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Current Education / Training Available for Professionals Working in Mental Health Services in the Republic of Ireland

A Scoping Study

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Report prepared for the Mental Health Commission

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Table of Contents

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List of Abbreviations

ANP:	Advanced Nurse Practitioner
AOTI:	Association of Occupational Therapists Ireland
APPI:	Association for Psychotherapy and Psychoanalysis in Ireland
BNS :	Bachelor of Nursing Studies
CCST:	Certificate of Completion of Specialist Training
CAIPE:	Centre for the Advancement of Interprofessional Education
CNS :	Clinical Nurse Specialist
COTEC:	Council of Occupational Therapists for the European Countries
CUILU:	Combined Universities Interprofessional Learning Unit
CMHT:	Community Mental Health Teams
CPD:	Continuous Professional Development
ESC:	Essential Shared Capabilities
EBP:	Evidence Based Practice
HSE:	Health Service Executive
ENOTHE:	European Network of Occupational Therapy in Higher Education
EHEA:	European Higher Education Area
HEI:	Higher Education Institution
IPE:	Interprofessional Education
IASSW:	International Association of Schools of Social Work
IASW:	Irish Association of Social Work
IFSW:	International Federation of Social Workers
IASLT:	Irish Association of Speech and Language Therapists
ICP:	Irish Council of Psychotherapy
IACP:	Irish Association for Counselling and Psychotherapy
IMC:	Irish Medical Council
IPTC:	Irish Psychiatric Training Committee
IPA:	Institute of Public Administration
MHC:	Mental Health Commission
MDT:	Multidisciplinary Team
NCNM:	National Council for the Professional Development of Nursing and Midwifery
NIMH:	National Institute for Mental Health
NSWQB:	National Social Work Qualifications Board
NQAI:	National Qualifications Authority of Ireland
NUI:	National University of Ireland
NUIG:	National University of Ireland, Galway
NMPDU:	Nursing and Midwifery Practice Development Units
OT:	Occupational Therapy
OSCE:	Objective Structured Clinical Examination
PSI:	Psychological Society of Ireland
PTF:	Psychological Therapy Forum
RCP:	Royal College of Psychiatry
RCN:	Royal College of Nursing
RCSI:	Royal College of Surgeons in Ireland
SCMH:	Sainsbury Centre for Mental Health
SLT:	Speech and Language Therapy
CPLOL:	Speech and Language Therapists and Logopedists
TCD:	Trinity College Dublin
UCD:	University College Dublin
UCC:	University College Cork
WHO:	World Health Organisation
WFOT:	World Federation of Occupational Therapists

Executive Summary

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The provision of high quality education and training that is responsive, relevant, accessible and evidence based is critical, if the modernisation agenda, and the vision for quality mental health services articulated in all of the recent publications, is to be realised. A review of international literature on the education and training of practitioners working in mental health suggest that education requirements vary significantly from country to country. These variances may be accounted for by differences among educational systems, licensing requirements by professional bodies and the health care system of a particular country.

This report presents the findings of a scoping study that addresses the education/training available to professionals working in mental health services in the Republic of Ireland. It focuses on the education of psychiatrists, nurses, social workers, psychologists, occupational therapists, and speech and language therapists. The research design was an exploratory, descriptive design using a combination of questionnaires and telephone interviews for data collection.

In total, 227 courses from 31 educational institutions were identified as fulfilling the inclusion criteria for the study. 149 questionnaires were returned from 129 Coordinators/ Directors. This represented a 65.6% return rate for the questionnaires from 72% of the Course Coordinators/ Directors targeted.

Key Findings

Analysis of the highest level of award demonstrated that the majority of courses considered within this study were offered at masters' level and for the greater part, these were taught masters. The majority of courses were self-financed with others being either completely or partially subsidised by the HSE, the Department of Health and Children and the Department of Education and Science. The remainder were funded from other sources. Responses indicated that the majority of courses held accreditation with a professional body with some in the process of gaining accreditation. Most courses have one student intake per year though some vary their intake. While it is evident that there is some degree of flexibility in course delivery, including a range of exit points from postgraduate courses, very few courses had provision for taking individual modules to achieve the award and few courses utilise online, blended or distance learning. In relation to continuing professional development, it is interesting to note that 61% of courses are self-financing and this may suggest a high degree of individual motivation to complete courses.

In relation to student recruitment, just under half of the courses who responded to this question did not meet their target number. Over half of the courses with difficulty achieving their targets were at postgraduate level, and a substantial proportion of these were within Nursing Schools/Departments.

When asked to indicate the rationale for course development, just under half indicated that the course was established to meet a specific health service need. Other courses were designed to respond to initiatives in report and policy documents, enhance competency development for practitioners or meet a specific professional development need.

Regarding unidisciplinary or multidisciplinary foci of courses, two thirds identified themselves as discipline specific and the remainder as the latter. Multidisciplinary courses were largely provided at postgraduate level, located in a variety of departments and were available to all mental health professionals that were the focus of this study. In addition, over half of the courses were open to a range of other allied health professionals, carers and service users who met the admission criteria. An analysis of student attendance on the multidisciplinary courses per department/school for the year 2008-9 revealed that doctors and nurses tend to attend courses run by their own departments/schools.

From the courses surveyed, there appears to be a wide distribution of lecturing staff from all professional backgrounds teaching on the programmes. In addition, a quarter of the courses have service user involvement but few accommodate carer involvement in teaching. Teaching staff are expected to keep up-to-date with policy, service and practice developments through reading research, policy and theoretical literature; through continuing professional development; and researching issues in practice. However, spending time teaching students in practice, carrying a case load, spending time on service and clinical developments, are less frequently used strategies. Attending clinical supervision was identified by a very small cohort, and these came from

respondents completing questionnaires for courses in counselling, psychotherapy and applied psychology.

While the didactic and lecture format was favoured as a teaching method, self-directed and experiential learning approaches were also employed. Both problem- and practice-based learning strategies were detailed by more than half the courses but very few indicated that online or distance learning was utilised. A variety of assessment methods were specified by courses and with the exceptions of direct observation of practice and OSCEs, these involved some form of written assignment. Some courses require a placement or supervised sessions for students.

In terms of quality assurance mechanisms, most courses have an external examiner and receive formal feedback from students. Various other mechanisms were detailed as utilised including feedback from professional accreditation bodies, management committees and lecturing staff. However, formal feedback from health service providers, service users or carers were infrequently reported.

Service users were involved in 37% of the courses surveyed by providing teaching about their experiences. Few were involved in other educational aspects of the courses, such as course design and evaluation, and the selection or assessment of students. Of those who indicated that there was no service user involvement, nearly half expressed their intention to include service users in educational provision at some point in the future.

