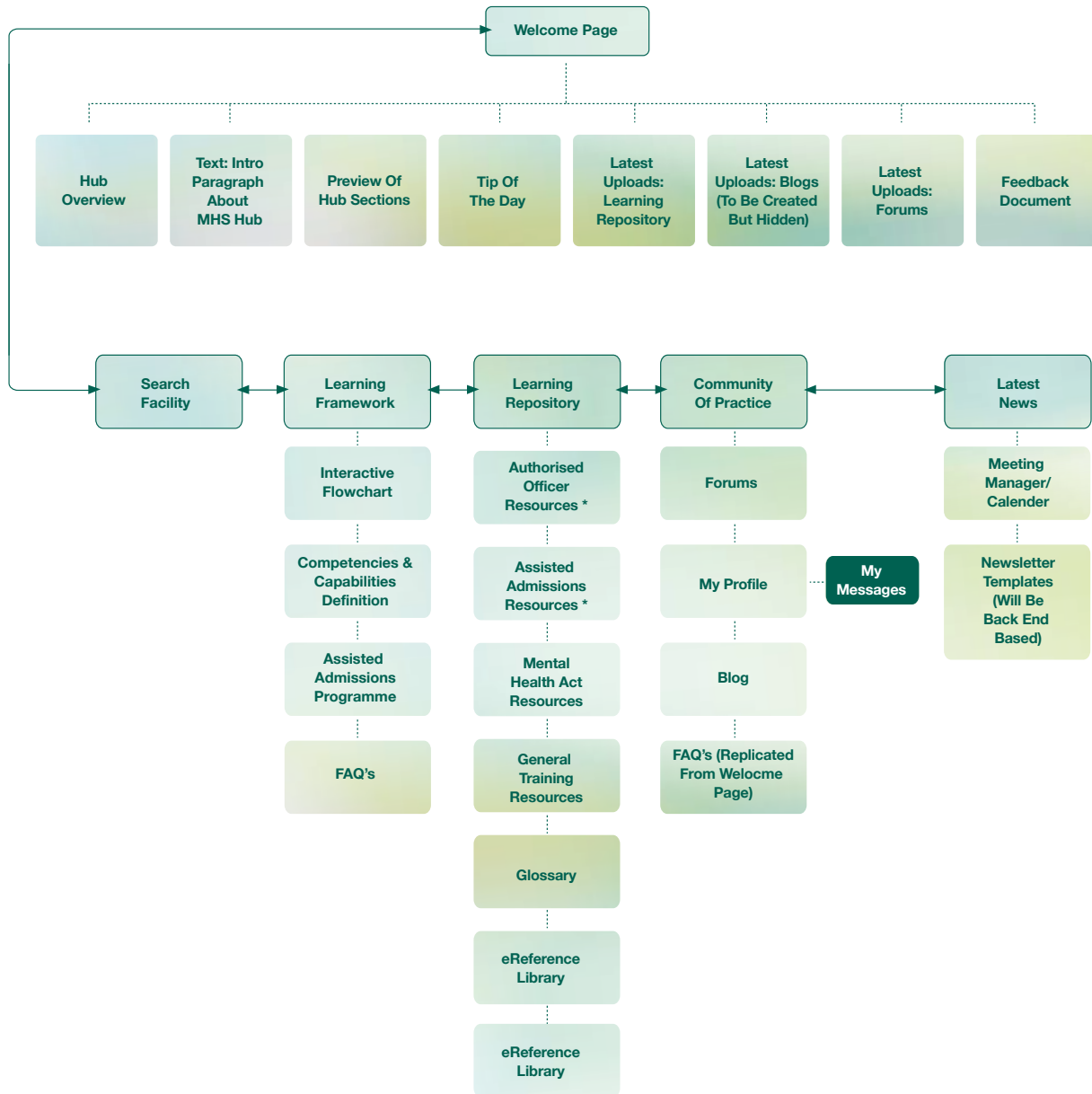
## Development Of A Mental Health Hub And eLearning Programmes

A hub can be described as an “electronic, central distribution warehouse facilitating a ‘one stop shop’ approach on a topic for theme”. This hub will not only provide the launch pad for mental health eLearning programmes but will offer a repository for useful information resources and tools and an online space for discussions, knowledge sharing and collaboration for all HSE mental health staff nationally. The aim of the mental health eLearning hub is to provide accessible, flexible and high quality education and training resource/programmes which will enable practitioners to achieve competencies for best practice. The mental health eLearning hub will also facilitate the introduction of training and linkages to ‘personnel developmental plans’ as recommended in the policy document *VfC* (recommendations 5.5 and 18.11).

As well as the establishment of a dedicated mental health micro site on HSELand, eLearning links with sites such as MHC website, Irish College of General Practitioners website, Irish College Psychiatrists website, Garda Síochána website, National Service User Executive website and other HSELand micro sites, would enable the currency of competencies and capabilities of mental health professionals to remain optimal. The possibility of developing common modules which could be shared on a number of these site exists , e.g. Assisted Admissions (from different perspectives), or reusable learning units could be developed for use in other health or social care programmes, e.g. approaches to culture and diversity.

The Mental Health e-learning Hub is designed to allow the MHS hub team to disseminate best practice resources and to allow staff to share their own experiences, provide links to other educational courses, resources, conferences, study days available online or otherwise. The development of the Hub is an evolving process, it is hoped that it will continue to grow, adapt and progress in line with further input of all the wider ‘community’ members.

# Overview Of Proposed Hub Set-Up



## LEGEND

\* = Only Visible By AA And AO User Roles

— = Main Level Navigation

..... = Second Level Navigation

3rd = Third Level Navigation

## Resources For eLearning

Research within the HSE would indicate that perhaps up to one thousand staff from a diverse range of disciplines and services may have a significant Learning & Development remit within their job role (Training, Development, Education & Lifelong Learning). In order to support Learning & Development within the HSE and also to promote quality, equity and best value across the organisation, this online Health Services 'Learning and Development Specialist's Network' is currently being established.

As well as hosting dedicated learning resources and bespoke development opportunities, this online network will offer a unique opportunity to share with and learn from other Health Services Learning and Development colleagues. It is being established as a password protected zone within [www.hseland.ie](http://www.hseland.ie) with a clear membership criteria and it is hoped that this will promote engagement among professionals in the field and support the development of the HSE as a Learning Organisation.

In supporting the culture of a learning organisation through continuing professional development, access to ICT will allow staff to access information, articles, learning resources and educational personnel on-line and via e-mail. This will broaden the range of options open to them and can conduct professional development via distance learning. The potential for a community of learning to be established is enhanced, facilitated by access to conference material's on-line, the ability to download journal articles (in facilitating for example journal clubs). This would improve practice and enable a rapid response to policy guidance or MHA alerts.

- The HSE Performance & Development (P&D) Department has developed a comprehensive PDP training programme which includes a template for portfolio development. This is in keeping with approaches proffered by the National Council for Nursing & Midwifery, The Office for Health Management (HSELand) as well as a number of professional bodies.
- The P&D Unit also provides a Trainers Forum with on-line resources for all trainers and facilitators in the HSE (West).