Analysis of the question on the degree of emphasis given within the curricula to theoretical and clinical issues deemed important in education of mental health professionals indicated that ten per cent of courses placed no emphasis, and 13% indicated a weak emphasis on these issues identified. Analysis of the degree of emphasis placed on policy and legal documents deemed important indicated that the documents are poorly emphasised within curricula across all courses and within all departments. Only 36% of courses placed either a very strong or strong emphasis on the policy documents within curricula. In addition, 31% of courses placed no emphasis on these documents.

Many of the respondents in this study outlined their commitment to the development of various courses for mental health professionals from certificate through to doctorate level. Respondents highlighted their key priorities for the future education of mental health professionals and the majority of these highlight a commitment to best practice in education. Increased interdisciplinary/multidisciplinary education and the development of competencies among professionals were the two most popular priorities identified by respondents. Other top priorities included: increased service user involvement, more community-based approaches, committing to recovery/social inclusion, increased research and evidence-based practice, developing clinical supervision/personal development, and utilisation of models of education delivery. However, it is clear that the prospect of future course development for mental health professionals may be hampered by a lack of funding and resources. Some respondents identified a number of areas of best practice in education on their courses including: service user involvement, interdisciplinary learning, dissemination of course material, initiatives in teaching, assessment and delivery, links to practice, clinical supervision, and personal analysis.

Recommendations for Course Development:

- While the current and future priorities for mental health training and education have been identified in this report, a long-term strategic plan is indicated. Further consultations among all the relevant stakeholders (e.g. HEIs, HSE, MHC) are required for educational partnerships to develop and an interprofessional approach to education and training of mental health professionals to be more fully explored and implemented.

- The HSE in partnership with HEIs and the MHC should develop an education strategy that will identify educational needs at local and national level.

- In the current economic climate, training and education for mental health care professionals must continue to be developed in an integrated manner and in liaison with health care providers and professional bodies.

- Course development needs to take place in line with contemporary service requirements, aligned to service policy and needs, and take cognizance of those priorities identified by the respondents in this study.

- There is a need for more imaginative ways to marry health service needs, as regards maintaining contemporary skills, with the individual needs of students. HEIs should be encouraged and supported in the development of a variety of flexible learning approaches and methodologies. The creation and delivery of stand-alone modules could offer students a greater degree of flexibility towards Level Eight and Level Nine programmes of study. Online and blended learning would facilitate students to engage in programmes through the process of distance learning and enable students to access learning materials at their convenience.

- Education programmes need to be underpinned by a recovery and social inclusion philosophy of practice, and greater emphasis placed on policy and practice documents that are fundamental to service development and delivery.

- Ongoing evaluation and quality assurance strategies are a key element of governance. In addition to the current evaluation and quality practices identified in the study there is a need to develop strategies that explore the impact of education programmes on service provision and health outcomes, incorporating the perspectives of service providers, service users and carers.

- As less than half of the courses succeeded in filling their entire course places, this information needs to be carefully examined locally and nationally in relation to course viability and resource effectiveness.

- Postgraduate pathways for certain disciplines, such as SLT and OT need to be explored and developed if there are to be sufficient numbers interested in working in the area of mental health in the future.

- It is essential that student learning, both at undergraduate and postgraduate level should receive adequate funding and other supports.

- Although not the focus of this study, there is a need to explore provision of short continuing professional development courses, either within the HEI or within clinical sites. This may involve the HEIs strengthening links with care providers and delivering programmes on an outreach basis.

Recommendations for Interprofessional Education:

- In order to promote an educational culture with respect to interprofessional learning, adequate financial resource must be committed to support this change.

- HEIs, in partnership with service providers, need to identify core elements of education programmes, at both undergraduate and postgraduate level, that are applicable to all professions and suitable for interprofessional education.

- HEIs in partnership with service providers need to develop work-based interprofessional learning initiatives.

- HEIs and service providers need to engage in a consultative dialogue with accreditation organisations and professional bodies so that their requirements and needs are acknowledged from the outset. The development of a single inclusive validation framework in the long term may be worthy of consideration.

- Professional accrediting bodies need to adopt a facilitative approach to interprofessional education and enable both HEIs and service providers' autonomy to develop creative and innovative programmes to meet the challenges of today's health care environment.

- Alongside the need to engage in dialogue with professional organisations and accrediting bodies there is a need to prepare teachers for IPE. It may be naïve to assume that lecturers/teachers can teach on IPE programmes without preparation, therefore we recommend that consideration be given to providing education on both the development of IPE curricula and the skills necessary to facilitate IPE and assess learning outcomes. In the absence of this, educators may simply resort to a multidisciplinary model of education, where people sit and learn in the same environment, but not 'from' or 'about' each others roles and contributions.

- Educators need to move away from the traditional didactic lecture approach to a greater emphasis on facilitation and small group learning. This necessitates a greater emphasis being placed within curricula on interactive and discovery styles of learning, such as action-learning sets and problem- enquiry-based learning.

- It cannot be assumed that providing opportunities for practitioners to learn collaboratively in higher education institutions will result in collaborative interprofessional team work in practice. Therefore to ensure there is no dissonance between education and practice, health service providers need to continue to promote the concept of interprofessional collaboration within practice.

- There is also a need for further rigorous evaluation studies on the impact of IPE on practice, health care processes, and client and family outcomes.

Recommendations for Service User Involvement:

- HEIs in partnership with the service user groups, health service providers, and professional bodies need to develop an overall strategy for the involvement of service users/carers in education. This strategy needs to address issues such as educational preparation, support and payment of service users/carers, as well as a strategy for evaluation.
- HEIs should review their philosophy/mission statements to ensure that they are underpinned by an explicit statement of values supporting service user/carer involvement in educational programmes in their institution/school/department.
- HEIs should collaborate with each other and service user/carer groups in the development and delivery of training for service users and carers who are contributing to programmes.
- HEIs need to broaden the scope of service user involvement beyond teaching into more areas of education, including assessment and student selection.
- Professional bodies with responsibility for guiding or accrediting curricula in mental health education have an important role in promoting service user/carer involvement and should include service user and carer involvement as one of the criteria for accreditation.

Recommendations for Clinical Supervision:

- There is a necessity for an agreed definition of clinical supervision to be developed for mental health practitioners.
- A service-wide clinical supervision policy should be developed for professionals working in mental health and adequate resources made available for the implementation of such policies and procedures.
- Key competencies for supervision in mental health need to be identified and specialised training should be made available for those who provide supervision.
- Research in this area is clearly indicated to establish the efficacy of clinical supervision with respect to client/patient outcomes and to develop, pilot and evaluate models and formats of supervision that are congruent with best practice in mental health provision.

Recommendations for Research and Evidence-based Practice

- HEIs should review their philosophy/mission statements/course literature to ensure that they explicate an active commitment to evidence-based practice and implement pedagogical methods which support EBP education.
- HEIs should promote a research attitude and an increase in research capability for practitioners working in mental health in a manner that is cognizant of the specific practice and research context.
- HEIs, in collaboration with professional bodies that hold responsibility for guiding or accrediting curricula in mental health education, have a vital role in promoting curricula which advance research and evidence-based practice.
- In the absence of Clinical PhDs, their development needs to be explored in order to provide progression and support for those wishing to remain in clinical practice.

Situational Factors and Limitations

As research is subject to situational factors, the findings and implications of this study need to be interpreted with reference to the following considerations:

- There was a high level of response to the survey instrument from Course Coordinators/Directors within mental health nursing, and Course Coordinators/Directors of programmes that led to professional qualifications in Social Work, Psychology, Occupational Therapy, and Speech and Language. A much lower response was achieved from Course Coordinators/Directors of courses that did not lead to a professional qualification.
- 95% of the Course Coordinators targeted within nursing responded to the survey. This means that 42% of the courses analysed in this survey represent the discipline of nursing and this should be considered in interpreting the findings of this study. Despite the apparently high response rate from mental health nursing, it should be noted that this group also comprised by far the greatest number of courses within the study remit.
- The courses included in this study are all provided by HEIs. Other CPD education programmes for mental health professionals may be delivered within the HSE

at local level or by the professional training bodies. These programmes are not included in this study.

- Findings in this study are reported responses to a survey instrument; analysis of curricula documentation was not undertaken. These may have provided further relevant information on the education provided to mental health practitioners.

- Interviews were not conducted with Course Coordinators/Directors due to the short time frame provided for the study. As a result they could not elaborate on responses to questionnaires.

- Some courses were suspended for 2008-09 while others had not commenced and these were not considered within the study.

- The research team recognise that the lack of a Social Work and Speech and Language Therapy professional/s on the study team may have been a limitation. It should however be noted that these were actively sought at the tender stage of the project and during the literature review and data analysis phases. Assistance and advice was provided by social work and speech and language at both the literature review and analysis stage.

- Currently, there is not a shared language of mental health concepts across disciplines, and while this is an issue outside of the remit of the study, it may have impacted on how items on the questionnaire were interpreted.

The report is presented in six parts. The first part provides a background to the study by reviewing literature on education for professionals working in mental health care. Information on the education of each professional group is considered separately, as the requirements and standards governing nurse education, for example, are very different to those required for psychology. This is followed by a review of the literature on interprofessional education. Section three presents an outline of the methodology used in the study. In sections four and five, a standard format is adopted to present the findings of the study, and some examples of innovative practice in the area of education are presented. Section six summarises the findings, draws conclusions and makes a series of recommendations. In addition the limitations of the study are identified.

Section 1:

Education of Mental Health Practitioners: National and International Perspective

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Introduction

This section provides a summary overview of the education of each professional group working in the area of mental health. The process by which education and training of each group is organised is complex, as a number of professional and regulatory bodies may be involved. Where considered appropriate, comparison is made between Irish and international versions of educational models, standards, and regulations. In addition to discussing the training and education of mental health/psychiatric nurses, occupational therapists, psychologists, psychiatrists, social workers, and speech and language therapists, a section is also included on psychological therapy training and education, as psychological therapy is currently offered by a range of the aforementioned mental health professionals. This is followed by a review of the literature on interprofessional education in the area of mental health.

Mental Health/Psychiatric Nursing Education and Training

Currently three models of nursing registration education operate across Europe, namely: the generic model, the generic core and specialist pathway, and the specialist (Cowman 2009). The generic model, which has been endorsed by the World Health Organisation (WHO 1999) and widely adopted throughout Europe, assumes that specialisation in mental health nursing will take place after initial registration. Within this model, nurses enter professional practice as a generalist nurse practitioner, and there is no distinction made between branches of nursing during the students training. In the UK, students follow the generic core and specialist pathway: a three year Diploma or Degree Programme, comprised of a generic core or common foundation year, followed by a two year specialist or branch specific component. The Republic of Ireland is the only EU country that adheres to a specialist entry model for psychiatric nurses and this programme has been wholly incorporated into higher education since 2002 (Cowman 2009). The suitability and lack of homogeneity in different educational models for specialist practice is widely debated. The specialist model has been criticised on the grounds that it is uneconomical, reduces mobility in the workplace and is particularly restrictive to nurses who wish to travel to countries where a generalist nurse is the norm for practice (Cowman 2009; Grant 2002). Notwithstanding these criticisms, there are calls for a return to the direct entry specialist model in countries like Australia, on the grounds that generic training is an 'unethical waste of resources, counterproductive to the task of creating an effective mental health care workforce' (Holmes 2001:237). Furthermore, it is believed that on graduation nurses lack discipline-specific knowledge and practice competence for mental health (Mental Health Nurse Education Taskforce (Australia) 2008; Stuhmiller 2005).

In the Republic of Ireland, the preregistration programme consists of a four year honours degree programme, which is placed at Level Eight Honours Bachelor Degree by the National Qualifications Authority of Ireland (NQAI 2004). The responsibility for approving programmes and monitoring standards for Psychiatric Nurse Education at preregistration level rests with An Bord Altranais. All preregistration education programmes must meet An Bord Altranais's Requirements and Standards for the Nurse Registration Education Programmes (An Bord Altranais 2005). An Bord Altranais (2005:42) require that the curriculum reflects the current evidence/research on educational theory and health care practice, and that it be sufficiently dynamic and flexible to allow for changes in nursing practice and health care delivery. Practice placements in mental health focused services are an integral component of the programme. During practice placements students are supernumerary with the exception of a continual 36 weeks rostered clinical placement (internship) in the fourth year. During this period the student is a paid employee of the health service. Throughout the programme students are supported by a registered psychiatric nurse who has completed a preceptorship course which

enables them to support, guide and assess students in learning the practice of psychiatric nursing (An Bord Altranais 2005). Upon successful completion of the education programme, a student is awarded a Bachelor of Science (BSc Hons) degree and may apply to have their name entered in the appropriate part of the Register maintained by An Bord Altranais. Although specific minimum educational standards for entry to the programme are laid down by An Bord Altranais, each Higher Educational Institution (HEI) may vary in their emphasis and requirements. Currently, there are 12 Programmes, with a total of 343 places, offered in 12 HEIs in association with 14 main Health Care Agencies (www.nursingcareers.ie). However, from October 2009 there will be a reduction in Psychiatric Nursing places by 53, from 343 to 290 (www.nursingcareers.ie/2009_reduction in places). In 2008, in one HEI, a one year higher diploma programme was introduced to prepare nurses already registered on the general or intellectual disability divisions of the register to practice as psychiatric nurses. This programme must meet An Bord Altranais's Requirements (An Bord Altranais 2007).