## Community Of Practice

The LAG proposes that a community of practice (CoP) should be established around engaging with best practice with reference to mental health legislation. There are a number of definitions of a Community of Practice, including a group of professionals, informally bound to one another through exposure to a common class of problems or common pursuit of solutions. They thereby embody a store of knowledge and are peers in the execution of 'real work'. What holds them together is a common sense of purpose and a real need to know what each other knows. They collaborate directly, use one another as sounding boards and teach each other.



Such a community of practice, organized nationally and interdisciplinary in nature would add significant potential for organizational learning and in time could be formalized through frameworks such as the National Digital Learning Repository.

It is anticipated a CoP would help to address organizational learning in the HSE by dissemination of learning cross-institutionally in response to the need for improvements in policy and practice arising from legal challenges to the MHA. The new grouping (CoP) will include regulators, administrators, service users, academics, professionals and service providers. We anticipate that learning resources would include a range of e-learning material, pod casts, adaptable learning resources, case studies, legal judgements, policies and supporting research or other published material. In addition, we hope service user experiences will be included to provide that perspective, for example a case study illustrating the experience of involuntary admission or s.23 of MHA.

An obvious benefit is the convenience and reduced disruption to patient care. Staff can also access material to support evidence based care and access the most up to date material and advice on best practice. The organisation will obviously benefit from improved staff clinical practice and patient care from a risk management perspective. The organisation will be able to communicate directly and more speedily with staff in order to ensure a timely and responsive change in clinical or administrative practice.

**Key Point:** Refresher training is an essential element for all training but in particular for compliance with mental health legislation and emerging court judgements.

## Accreditation

The training programme that develops from mental health legislation should, where possible, be integrated into award structures and accreditation bodies, from both an academic and professional perspective. It should also fit within the National Framework of Qualifications. Possible arrangements may include:

- Linking awards with specific HEI's
- Development of a HSE training unit registered with the Higher Education Training Awards Council (HETAC) for levels 7-10 programmes, or with FETAC for awards at level 5-7
- Development of continuing professional development (CPD) credits with relevant professional bodies e.g. An Bord Altranais, Royal College of Psychiatrists of Ireland
- Assessment process that support the accumulation of academic and CPD credits are an important pathway that will necessitate the involvement of HEI's and professional bodies in partnership arrangements with the HSE. This includes flexible, creative arrangements to assess and accredit workplace learning achieved through a framework

that allows practitioners to present a body of evidence that supports having achieved required learning outcomes. This typically will include work based projects, policy and practice development, hosting work based seminars to name a few options

HSELand issues certificates to all learners who successfully complete a learning programme. Certificates are issued 4 times per year and sent to successful candidates work addresses. It would prove useful if these certificates could be linked to a continuing professional development programme with perhaps a HSE requirement that a certain number of 'credits' be met as mandatory each year/ two yearly, especially in terms of mental health legislation capability.

## Commissioning Training And Learning Programmes

There may also be, in the near future, an opportunity to develop commissioning arrangements in the provision of training and education programmes both from internal HSE 'providers' as well as from other external providers such as HEIs or private educational consortia.

The advantages are that:

- Core training needs in relation to mental health policy can be standardised in terms of a contractual agreement by one or many providers
- Programmes can be tailored to meet specific training requirements
- Commissioned on the basis of need, both service and professional
- Programme costs can become more competitive, and may be amenable to benchmarking in terms of price against those offered by other providers in other regions
- Quality Assurance requirements can be evaluated in relation to activity and quality monitoring of the programmes commissioned

This approach may help training programmes to be more transparent in terms of

- Evaluating accessibility to programmes by participants
- Likely participant experience
- Clear outcomes and competencies achieved
- Evaluating the impact of training on service
- The processes and resources for facilitation of learning within the clinical area
- 'How much bang you get for your Buck'!

It may only be suitable to adopt commissioning practices, when all internal resources are fully utilised, or there is no specialist resource capacity within the HSE, in the particular area of training / education, e.g. a specialist programme.

## Summary Of Recommendations

1. Include mental health legislation competency development in the curriculum of all mental health professional training programmes which lead to professional registration.
2. Encourage each health service agency within the Health Service Executive to develop a management position, which supports and drives the implementation of mental health legislation competency, as well as, a system that responds to developments in case law and legal judgements.
3. Ensure that a national transferable mental health legislation education and training programme is developed for mental health professionals, based on best educational evidence and which incorporate blended learning delivery options (e.g. CD ROM, e-learning and mentoring).
4. Ensure that a national mental health legislation education and training competency framework for mental health professionals, is developed, based on best practice evidence. This could be facilitated through the Centres of Nurse/Midwife Education.
5. Ensure that evaluation tools and processes are developed and implemented for assessing and deeming competent, where necessary, mental health professionals employed in the healthcare systems who have received mental health legislation education and training. This could be facilitated through the Centres for Nurse/Midwife Education in conjunction with local Nurse Practice Development co-ordinators.
6. Drive and monitor the further introduction of mental health legislation in the Health Service Executive. This function could be overseen by a regional multi-disciplinary group, supported by HSE Area Directors of Nursing and Midwifery Planning, Centres of Nurse/Midwife Education, HSE Performance & Development Units.
7. Develop and implement a national mental health legislation training policy.
8. Develop and implement a national mental health legislation repository incorporating clinical practice guidelines for mental health professionals, based on best practice evidence and court judgements and best legal advice.

## Next Steps

- Work with a range of bodies including HSE Performance and Development, Higher and Continuing Professional Education Institutes and Mental Health Act Regulators to scope out minimum standards of competence, (e.g. MHA knowledge), maintaining knowledge as well as advanced practice (e.g. legal interpretation of court judgements).
- Work with a range of bodies including HSE Performance and Development, Higher and Continuing Professional Education Institutes and Mental Health Act Regulators to enhance traditional learning strategies by combining them with innovative approaches to learning.
- Work with a range of bodies including HSE Performance and Development, Higher and Continuing Professional Education Institutes and Mental Health Act Regulators to review training and education curricula to maximise interdisciplinary educational processes that incorporates service user input.
- Work with a range of bodies including HSE Performance and Development, Higher and Continuing Professional Education Institutes and Mental Health Act Regulators to incorporate capability models into training and education.
- To foster practice based teaching methodologies that build on the latent expertise in the workforce that facilitates learning and development as part of everyday working lives and practice, in order to contribute measurable improvements in service experience for service users and providers.
- To work with all relevant agencies involved in mental health service delivery that harness internal resources formally and informally in order to integrate education and learning with everyday practice.

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# Appendices

## **Appendix 1**

Vision for Change Recommendations in relation to training & education

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## Appendix 1: Vision For Change Recommendations In Relation To Training & Education

### Key recommendations made by the Report include:

**Recommendation 18.1:** Education & Training should be directed towards improving services as a primary goal and must have the welfare of service users as its ultimate objective.