All countries in Europe provide some degree of continuing education for mental health nurses. However, the literature suggests that courses are dissimilar in terms of length, content and range and include hospital-based post-registration short courses to university-based diplomas and degrees. Similarly within the Republic of Ireland, prior to 1992, post-registration education for psychiatric nurses consisted mainly of short courses run by health care organisations, which were not accredited by Higher Education Institutions. In 1999 the National Council for the Professional Development of Nursing and Midwifery (NCNM) was established, as a statutory body in response to a recommendation from the Report of the Commission on Nursing (Government of Ireland 1998). The NCNM was charged with the responsibility for the creation of a framework for the development of clinical career pathways and comprehensive monitoring, in the context of health care needs. In 2001 the NCNM published frameworks for the development of Clinical Nurse Specialist (CNS) and Advanced Nurse Practitioner (ANP) roles and recommended educational preparation for these roles at Diploma and Masters level (National Qualification Framework level 8 and 9) respectively (National Council for the Professional Development of Nursing and Midwifery 2001a; 2001b; 2004a; 2004b). In response, many HEI's developed post-registration education programmes to prepare practitioners for specialist and advanced practice roles. In 2008, the Post-registration Nursing and Midwifery Education Review Group found that of the 283 nursing and midwifery courses offered, 224 were at NQAI level 8 and 9, of which 97 were not delivered. The numbers of courses designed to meet the needs of the 531 CNS's and 9 ANP's (National Council for the Professional Development of Nursing and Midwifery 2009), currently approved in the mental health services was not evident from the study. The review group also identified a strategic approach for the future development, commissioning, delivery and evaluation of post-registration nursing and midwifery education, and recommended that all future developments be underpinned by the following eight principles: driven by service and client needs, equity of access to courses, flexible approaches to delivery, clinical focus within curricula, standardisation, quality, partnership, and sustainability.

In the past three years both England and Scotland have completed reviews of mental health nursing (Department of Health (UK) 2006; Government of Scotland 2006). Both reviews noted that mental health nurses are a key resource in the effective delivery of a modern health service. In addition they highlighted the need for mental health nursing to embrace the recovery approach, improve their skills in the delivery of psychological therapies, the promotion and support of people's physical health, and focus on working with people with severe mental health problems.

Occupational Therapy Education and Training

The World Federation of Occupational Therapists (WFOT) acts as the official international organisation for the promotion of occupational therapy as a profession. WFOT sets out the minimum ethical, educational and practice standards for occupational therapy (World Federation of Occupational Therapists (WFOT) 2005), and in association with the World Health Organisation provides both organisational structure and acts as the governing body for member countries. A country may become a member of WFOT if it has at least one professional educational programme that has been approved by WFOT. WFOT evaluates and approves an occupational therapy educational course in the first instance, and thereafter, reviews and ongoing approval are the domains of the local professional body. Local professional occupational therapy associations may implement an additional accreditation process to ensure programmes meet requirements, in addition to WFOT's minimum standards.

Debate continues in some countries about the relevance of the WFOT approval of courses. There is some criticism that it is not sufficiently fine-tuned to reflect changing and complex local needs, and to adequately meet the requirements of national stakeholders such as the profession, health care funders, educational establishments and service users (Cusick 1999). Some countries are moving to have the national professional body act as the sole accrediting body, whilst also maintaining WFOT membership and accreditation. This would facilitate higher accreditation standards to be set than those required by WFOT, while allowing for employment mobility worldwide for national graduates and WFOT members (CAOT 2005; Cusick and Adamson 2004). In Europe, the European Network of Occupational Therapy in Higher

Education (ENOTHE) was established in 1995 under the umbrella of the Council of Occupational Therapists for the European Countries (COTEC), which represents 120,000 members and 26 European countries. ENOTHE promotes and advances the education and body of knowledge in occupational therapy in higher education.

Occupational therapists qualify as generalist practitioners internationally, and achieve clinical specialism through clinical experience and additional education. Programme planners are guided by the World Federation of Occupational Therapy Minimum Standards for the Education of Occupational Therapists (Thompson et al. 1997). There are various educational levels for entry to the profession worldwide, depending on local regulations and standards. These levels include diploma, baccalaureate, honours bachelor degrees, master degrees to doctoral degrees. In 2007 a masters degree became the minimum entry level qualification for occupational therapy in the United States of America and Canada. The Accreditation Council for Occupational Therapy Education has also approved a doctoral-level entry qualification (Coppard and Dickerson 2007). It is expected that all occupational therapists 'will have the knowledge and skills to engage individuals in therapeutic processes. Those with higher postgraduate qualifications will have advanced skill in evidence-based practice and producing new knowledge to inform the profession' (World Federation of Occupational Therapists (WFOT) 2005:1). In Ireland in 2008, the Therapy Project Office published a set of competencies for occupational therapists working at three grades of professional practice, namely, graduate/entry level, senior therapist and clinical specialist therapist (Clyne, McCoubray, and Hamilton 2008). Included in the specified competencies is a focus on professional relationships and roles which requires that the therapist 'participates effectively in a variety of multi-, inter-, and intra-professional teams, keeping the rights and needs of the client central to such participation', and takes cognizance of professional boundaries and roles. These competencies are incorporated into all entry level programmes.

In Ireland occupational therapists qualify for practice on completion of either a four year Bachelor of Science degree in Occupational Therapy (provided by the National University of Ireland Galway, University College Cork and Trinity College Dublin), or a full-time two year period postgraduate Masters of Science in Occupational Therapy (Professional Practice) (provided at the University of Limerick). The Association of Occupational Therapists Ireland (AOTI) accredits courses for professional requirements in addition to the universities' own Higher Education Authority accreditation processes. The colleges are members of the European Network of Occupational Therapy in Higher Education (ENOTHE). An integral course requirement is that students complete 1,000 hours of fieldwork education, and at least 250 of these hours must be in a psychosocial practice setting (AOTI 2008). Each of the four universities engaged in occupational therapy education in Ireland also provide postgraduate masters and doctoral degrees. The four colleges and AOTI all provide continuing professional development courses to support lifelong learning and reflective practice.

Prior to the Health and Social Care Professionals Act (2005), occupational therapy did not have a legal framework for statutory registration. This act provides for a system of statutory registration for twelve health and social care professions in Ireland, including occupational therapists and provides for the establishment of Registration Boards to register professionals for practice. The Health and Social Care Professionals' Council set up under the act oversees professional regulation in the interests of patient safety and best practice and also considers the development of the professions themselves.

Psychology Education and Training

The education and training of psychologists varies significantly from country to country around the world (McCarthy et al. 2007). Newstead & Makinen (1997:5) identify three training pathways in Europe: the 'five year specialist' whereby the student commences with a psychology course which specialises in one professional area, the 'five year generalist' where specialisation occurs in the final years of the degree or afterward, and the 'three plus three' model where students complete an undergraduate course of study in psychology and may then specialise in postgraduate study. The 'three plus three' process of training is pertinent to UK and the Republic of Ireland (Newstead and Makinen 1997).

Within Ireland, to embark on a career in psychology, an accredited honours undergraduate degree where psychology is the major subject is initially required, the duration of which is a minimum of three years. Following this, additional postgraduate qualification and specialised training is necessary to develop a career in psychology. Depending on the specialism undertaken and level of qualification pursued (namely masters or doctoral levels) the length of time will usually vary, up to three years full-time. At this point in time, many postgraduate professional psychology programmes in Ireland and the UK have or are in the process of moving toward a doctoral level qualification.