**Recommendation 18.2:** Training programmes should emphasise the acquisition of skills that are clinically meaningful, should train personnel for leadership and innovative roles, and should foster an attitude of critical enquiry and self-scrutiny in relation to service delivery.

**Recommendation 18.3:** There should be centralisation of the planning and funding of education and training for mental health professionals in new structures to be established by the HSE in close association with the National Directorate of Mental Health Services. This centralised Education & Training authority should be constituted to represent stakeholder and service user interest and Education & Training bodies representing all disciplines.

**Recommendation 18.4:** The HSE should commit itself to adequate, rational and consistent funding of Education & Training. However the accreditation of courses should remain the responsibility of the respective professional bodies.

**Recommendation 18.10:** Within the context of overall service changes, many currently employed staff will need to redefine their role in the light of the development of new community-based teams focusing on early intervention, assertive outreach, crisis resolution and home treatment. Appropriate training should be available for affected staff.

**Recommendation 18.11:** A personal training and development plan or equivalent should be introduced for all grades of staff in the mental health services. This should help managers set priorities for the use of resources in order to meet common needs more efficiently, organise staff release and target and schedule in-house education and training.

**Recommendation 18.20:** Specialist and advanced nurse practitioner roles for nurses in intellectual disability should be developed in response to identified needs of people using the service.

**Recommendation 18.21:** A mental health training module should be mandatory and standardised in social work training to ensure all staff especially those without practice experience have a basic understanding of mental health issues and mental health services.

**Recommendation 18.24:** It is recommended that the position of mental health support worker be established in the mental health system to support service users in achieving independent living and integration in their local community.

**Recommendation 18.25:** Advocacy training programmes should be encouraged and appropriately financed.

**Recommendation 18.27:** A variety of programmes should be in place for the workplace such as induction programmes, health and safety programmes (for example, cardio-pulmonary resuscitation) and training in conducting staff appraisals.

**Recommendation 18.28:** The establishment of structured, accredited training courses and other measures to support and encourage volunteering in the mental health service should be considered within the broad context of education and training.

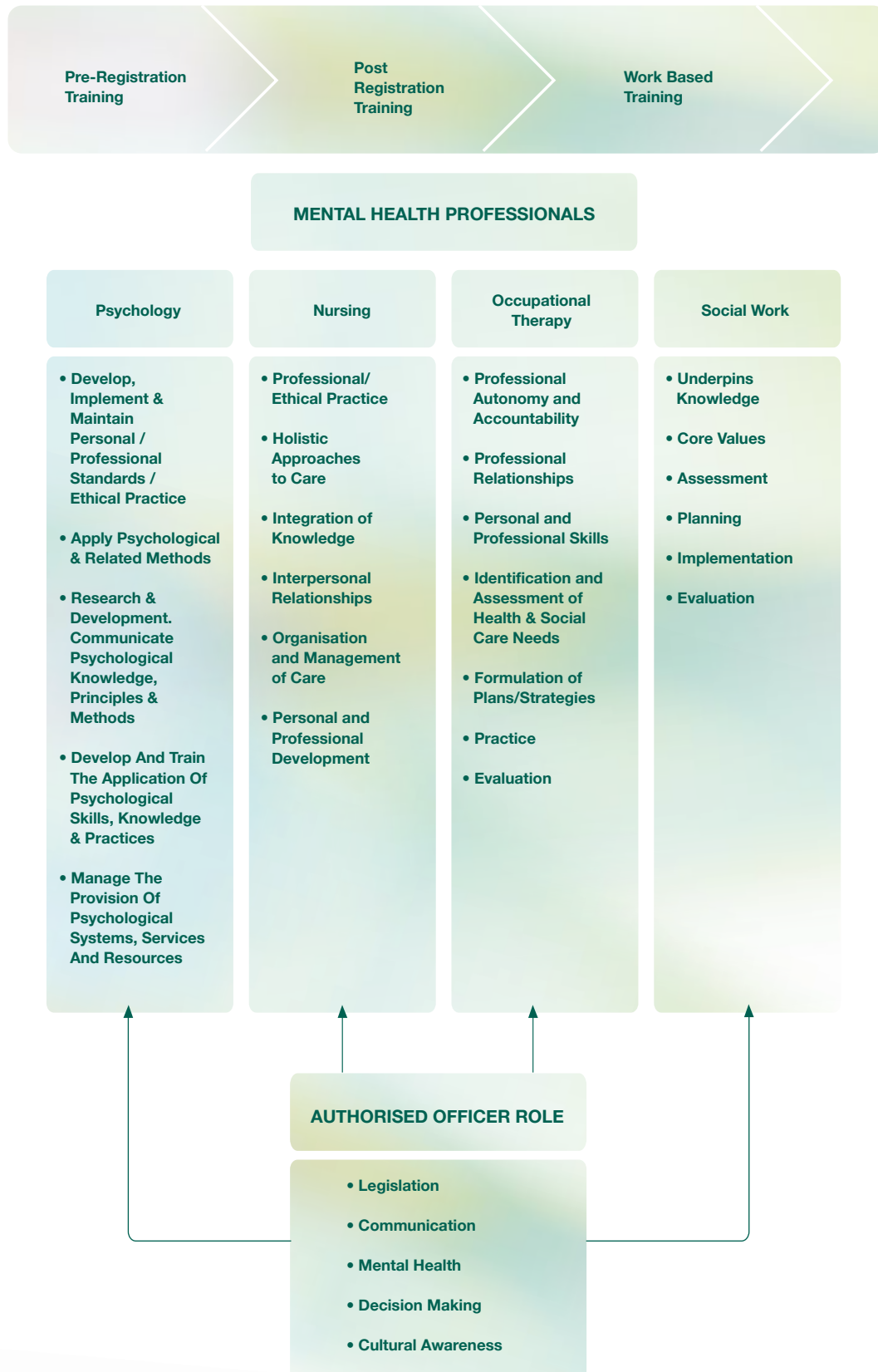
**Recommendation 19.13:** Mental health research should be part of the training of all mental health professionals and mental health services should be structured to support the ongoing development of these skills.

## Appendix 2: The Ten Essential Capabilities For Mental Health Practice

1. **Working in Partnership.** 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.
2. **Respecting Diversity.** 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.
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.
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.
5. **Promoting Recovery.** 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.
6. **Identifying People's Needs and Strengths.** 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.
7. **Providing Service User Centred Care.** 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.
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.
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.
10. **Personal Development and Learning.** Keeping up-to-date with changes in practice and participating in life-long learning, personal and professional development for one's self and colleagues through supervision, appraisal and reflective practice.