Primary degrees may be undertaken as a single honours degree or as a joint degree whereby another subject is combined as a minor area or equal area of study. A number of postgraduate 'conversion' courses are available to facilitate a change of career for individuals who hold an honours degree in a different discipline and who wish to pursue a career in psychology.

Diverse career pathways are available in psychology for those who wish to undertake postgraduate level study. Currently, postgraduate education is available in the Republic of Ireland in the following applied psychology sub-disciplines: clinical, counselling, forensic, health, educational, and organisational psychology, many of which are now available at doctoral level (for example, clinical, counselling and educational psychology). While research doctorates may be pursued in a number of areas in psychology, there is a growing international interest in applied programmes in psychology (Karandashev 2008).

The Psychological Society of Ireland (PSI) is currently the main professional body that regulates psychology in Ireland. PSI accredits undergraduate and postgraduate psychology courses and has a measure of influence in the curriculum design and course provision. While the PSI does not mandate course curricula, it does outline core components and guiding principles for undergraduate and postgraduate degrees (clinical, counselling, health, educational, forensic, and work and organisational psychology). Graduates of accredited postgraduate programmes are eligible to apply for registered membership of the PSI and may, if they meet with additional criteria (which may include clinical practice and supervision), become registered psychologists with PSI. Continuing professional development activity is a requirement for membership (Psychological Society of Ireland 2004).

Although a number of different education models inform the education of psychologists, they all attest to the need for research to inform practice (Cheasty, Clare, and Collins 1998; Goodheart and Carter 2008; Hunsley 2007) and to the need for integration of science and practice in applied psychology (Borden and Ilvried 2008; Neimeyer and Goodyear 2005; Rodolfa, Ko, and Petersen 2004). The model that has been widely adopted within the profession is more commonly referred to as the 'Scientist-Practitioner' model (Cheshire and Pilgrim 2004; Huey and Britton 2002). The 'Scientist-Practitioner' model (Benjamin and Baker 2000) focuses on training for scientific research and clinical practice while emphasising the science of psychology and the application of research to clinical practice (Cherry, Messenger, and Jacoby 2000). It is this model that is recommended for the education of 'all mental health professionals' (Huey and Britton 2002:72).

In response to mental health legislation in the UK, an increasing number of professional working groups [for example, the Psychology Network Mental Health Group (PNMHG), the British Psychological Society (BPS)] are concentrating their efforts on developing psychology in mental health (Harper et al. 2007). In an attempt to promote such a discourse on mental health policy, the BPS produced a discussion paper entitled *Psychological Health and Well-being: A new ethos and a new service structure for mental health* (Kinderman and Tai 2008). The authors note, with reference to the Department of Health's National Framework for Mental Health (1999) states that it is timely to reconsider the role and perspectives of psychology in service provision. The group advocate a shift from diagnostic categories to psychological formulation of mental health issues. They conceptualise service user involvement as crucial and propose that evidence-based psychological therapies should be established and provided in accordance with National Institute for Health and Clinical Excellence recommendations (National Institute for Health and Clinical Excellence 2008). In order for these initiatives to be developed and implemented, government investment in mental health services is seen as essential. These propositions are supported by other experts in the field (Cromby, Harper, and Reavey 2008; Gelso 2006; Soffe 2004; Tait and Lester 2005).

In the Republic of Ireland, similar developments are evident in recent policy documents and discussion papers. With reference to working in the area of mental health, the definition of multidisciplinary competencies as called for by the Mental Health Commission (Mental Health Commission 2006) may have implications for teaching of psychology. A review of clinical and counselling psychology course content has been called for in the *Vision for Change Report* (Department of Health and Children 2006) to ensure that adequate provision is being made to meet the mental health service described in the policy. The imminent introduction of Statutory Regulation may also be influential in education provision (Government of Ireland 2005). Such initiatives may have many implications for the education and training of psychologists at undergraduate, postgraduate and CPD levels.

Social Work Education and Training

The knowledge base for social work is constantly changing in order to respond to developments in mental health policy, legislation and practice. These changes present substantial challenges to how services are conceptualised, organised and delivered (Government of Ireland 2006; Department of Health and Children 2008). Commentators have highlighted the ways in which social work practitioners, researchers and educators have responded to the challenges both in the Irish context and internationally (Payne 2001; Stanhope and Solomon 2008; Steiner et al. 2008). Recent social work discourses have explored practice developments in Ireland linked to de-institutionalisation, community care and the voice of the service user (Wilson & Kirwan 2007). Consequently, social work education may be reflected as holistic, less biomedical and increasingly service user focused (Beresford & Croft 2004; Levin 2004, Duffy 2008). Furthermore, there has been a long tradition of supervision within social work (Shulman 1995; Bruce & Austin 2001; Munson 2002) which is seen as a necessary and valuable resource for professional development and administrative activity in this context (Bruce and Austin

2001; Hensley, 2003; Bogo & McKnight 2006; Nobel & Irwin 2009).

There is enormous diversity and variation across nations and regions in the form, content, and provision of social work education and training. The International Association of Schools of Social Work (IASSW) and the International Federation of Social Workers (IFSW) published the Global Standards for Social Work Education and Training (IASSW and IFSW 2004) as a joint initiative in 2004. This comprehensive document is the first set of standards for social work education at the global level. Although compliance with the standards is voluntary, they have been welcomed and viewed by schools of social work, especially in the developing world, as helpful targets that will contribute to developments within social work training. A review of the literature suggests that the 'academisation' of social work is becoming the norm, with many countries opting for either a three or four year Bachelors degree in social work (Sheehan & Ryan 2001; Karban 2003; IASSW and IFSW 2004; Wilson et al., 2005).

Before 1995, social work education in Ireland had been accredited by the UK-based Central Council for Education and Training in Social Work. The National Social Work Qualifications Board (NSWQB), soon to be subsumed under the terms of the Health and Social Care Professionals Act (Government of Ireland 2005), is now responsible for the accreditation of social work education. Additionally, the NSWQB grants the professional qualification in social work to those who complete accredited courses, advises the government and employers on social work qualifications and produces research on workforce developments. Similar to other European countries, social work education in Ireland is a generic programme. While not advocating or seeking to enforce a single approach, the NSWQB does specify certain requirements and essential core content for education programmes. The guidelines provided are built around generic competencies and values, which are transferable across different practice settings.

The undergraduate training curriculum includes academic subjects such as social policy, sociology, psychology, social research, economics, political science, legal studies, and courses related to social work skills, knowledge and values (Christie 2005). Students learn communication and counselling skills and methods of working with individuals, families, groups and communities. Students are also required to spend at least 1000 hours in practice placements supervised by a practice teacher who is a qualified social worker (Gould 2006). In the Handbook of Accreditations Standards, specific reference is made to the inclusion of issues relating to mental health, mental illness and mental health legislation (NSWQB 2003:14-15). However, few studies exist that evaluate social work and mental health practice (McCrae et al. 2005). Nevertheless, recent policy changes are seen by some as providing opportunities for practitioners to investigate contemporary social work issues and postgraduate programmes are encouraging student practitioners to undertake research in this respect (Skehill 2003; Gould et al. 2007; Wilson et al. 2005). Students wishing to register with the NSWQB must have studied at bachelors or masters level. Two undergraduate courses combining an academic social sciences degree, with professional social work training and four years full-time study, are offered at University College Cork (UCC) and University of Dublin Trinity College (TCD). Four third-level institutions offer a Graduate/Postgraduate Diploma/Masters in Social Science or Social Work for students who already hold a relevant social science bachelors degree or equivalent and have previous work experience. These institutions include: University College of Cork (UCC), University College of Dublin (UCD), University of Dublin Trinity College (TCD) and National University of Ireland Galway (NUIG) (www.nswqb.ie).

Whilst continuing professional development (CPD) is not mandatory, recent guidelines from the Irish Association of Social Work (IASW) have recommended a process that permits social workers to record and validate their CPD activities (IASW 2009). Social workers working in specialised mental health fields such as Child and Adolescent Mental Health Services (CAMHS) can embark on programmes such as MSc in Family Therapy or MSc Interprofessional Mental Health (Trinity College Dublin). IASW also recognises the importance of clinical/professional supervision and believe that this becomes a fundamental part of lifelong learning in order for social workers to develop their practice (IASW 2009).

Speech and Language Education and Training

General communication between individuals plays an important role in human expression. In potential therapeutic interventions it can impact upon future recovery (Law et al. 2007). One key Irish study demonstrated the importance of the need for specialist speech and language therapy assessment and support among adults with mental health problems in both community and inpatient settings (Walsh et al. 2007). The authors argue that with the rise in 'talking therapies' and the growing evidence to support psychosocial approaches to mental health issues, opportunities have arisen for the increased participation of speech and language therapists (SLTs) in future treatment, intervention, and service developments. Through including SLTs in the multidisciplinary team, the investigators believe that people who use mental health services may feel less 'misunderstood, misinterpreted and mismanaged' (Walsh et al. 2007:93).

Speech and language therapists normally undertake a three to four year undergraduate degree course devoted to the study of clinical language sciences and communicative

disorders. The course, which varies according to each university, includes intensive study of core theoretical components underpinning competence to practice including linguistics, psychology and medical science. Additionally, there is the study of a range of communicative disorders in children and adults. Throughout the course students undertake a variety of clinical placements in which their ability to practice is continually assessed. Upon successful achievement of course competencies students become an accredited practitioner. SLTs in the UK are required by law to register with the Health Professions Council (HPC) and Irish SLTs wishing to work in the UK must register with them (Lubinski and Frattali 2003). Up until 2003 Trinity College Dublin remained the only place for the education of speech and language therapists. Following publication of the Bacon Report (2001), which identified a shortfall of 588 speech and language therapists to meet clinical demand in Ireland, additional undergraduate education programmes were established in University College Cork, the National University of Ireland Galway, and a two year graduate-entry programme in the University of Limerick.

In 2007 the Standing Liaison Committee of EU Speech and Language Therapists and Logopedists (CPLOL), who represent the profession at European level, published minimum standards for education in speech and language based on recommendations by the European Education Commission. The standards address competencies in a number of areas and provide guidance on curriculum content, lecturer qualifications, assessment of students, and application of theory to practice (CPLOL 2007). In Ireland, all university courses in speech and language therapy are accredited by the Irish Association of Speech and Language Therapists (IASLT 2006). The IASLT do not directly outline course curricula but they do outline core subjects that are agreed nationally and internationally (Leahy and Supple 2002). Though comprehensive in nature, none of the guidelines pay particular attention or place particular emphasis on either mental health modules or components in speech and language courses.

Leahy and Supple (2002) argue that it is impossible for undergraduate students to develop clinical expertise at a sufficiently high level in each diagnostic category due to the broad range of the field of communication disorders. Consequently, postgraduate training is required for SLT's to specialise. Qualified practitioners may choose to undertake postgraduate study up to and including doctoral level (Lubinski and Frattali 2003). Taught MSc programmes are offered in a number of universities. TCD currently offers part-time two-year taught MSc courses with specialisms in Dysphagia, Child Language or Acquired Communication Disorders. The University of Limerick offers a taught MSc in Clinical Therapies. UCC offers an MSc in Advanced Health Care Practice. In addition, therapists can access a wide range of related graduate degrees, such as: an MPhil in Applied or Theoretical Linguistics; MSc in Health Service Management; or MPhil in Speech Processing. It is not clear from the literature how SLT practitioners are being prepared in educational programmes to rise to this challenge of working within the area of mental health or interdisciplinary working.

Medical/Psychiatrists Education and Training

In line with international trends, Irish universities involved in the delivery of medical education are reviewing and modifying the psychiatric component of the undergraduate curriculum. There is an increased awareness that although the majority of doctors will not undertake any postgraduate psychiatric training, they will come into contact with clients in most medical specialties, who will have some degree of psychological distress (Ring, Mumford, and Katona 1999). Consequently, undergraduate education is 'embracing the concept of evidence based medicine in the delivery of psychiatric care' (Guerandel, MacSuibhne, and Malone 2008:120). There is also an increasing emphasis placed on psychiatric knowledge and skills integration within a more general medical context and psychiatry being 'verticalised' throughout the curriculum. In addition to the lectures, seminars, and tutorials, all students will spend six to eight weeks in their core clinical attachments in psychiatric units throughout the country.

Psychiatrists play a significant role in the delivery of mental health services. However, very little is known about the availability and quality of education in psychiatry worldwide. In 2005 the WHO and the World Psychiatric Association published the first set of data on psychiatric education and training around the world (WHO 2005). Despite the availability of the World Psychiatric Organisation Core Curriculum in Psychiatry (World Psychiatric Association 2001), findings from the WHO study suggested that there is a huge variance and disparity in the quality of education across and within countries.