(DOH UK)

## Appendix 3: Example of Competencies for Authorised Officer Training



## Example Of Specific Authorised Officer Competencies

### Legislation

	COMPETENCY		PERFORMANCE INDICATORS
1	Demonstrates knowledge of relevant healthcare legislation	1. 2. 3. 4.	Can explain the Mental Health Act 2001 in detail Has knowledge of the Criminal Law (Insanity) Act, 2006 Is familiar with the Mental Health Commission Codes of Practice Demonstrates knowledge of other relevant healthcare legislation and Codes of Practice
2	Demonstrates ability to apply knowledge of Mental Health Legislation to practice	1.	Can accurately describe and explain the legal framework and legal jurisdiction of the Authorised Officer role. Is able to explain how the legislation pertains to a given situation

### Communication

	COMPETENCY		PERFORMANCE INDICATORS
1	Demonstrates the ability to communicate appropriately and effectively using appropriate information strategies	1. 2. 3. 4.	Demonstrates ability to engage and establish effective relationships with service users, carers and families in undertaking the statutory role Can provide information to persons in distress in a meaningful manner Can adapt style of communication to people with a wide range & levels of cognitive ability, sensory acuity and modes of communication Exhibits skills in gaining an understanding of individuals experiences
2	Demonstrates knowledge of how to measure information in the context of urgency, risk & danger	1. 2. 3.	Uses a wide range of information sources and knows how to access relevant information to address issues. Able to articulate needs of the client clearly Displays the ability to provide reasoned verbal and written reports, to promote effective decision making and accountable practice
3	Demonstrate an ability to articulate the role of the Authorised Officer	1. 2. 3. 4. 5. 6.	Consults with the individual and nearest relatives where possible, to discuss the reasons for considering involuntary admission and the role of the Authorised Officer within the process. Respect individuals abilities and diverse backgrounds, enabling them to contribute to decisions which affect their quality of life and which may affect their liberty. Display through own actions how the role of the Authorised Officer acts in the best interests of the person. Ability to assist with arrangements concerning conveyance and admission to hospital. Ability to liaise with the recommending medical practitioner and Clinical Director of Approved Centre. Ability to liaise with Clinical Director and Staff of Approved Centre should Escorts or Garda assistance be required.
4	Demonstrate the ability to protect the rights of the service user	1. 2.	Demonstrate the ability to provide pertinent information to the individual including: awareness of their rights; choices available, likely outcomes of options, to enable them to make informed decisions (where practicable) Acts in the best interests of the individual at all times

## Mental Health

	COMPETENCY		PERFORMANCE INDICATORS
1	Demonstrate knowledge & Understanding of the range of mental disorder within a bio/psycho/social framework	1. 2. 3. 4.	Can identify key elements of possible mental disorder Can identify possible causative factors of the disorder e.g. life event stress Can relate / align mental health needs with the MHA 2001 definitions / ICD 10 Understands the exclusion criteria for involuntary admission
2	Demonstrates an understanding of the implications of mental illness for service users, families & carers	1. 2.	Display insight into the lived experiences of individuals experiencing mental health crisis Can describe the effects and impact of mental disorder in the everyday experience of carers and relatives
3	Demonstrate knowledge & understanding of mental health interventions & treatments	1. 2. 3. 4.	Can describe the persons condition Displays knowledge of behavioural, physical & social signs & symptoms of mental illness and mental impairment Can describe the range of interventions appropriate to the disorder Has awareness of evidence based approaches to interventions and treatments
4	The ability to evaluate the outcomes of interventions with service users and others	1. 2. 3.	Seeks the clients, nearest relatives, other stakeholders view of the intervention Analyses the significance of the assessment with the service user where possible, discuss the assessment with other professionals and communicate outcomes of assessment with relevant others Determines through reflection / peer review whether or not the intervention was appropriate or not
5	Knowledge of the range of mental health services and other resources available	1. 2. 3. 4. 5. 6.	Is familiar with both the statutory and voluntary provision of services / interventions available within the locality Has an understanding of the principles & provision of local mental health services Has knowledge of the roles & functions of those with responsibility for mental health services Can justify choice of strategy Can determine realistic options Supports choice for individual

## Decision Making

	COMPETENCY		PERFORMANCE INDICATORS
1	Demonstrate an ability to obtain, analysis and share appropriate information from individuals and other resources in order to manage the decision making process	<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> <li>6.</li> </ol>	<ol style="list-style-type: none"> <li>1. Uses a wide range of information sources and knows how to assess relevant information to address the issues</li> <li>2. Can undertake a systematic whole systems assessment that has, as its focus, the strengths and needs of the individual and those family and friends who support them</li> <li>3. Takes an overview of complex problems before generating solutions</li> <li>4. Can generate a number of solutions alone or in consultation with others before deciding on a particular solution</li> <li>5. Anticipates consequences to different solutions</li> <li>6. Has the ability to plan for alternatives to hospital based care.</li> </ol>
2	Utilises evidence based decision making	<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> </ol>	<ol style="list-style-type: none"> <li>1. Bases judgements on logic and analysis</li> <li>2. Has confidence to take decisions up to own level of discretion but will also recognise when to take an issue to the next level</li> <li>3. Engages in review of the evidence base on which assessment decisions were made</li> <li>4. Identifies gaps in information gathering</li> </ol>
3	The ability to plan, negotiate and manage an involuntary admission to an approved centre	<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> </ol>	<ol style="list-style-type: none"> <li>1. Ability to plan for involuntary admission, informing individuals of their rights and consulting with family members</li> <li>2. Displays an ability to make judgements based on knowledge of service users / family &amp; information regarding social and environmental pressures pertaining</li> </ol>
4	Demonstrates the ability to manage risk situations	<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> <li>6.</li> </ol>	<ol style="list-style-type: none"> <li>1. Conducts appropriate risk assessment to self and uses this to guide practice</li> <li>2. Able to establish risk to self / others</li> <li>3. Can produce accurate and effective assessments, identifying specific risk factors of relevance to the individual, their family and carers and the wider community (including risk of self-harm, self neglect &amp; violence to self &amp; others)</li> <li>4. Integrates a risk assessment for suicidality &amp; other possible risks early in the interview – able to take appropriate measures to ensure own / others safety (given own limitations / vulnerabilities)</li> <li>5. Demonstrates sound knowledge of risk &amp; protective factors in assessing risk for suicide</li> <li>6. Plans actions in a manner that ensures that priorities reflect clients needs / rights balanced with those of others e.g. relatives</li> </ol>
5	The ability to effectively manage difficult situations of stress, suicide risk, interpersonal conflict & aggression	<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>	<ol style="list-style-type: none"> <li>1. Can make decisions in a timely manner in a crisis &amp; will be comfortable about making a decision (even in the absence of complete information)</li> <li>2. Can collaboratively develop a safety plan that assures safety for all</li> <li>3. Clearly articulates risk to other colleagues / family members</li> <li>4. Is proficient in recognising aggression &amp; violence requiring the maintenance of safety i.e. de-escalation techniques</li> <li>5. Ensures that the person's needs are met in the least restrictive manner</li> </ol>
6	Demonstrates the ability to review decision & judgements made	<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> </ol>	<ol style="list-style-type: none"> <li>1. Demonstrates ability to evaluate the outcome of interventions</li> <li>2. Can provide the basis for options chosen and justify with rationale</li> <li>3. Maintains accurate records &amp; documentation regarding the process</li> </ol>
7	Demonstrates client advocacy	<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> </ol>	<ol style="list-style-type: none"> <li>1. Enables clients / families to participate in decisions about their health needs</li> <li>2. Articulates &amp; represents individuals interest</li> <li>3. Adopts different strategies in response to the individuals needs</li> <li>4. Adopts different strategies in the light of ongoing interventions &amp; when necessary reformulating the problem</li> </ol>