Within Ireland the Irish Psychiatric Training Committee (IPTC) is the body responsible for all aspects of training in psychiatry in Ireland, and is recognised by the Medical Council for this purpose. Graduate medical practitioners who wish to pursue a career in psychiatry apply to one of the Rotational Training Schemes in Psychiatry, commonly called Basic Specialist Training, in the Republic of Ireland, which are recognised by the Royal College of Psychiatrists for training purposes. The training consists of approximately three to four years as a psychiatric registrar, during which time the trainee is expected to attend a regionally-run series of lectures delivered by consultants, on a half-day basis, every week. In addition, trainees rotate to a new post every six months under the guidance of a consultant. During the registrar's period of training, it is mandatory to spend at least six months working in Child and Adolescent Psychiatry or in the Psychiatry of

Learning Disability in order to be awarded membership of the Royal College of Psychiatrists. The idea of a rotating number of posts is to give all the trainees the opportunity to gain a broad range of experience both with differing patient populations/disorders as well as with consultants who have varying skills bases and clinical approaches. As with other branches of medicine, the bulk of the professional learning process is through mentorship from the consultant and other senior colleagues. This is in line with the findings of the Buttimer Report (2006) as well as the HSE strategy *Medical Education, Training and Research* which acknowledges the centrality of the HSE 'in medical education, training and research' (Oct 2007: 8). The completion of the training is marked by the trainee passing the MRCPsych examination, awarded by the Royal College of Psychiatrists (London). This examination will shortly be run by the newly-founded College of Psychiatry of Ireland. (http://www.irishpsychiatry.ie/postgraduate_training.aspx#HST)

To date the focus of the examination is on all aspects of psychiatry, clinical and theoretical, along with neuroscience as well as legal aspects. In the latter respect, due to differences in law between Scotland, England and Wales, and Ireland, examinations tend not to be very specific about legislation. Therefore candidates do not have to have a very detailed and in-depth knowledge of Irish mental health legislation. However, this anomaly may be rectified with the change to the College of Psychiatry of Ireland,. It is anticipated (as is now the case in the UK) that in addition to the examination, trainees will be formally evaluated by colleagues (including, most importantly, the supervising consultant) in relation to competencies during every six-month attachment. A further source of mentorship and evaluation is the tutor system: every training scheme has a regional tutor in each hospital base and the tutor is responsible for ensuring the trainee is receiving appropriate educational input. Both the tutor and supervising consultant must 'sign off' an approval form from the Royal College to allow a trainee to sit a part of the MRCPsych examination.

Once doctors have achieved the basic specialist training and obtained the MRCPsych qualification and membership, they are required to spend a minimum of three years in Higher Specialist Training (Senior Registrar (SR) position). The principal aim of this training is to provide the person with an educational programme, which will prepare them for the independent practice of psychiatry as a consultant. As well as improving the trainees' core psychiatric knowledge and skills, their professional attributes, experience of research and audit, teaching and supervisory skills, and management ability will also be expanded. It is possible for psychiatrists to obtain a higher qualification in psychiatry by completing a Medical Doctorate (MD) or a PhD in Psychiatry. However, in order to be entered on the Register of Medical Specialists, the person must satisfy the Medical Council that they have completed a programme of higher specialist training of an adequate standard. In reality, in order to be competitive at interview for consultant, the SR will have collected a number of postgraduate qualifications. These will usually be in the field of psychotherapy, medical teaching and/or medical administration. The successful consultant candidate will also be expected to have published a number of peer-reviewed international publications.

While it is not within the remit of this report, it is interesting to note that at consultant level, education continues. In recent years the Medical Council has issued guidelines for continuous professional development (CPD). In order to be placed on the register of medical specialties, the consultant is expected to keep a log of internal and external CPD as well as peer review, and these requirements are further outlined in the booklet *Interim CPD Handbook: Good Psychiatric Practice in Ireland* (2009). As regards general practitioner training, while there is a mandatory requirement that trainees must complete six months pediatric and six months medical experience, there is no mandatory requirement that they complete a placement in mental health. However, the remaining 12 month period can be chosen from a menu of possible specialities and would involve a period of no less than four months in a mental health learning environment for many trainees, particularly if they have not had this experience previously (Criteria for Postgraduate Training Programmes in General Practice, 2004:14).

In terms of specific teaching in mental health legislation, medical students in all Irish medical schools would receive at least one hour on the mechanisms of the Mental Health Act (Government of Ireland, 2001). During their core clinical attachment, students would also be involved in caring for a number of detained patients. At trainee level, the formalised lecture programme provides ample space for delivery of information on the same topic, but obviously to a higher level than at student level. Trainees are responsible for only a small part of the administrative aspects of the MHA (this being done by the responsible consultant), but often sit in on mental health tribunals with their consultant and are responsible for the completion of clinical practice forms pertaining to the MHA. Finally, at consultant level the Mental Health Commission provides scheduled workshops and e-learning facilities.

Psychological Therapy Training and Education

Within the mental health services, psychological therapy is one of the main treatments for mental health issues, the other being physical treatments (Irish College of Psychiatrists 2005). In Ireland, psychological therapy may be offered by a range of mental health professionals including psychiatrists, psychologists, therapists/counsellors, social workers and

nurses who have undertaken specialist training in psychotherapy and counselling through diverse educational pathways. With the exception of clinical and counselling psychology, training routes into psychological therapy for other professionals are non-standardised. Additional training in psychotherapy and counselling is frequently taken as an adjunct to primary qualification or training. Qualifications within this area range from professional certificates and diplomas to academic degrees from undergraduate to doctoral levels.

With reference to psychotherapy training for psychiatrists, this is considered as integral to psychiatry training for all trainees and some may pursue further specialist training thereafter (Irish College of Psychiatrists 2005). According to the ICP literature, two training routes are available for specialist training in psychotherapy. Firstly, a psychiatrist may become a Consultant Psychiatrist in Psychotherapy by under taking a Certificate of Completion of Specialist Training (CCST.) which is accredited by the Royal College of Psychiatrists in the UK but not currently available in the Republic of Ireland. Secondly, they may pursue available qualifications in psychotherapy which are normally university-based diploma or masters degrees (Irish College of Psychiatrists 2005).

Similarly, psychotherapy training for clinical and counselling psychologists is central to the postgraduate qualification. Clinical psychology training occurs at doctoral level in the US, UK and in the Republic of Ireland and counselling psychology has followed the same development pattern. Entry requirements to both clinical and counselling psychology courses in the UK and Republic of Ireland usually require an honours degree (1.1 or 2.1) in psychology (which confers graduate basis for registration with the British Psychological Society in the UK or graduate membership with the Psychological Society of Ireland). In addition, relevant postgraduate experience is normally required (Cheshire and Pilgrim 2004). Course content for both focuses on academic input, supervised clinical practice, research, and to varying degrees, personal development.

Traditionally in the UK and Ireland, counselling and psychotherapy training courses for allied health practitioners tended to be offered by professional institutes outside the University. More recently a number of undergraduate and postgraduate degrees in counselling and psychotherapy have become available. While some advocate that such training ought to be conducted in universities (Jacobs 2002) not least of all, to facilitate the cross fertilization of ideas and develop research in the approach, it is also argued that the purity of the therapeutic approach may be diluted outside specialist institutes (Parker 2002).

Currently, psychotherapy and counselling training and provision are self-regulated practices in many countries including Ireland, United Kingdom, Australia, and Spain (Scofield 2008). In the absence of statutory standardisation for education and training in the UK and Ireland, many professional organisations have been established to self-regulate and professionalise training and practice in psychotherapy and counselling. In Ireland, the largest professional psychotherapy organisations, namely the Irish Council of Psychotherapy (ICP) which is an umbrella organisation for a number of associations, and the Irish Association for Counselling and Psychotherapy (IACP), both seek to regulate psychological therapy training and provision through Codes of Ethics, time-limited (five years) individual accreditation process, course recognition procedures, directories of members, complaints committees, continuing professional development requirements and mandated career-long supervision. The Psychological Society of Ireland (PSI) also provides gate-keeping for counselling and clinical psychology training and practice.

In line with international standards, statutory regulation is currently underway in Ireland for psychological therapists. In response to the Health and Social Care Professionals Act 2005, an umbrella group (Psychological Therapy Forum, (PTF) 2005-2008) convened at the request of the Department of Health and Children (The Psychological Therapy Forum 2007). The PTF (2008) submission proposed a registration board for 'Psychological Therapists', which would require an academic qualification for entry to training (degree or equivalent in human sciences for psychotherapy and Leaving Certificate for counselling), a baseline qualification on exit (Master's level for psychotherapist and undergraduate degree or equivalent for counsellors) together with professional experience for registration. It was also proposed that course input, clinical practice hours, clinical supervision, and personal therapy would have baseline standardised requirements. The forum called for the titles of 'psychotherapist' and 'counsellor' to be protected as professional titles.

Conclusion

The education and training of practitioners working in mental health vary significantly from country to country. These variances may be accounted for by differences among educational systems, licensing requirements by professional bodies, and the health care system of a particular country. It is anticipated that the establishment of the Bologna Declaration in 1999 will move all disciplines involved in mental health towards a more coherent and compatible educational approach. It is envisaged that this will facilitate development of consistency in philosophical and educational standards and promote a wider use of evidence-based practice and the development of research. In addition, the Health and Social Care Professionals Act (2005) will provide for a system of statutory registration for twelve health and social care professions in Ireland. The Health and Social Care

Professionals' Council set up under the Act will oversee professional regulation in the interests of patient safety and best practice and also the development of the professions themselves.

Although increased emphasis is being placed on interdisciplinary team working in health care delivery, students traditionally have little formal contact with one another during their education experience, or experience very little planned collaborative learning to promote teamwork. The next section of the review will explore the literature on interprofessional education.

Section 2:

Interprofessional Education

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Introduction

Ever since the World Health Organization published the document *Learning Together to Work Together* (1988:30), national and international policy and research has called for greater interprofessional cooperation and collaboration between staff working in health and social care services (Department of Health (UK) 2001; Department of Health and Children 2006; NIMH and RCP 2005; Sainsbury Centre for Mental Health 1997). Interprofessional collaboration has been advocated as a means of enhancing quality patient care and health outcomes (Curran et al. 2007), by synergistically maximising each professionals contribution (Hoffman et al. 2008). Within the Irish context, with the move to primary and community care and the development of multidisciplinary mental health teams, the need for health care professionals who understand each other's role, and who can collaborate and coordinate client and family care effectively, is viewed as a critical element in the advancement of the recommendations made in *Vision for Change* (Department of Health and Children 2006; Mental Health Commission 2006). This section explores the literature on interprofessional education. Interprofessional education (IPE) has been invoked with increasing intensity as a means of enhancing collaboration and team working (Barr 2002; Department of Health and Children 2006; Mental Health Commission 2006; Reeves and Freeth 2006). The UK Centre for the Advancement of Interprofessional Education (CAIPE) defines interprofessional education as occasions when professionals 'learn with, from and about each other to improve collaboration and quality of care', whereas multi-professional education describes 'occasions when two or more professions learn side by side for whatever reason'(CAIPE 1997:3).

Multidisciplinary Team Working and Interprofessional Education

The success of multidisciplinary team working depends on a shared commitment to the approach, with a willingness to transcend disciplinary boundaries and perspectives for the benefit of clients. The ability to work effectively with other mental health professionals depends on core capabilities in team working, together with the continuous development and application of effective clinical skills. Barr (2002) is of the view that rigid demarcation and hierarchical relationships have no place in community-based services, where highly vulnerable people are depending on a flexible, responsive and well coordinated service for survival and recovery. In addition, there is a need for an acceptance on the part of different mental health professionals that their relative status within the team is of less relevance than the collective effectiveness of the team in improving patient outcomes. Effectiveness of the team also relies on role-clarity and collaborative skills, as well as the unique clinical skills of different team members (Horder 2004). The importance of these factors were demonstrated in a study that used a national sample of 400 health care teams involved in primary, secondary and community health care. The results suggest that teams with clear aims and higher levels of collaboration were supportive of innovation and focused on quality delivery and improved patient outcomes. These factors were also associated with lower stress levels amongst team members and higher staff retention rates. The authors conclude that the core principles underlying interdisciplinary working need to be addressed across all professional courses, at undergraduate and postgraduate level (Borrill et al. 2000).

Despite the policy drive towards increased interprofessional working, research reveals that the delivery of well-coordinated, responsive and effective mental health services may be obstructed by a number of factors. These include concerns about overlapping professional boundaries within mental health teams (Sainsbury Centre for Mental Health 1997), lack of clarity associated with managerial responsibility for

different mental health staff (Ovretveit 1993); strong allegiances to professional cultures and agendas (Mental Health Commission 2006; Reeves et al. 2001), conflicting power relations, ideological differences (Kutner et al. 2006), strongly-held beliefs about professional roles (Carpenter et al. 2006), and lack of respect for the contribution of different disciplines (Simpson 2007).

Barr (2002: 30) conducted a review of interprofessional education for the Learning and Teaching Support Network Centre for Health Sciences and Practice in the UK and concluded that interprofessional education can in 'favourable circumstances and in different ways, contribute to improving collaboration in practice'. A literature review by Clifton et al. (2006) on the impact and effectiveness of interprofessional education in primary care for the Royal College of Nursing (RCN) found that there is strong policy support throughout the UK for interprofessional education at both pre- and post-registration levels. In addition statutory bodies for health care professions internationally are committed to supporting interprofessional education (General Medical Council 1993; National Board for Nursing 2000; National Health Service Scotland 2006). Within Ireland government policy for mental health services, *Vision for Change* (Department of Health and Children 2006: 186), suggests that 'consideration 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 team work'.

Interprofessional Capability Frameworks

As the composition of mental health teams changes there is an increased need for shared values and accountability, which is wider than traditional professional boundaries. The move to interprofessional and multidisciplinary working, together with an increase in the number of unqualified staff from a variety of backgrounds is changing professional boundaries and blurring lines of accountability (Sainsbury Centre for Mental Health 1997).

In the UK these changes prompted the development of the Ten Essential Shared Capabilities Framework (Department of Health (UK) 2004) which has also been adopted in Scotland and is being cascaded to the workforce via a network of trainers. The framework sets out the shared capabilities that all staff working in mental health services should achieve as best practice as part of their pre-qualifying training. The framework is intended to form the building blocks for teaching, learning and professional development, not just for qualified staff, but for all staff working in the NHS, Social Services and the statutory, private, or