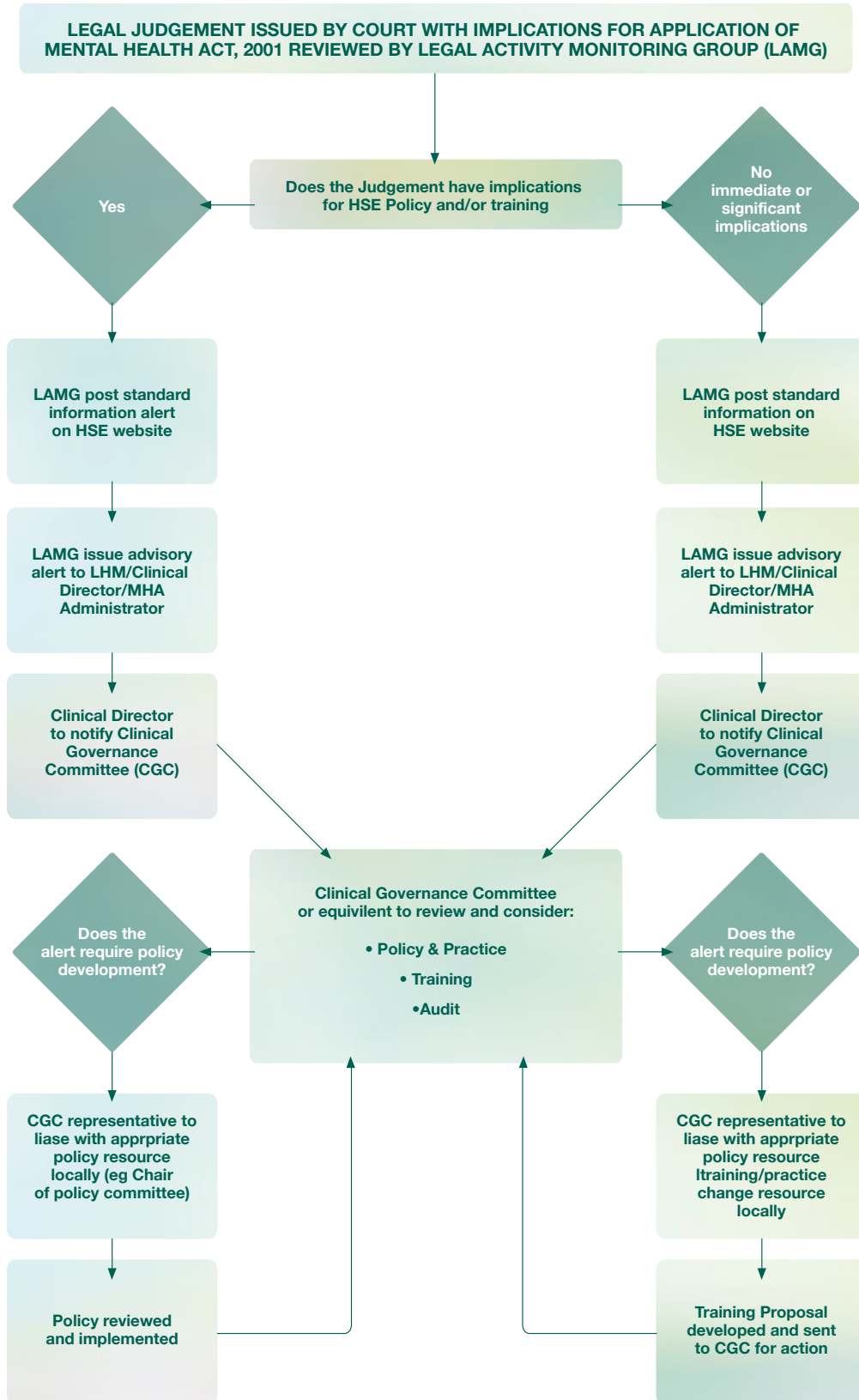
## Cultural Awareness

	COMPETENCY		PERFORMANCE INDICATORS
1	Understands the impact of culture on identity	1. 2. 3.	Displays an understanding of the diversity of culture, gender, religion, ethnicity, disability, age and social practices within those with mental health problems Develops and understanding of the diversity of sexuality as comprising sexual identity; orientation and behaviour Is able to explain how alienation and isolation upon mental illness
2	Plans for cultural, social and ethnic diversity	1. 2. 3.	Ensures provision of personal mental health services is not hindered by language difficulties, social exclusion, labelling, stigma Can relate to individuals from different communities in an open and respectful manner Displays knowledge of provision of interpretation services, sign readers and supports for all ethnically diverse individuals
3	Demonstrates ethical practice	1. 2. 3. 4.	Has an understanding of & commitment to the legal & human rights of service users and carers Is able to respond to the needs of people in an ethical, honest and non-judgemental manner Promotes the individuals rights and responsibilities Recognises & maintains their rights to privacy, dignity, safety, effective treatment & care based on the principle of informed consent

## **Appendix 4: Current providers in the Health Service Executive of Education & Training**

- 1.** Performance & Development (HSE P&D)
- 2.** Centres for Nursing & Midwifery Education (CNMEs)
- 3.** Higher Education Institutions (HEIs)
- 4.** Nursing/Midwifery Planning & Development Units (NMPDUs)
- 5.** HSE Trainers/ Facilitators, Clinical Nurse Specialists (CNS)/ Advanced Nurse Practitioners (ANP).
- 6.** External Providers/ Consortia
- 7.** Allied Health Professionals within Mental Health Services
- 8.** Allied Health Professionals outside Mental Health Services
- 9.** Service Users & Carers
- 10.** Irish College of General Practitioners (ICGP)
- 11.** Royal College of Psychiatrists, Ireland (RCPI), Clinical Directors/ Consultants
- 12.** Drug & Medicine Companies

## Appendix 5: Flowchart Of Process For Circulation Of MHA Decision



## Appendix 6: Mental Health Commission Training and Development

eLearning Programme for training in the Mental Health Act, 2001.

Mental Health Act, 2001 – Train the Trainer Programme

Mental Health Tribunal Panel Members Training Programme (M)\*

Legal Representatives Training Programme (M)\*

Section 17 Consultant Psychiatrists training programme(M)\*

\*(M) = Mandatory

The eLearning programme is made up of 7 modules of interactive learning with a total of 14-15 hours. Online assessment on the Act is available and on successful completion a certificate of evidence can be downloaded. [Modules are numbered in a suggested study order]

Modules available within the MHC site are:

- Getting in on the Act
- Mental Health Commission
- Admission of an Adult
- Mental Health Tribunals
- Consent to treatment
- Admission and Treatment of a Child
- Transfer, Leave & Discharge.

Building on these modules developed by the MHC, it is proposed to add specific modules (which will have a strong practice basis to them) on the following:

- Admission of an Adult specific to Intellectual Disability
- Admission of an Adult specific to Dementia
- Renewal Orders
- Approved Centre Regulations incl. Policies, Procedures & Guidelines
- Assessing mental health
- Enabling Patient rights
- Incident Reporting
- Powers to detain a person, a voluntary patient or a child within an approved centre.
- Electro-Convulsive Therapy
- Seclusion & Mechanical means of bodily restraint
- Excellence in mental health records / Record Keeping

- Authorised Officer
- Assisted Admission / Removal of person to Approved Centres
- Assisted Admissions Co-ordinator
- Mental Health Act Administrator
- Criminal Law (Insanity) Act 2006
- Powers of Garda Síochána
- Legal Representatives
- MHC Inspection Process & Powers incl. Quality Standards
- Central Mental Hospital Provisions
- Legal updates refresher training

## Appendix 7: Table Of Competencies For Tiers Of Training

GRADE	LEVEL OF COMPETENCE REQUIRED	CORE TRAINING	METHODOLOGIES	RESOURCE
<b>Front line clinicians</b> (Staff nurse, OT, SW, Psychologist, NCHD)	Sound value base with ability to reflect on performance.  Understanding, application and knowledge of the Mental Health Act, 2001	<ol style="list-style-type: none"> <li>1. MHA (2001)</li> <li>2. CoP/ Rules/Reg arising from s. 33(1) MHA (2001)</li> <li>3. S. 23/24</li> </ol>	<ol style="list-style-type: none"> <li>1. Classroom based</li> <li>2. Mentorship combined with eLearning, portfolio or learning log identified in PDP</li> <li>3. Mentorship by buddy system combined with e-learning, portfolio or learning log identified in PDP</li> </ol>	<ol style="list-style-type: none"> <li>1. NMPDU/ MHA trainers</li> <li>2. Line Manager/ MHA Leads</li> <li>3. Line Manager /MHA Leads</li> </ol>
<b>Front line managers (CNM)</b> <b>Service Managers (CNM III/ ADON)</b> <b>Consultants</b> <b>HoDs</b> <b>Local MHA Leads (NPDC MHA Trainers)</b> <b>LHM</b> <b>Clinical Director</b> <b>MHA Risk Manager</b>	Knowledge of audit  Establish support and supervision structures  Develop practice/ policy and standards	<ol style="list-style-type: none"> <li>1,2,3 (above) and the following;</li> </ol> Inspection and governance process  Integrating governance and policy/standards  Legal case studies	<ol style="list-style-type: none"> <li>1. Facilitated learning from HEI, NPDC, CNE through resource pack including e-learning</li> <li>2. Action learning and mentoring based on individual PDP</li> </ol>	<ol style="list-style-type: none"> <li>1. Facilitated learning from HEI, NPDC, CNE</li> </ol>

## Appendix 8: Table Of Indicative Modules Commensurate With Level Of Practice

GRADE	LEVEL OF PRACTICE	KNOWLEDGE & SKILLS
Level 1	All staff	<p><i>Process of Care 1</i> (MHA, Clinical Governance, Policy &amp; Standards)</p> <p><i>Process of Care 2</i> (collaborative care planning, health promotion)</p> <p>Assessment 1 (BPSI assessment)</p> <p>Assessment 2 (risk, side effects)</p> <p>Physical health of SEMI</p> <p>Engagement &amp; intervention (SFT, group work)</p> <p>Medication Management (adherence, education)</p> <p>Values oriented practice (cultural &amp; gender awareness)</p> <p>Multi-disciplinary health and social care planning.</p>
Level 2	Frontline Managers/ leaders	<p>All above +</p> <p>Modelling transformational leadership</p> <p>Developing and sustaining team structures (Supervision, staff development)</p> <p>Service users experience of service enhancement through attending to <i>Process of care 2</i> (collaborative care planning, health promotion)</p>
Level 3	Middle & Senior Managers/leaders	<p>Whole systems approach to ensure adherence to and enhancement of <i>Process of care 1</i> (MHA, Clinical governance, policy &amp; standards, audit)</p> <p>Leading service development</p> <p>Leading policy &amp; protocol development</p> <p>Excellence in leadership</p>

## Appendix 9: Example of Professional Development Plan

### Professional Development Plan

The following section will give you guidance on the Professional Development Plan (PDP) what it is and how you can utilise it in support of your learning.

3 key questions to ask yourself...

- 1. What is a PDP?**
- 2. Why should I have one?**
- 3. How can I identify my learning?**

The answers are straightforward...

#### **1. What is a Professional Development Plan (PDP)?**

A PDP is just another name for a plan of action, only this one refers specifically to your learning in order to enable you to fulfil your role. We make plans every day, but do not always write them down; a PDP allows you to set your own professional learning targets and identify the best way to achieve them.

#### **2. Why should I have one?**

A PDP will help you to keep track of your learning, to provide evidence of maintaining competence and to identify areas for learning. To be effective, it must be reviewed at regular intervals to ensure that it is relevant and realistic.

#### **3. How can I write one to reflect my own learning needs?**

You may feel confident enough to go straight ahead and fill in a PDP. Please note that the design used for the template is only a suggested format. The questions aim to promote thought and consideration of the learning you need to achieve and the methods you might use.



## Simple Steps To Writing A PDP

Ask yourself a further 3 questions...

1. **Where am I now?**
2. **Where do I need to be?**
3. **How can I get there?**

## Getting Started

### Where am I now?

Firstly you will need to decide what your current situation is. This will form the lower edge of your "Learning Gap". You may find it helpful to consider the following questions.

- What am I good at?
- What do I need to work on?
- What could help me along?
- What might stop me?

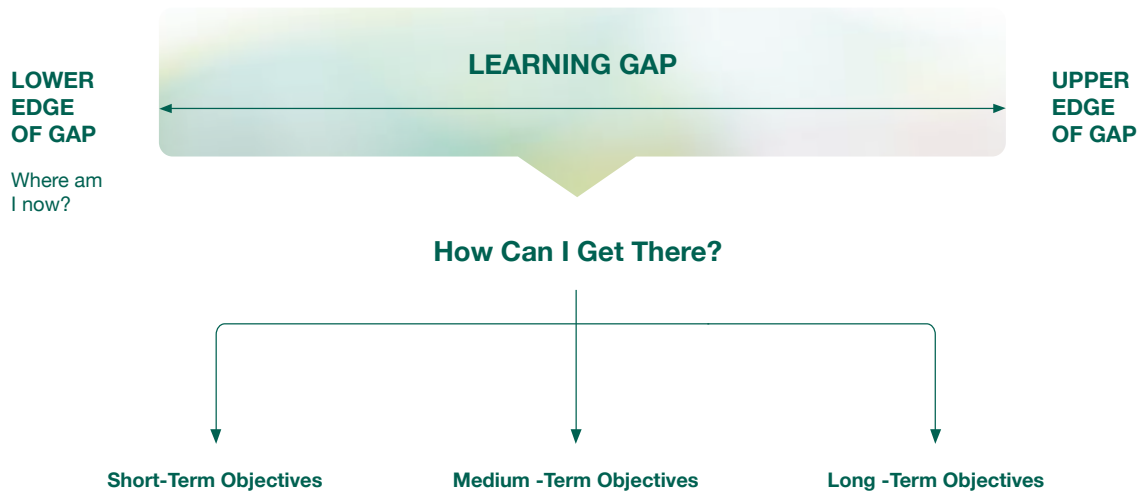
Consider the following example and then repeat the exercise to reflect your own circumstances.

<b>BOX 1: WHAT AM I GOOD AT?</b>	<b>BOX 2: WHAT DO I NEED TO WORK ON?</b>
<ul style="list-style-type: none"><li>• Good interpersonal skills</li><li>• Qualifications achieved relevant to workplace</li></ul>	<ul style="list-style-type: none"><li>• Limited knowledge of policies</li><li>• More input to therapeutic development in workplace</li></ul>
<b>BOX 3: WHAT COULD HELP ME ALONG?</b>	<b>BOX 4: WHAT MIGHT STOP ME?</b>
<ul style="list-style-type: none"><li>• Attending facilitation/refresher course</li><li>• Projects underway at work</li></ul>	<ul style="list-style-type: none"><li>• Lack of support</li><li>• Possible personal detachment</li><li>• Lack of resources (money/time)</li></ul>

- The above example could apply to someone wanting to improve their contribution to the workplace by concentrating on vocational skills (see box 1) rather than more formal exam-based courses (see box 2).
- They could use this exercise to identify that work-based learning would be an ideal solution as it involves gathering evidence from the many and varied projects that service personnel get involved with on a daily basis (see box 3).
- The skills gained are transferable and learning could continue wherever they are in the world (see box 4).

## How Can I Get There?

You have now identified your Learning Gap. The question of “How can I get there?” can be answered by splitting your task into “bite-size pieces”. This is a good way to plan effectively without losing sight of your overall aim, and will motivate you to continue as you achieve small victories on your way to completing the final goal.

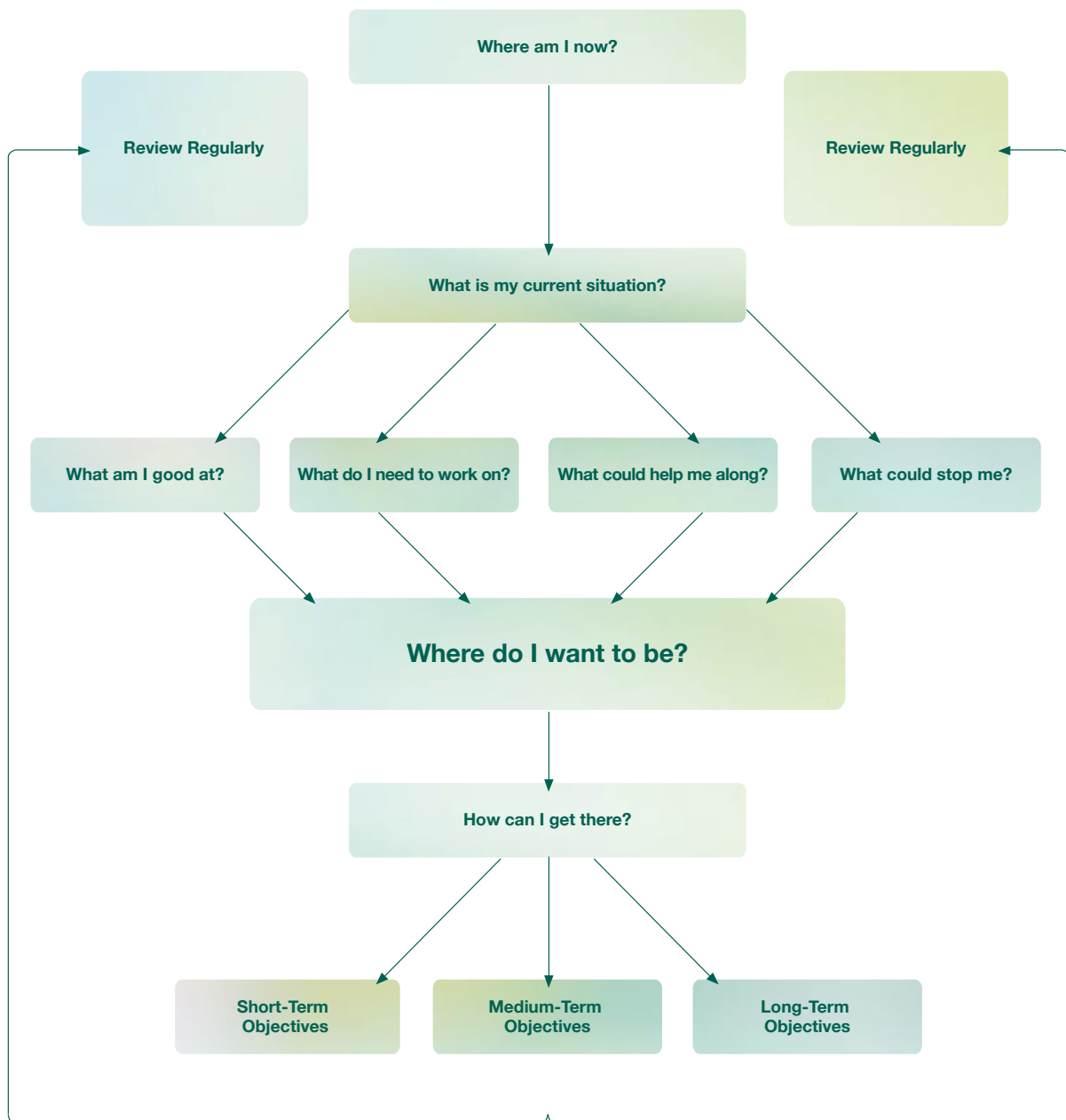


The best way to organise your work into manageable chunks is to set **short, medium and long-term** objectives. Always remember, short, medium and long are all relative terms and will mean different things to different people. Some plans may only last over a 6 month period, others may last up to 3 years, it all depends on you and your own learning needs.

It is also important to remember that these short, medium and long term objectives are fluid and must be reviewed on a regular basis to ensure that they are still relevant. If your plan changes, that is OK, just follow the basic principles outlined here, and continually ask yourself the 3 main questions (see diagram above). Your plan will then remain an effective tool to support your personal development.

Now check the summary flow chart before completing your own PDP.

## Summary Flow Chart For Writing Your PDP



Remember, these are relative terms and will mean different things to different people -  
(for more information see Pg 2-A-2)

## Professional Development Plan (Example)

Name					
Course Title					
Learning Facilitator/Provider					
Level					
Start Date		End Date			
Date Plan Written		Date Plan Reviewed No.1		Date Plan Reviewed No.2	

Why am I undertaking this learning?	<i>What is my ultimate goal?</i> A qualification, personal fulfilment, career development...
What is the direct benefit of the Service?	
What other qualifications have I done (if any) that are relevant to learning?	<i>What qualifications and/or experience do I already have?</i> Some of these may be transferable.

Time Scale	Start Date	End Date	Learning Resource	Comments
Short-Term Objectives				
Medium-Term Objectives				
<b>Long-Term Objectives</b>  <i>Identify where the qualifications will lead. Is it to further study, an overall qualification, a different career, resettlement, promotion or a better understanding of your job?</i>  <i>Recognise your achievement and use these to determine the way forward.</i>				

## Development Plan (Template)

Name					
Course Title					
Learning Provider					
Level					
Start Date		End Date			
Date Plan Written		Date Plan Reviewed No.1		Date Plan Reviewed No.2	

Why am I doing this course?	
What is the direct benefit to the Service? (not applicable to Service leavers or Claimants no longer in Service)	
What other qualifications have I done (if any) that are relevant to this Course?	

Time Scale	Start Date	End Date	Resource	Comments
Short-Term Objectives				
Medium-Term Objectives				
Long-Term Objectives.				

## Glossary

**Approved Centre:** A hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder. An “approved centre” is a centre that is registered pursuant to the Act. The Mental Health Commission establishes and maintains the register of approved centres pursuant to the Act.

**Authorised Officer:** Refers to Authorised Officer as set down in Statutory Instrument 550, Mental Health Act 2001.

**Admission Order:** The order authorising the reception, detention and treatment of the patient concerned and shall remain in force for a period of 21 days from the date of the making of the order in accordance with section 15.

**Clinical Director:** A consultant psychiatrist appointed in writing by the governing body of each approved centre to be the clinical director of the centre under Section 71 of the Act.

**CPD:** Refers to Continuing Professional Development which is a “a systematic maintenance, improvement and broadening of knowledge and skills and the development of personal qualities necessary for execution of professional and technical duties throughout the individual’s working life” (Friedman et al., 2000)

**DoHC:** Refers to the Department of Health and Children.

**ECT:** Refers to Electroconvulsive Therapy: A physical treatment used primarily for the treatment of severe depressive illness.

**Habeas Corpus:** Where an application is made to the High Court against the detention of a patient under the Mental Health Act, 2001 in accordance with Article 40 of the Constitution which guarantees the right to liberty.

**HSE:** Refers to the Health Service Executive

**IPE:** Refers to Interprofessional Education “two or more professions learn with, from and about each other to improve collaboration and quality of care” (Freeth et al., 2005).

**Judicial Review:** An application made to the High Court in respect of the fairness of an aspect of the legislation.

**MHA:** Refers to the Mental Health Acts 2001 and 2008 (Government of Ireland)

**MHAIG:** Refers to Mental Health Act Implementation Group which was established in 2004-2009 to provide a conduit for advice and guidance to stakeholders in mental health services in relation to the requirements of the planned implementation of Part 2 of the Mental Health Act, 2001.

**MHC:** Refers to the Mental Health Commission, provided for under Section 32: (1), (2) and (3) of the MHA. The MHC is an independent statutory body with the principal functions of promoting, encouraging and fostering the establishment and maintenance, high standards and good practice in mental health services and protecting the interests of persons detained under the Mental Health Act.

**MHS:** Refers to Mental Health Service. A service which provides care and treatment to persons suffering from a mental illness or a mental disorder under the clinical direction of a consultant psychiatrist.

**Section 25 of the Mental Health Act, 2001:** Provides for the making of an order by the District Court which states that a child may be admitted and detained for treatment in a specified approved centre for a period not exceeding 21 days.

**Vision for Change:** Refers to *Vision for Change; Report of the Expert Group on Mental Health Policy* (DoH&C, 2006) a mental health service policy document.

**WBL:** Refers to 'work based learning' which allows Mental Health Service practitioners to learn from their work in a structured manner, testing out changes in practice (Clarke, 2004)

## Acknowledgments

### Consultation Process

**1st Consultation Day / Workshop held in St. Mary's Hospital, Phoenix Park  
on the 4th June, 2009 – in attendance were:**

Seamus McNulty	Assistant National Director, PCCC, Lead in Mental Health
Martin Rogan	Assistant National Director, Mental Health
Tony Leahy	National Planning Specialist
Prof. Harry Kennedy	Executive Clinical Director
Jim Ryan	Local Health Manager, Lead LHM for Mental Health
Stephanie Lynch	Administrator, St. Senan's Hospital
PJ Harnett	Nurse Practice Development Co-ordinator
Anthony Fitzpatrick	Nurse Practice Development Co-ordinator
Amelia Cox	A/Clinical Nurse Manager III
Martin McMenamain	Nurse Practice Development Co-ordinator
Kevin Cleary	Head of Business Unit, HSE, DML

**2nd Consultation Day / Workshop held in St. Mary's Hospital, Phoenix Park  
on the 8th June, 2009 – in attendance were:**

Thomas Kearns	Representative from An Bord Altranais
Dr. Raju Bangaru	Representative from Irish College of Psychiatrists
John Redican	Representative from National Service User Executive
Henry Blake	Representative from National Service User Executive
Franke Browne	Representative from Irish Association of Social Workers
Jutta Kirkam	Representative from Irish Advocacy Network
Aine Clyne	Representative from Association of Occupational Therapists in Ireland
Esther Crowe Mullins	Representative from Association of Occupational Therapists in Ireland
Deirdre Dunne	Representative from Heads of Psychology in Ireland
Mary Farrelly	Representative from the National Council of Nursing & Midwifery
Aine O' Reilly	Representative from Association of Occupational Therapists in Ireland



**Written submissions were received from the following:**

**Professor Agnes Higgins**, Psychiatric Nurses Forum, School of Nursing and Midwifery, University of Dublin, Trinity, College.

**Professor Seamus Cowman**, Head of Department, Royal College of Surgeons in Ireland.

**Rosemary Smyth**, Director of Training, Mental Health Commission.

**Irish Institute of Mental Health Nursing.**

**Mr. Tom O’Grady**, Lecturer, Department of Nursing & Health Studies, St. Angela’s College, Sligo.

**Irish Association of Social Workers** compiled by Mr. Frank Browne, Social Work Team Leader, Dublin Mid Leinster.

**Dr. Harry Gijbels & Dr. John Sweeney**, Catherine McAuley School of Nursing & Midwifery, University College Cork.

**Jutta Kirkam**, Irish Advocacy Network.

**Henry Blake & John Redican**, National Service User Executive.



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive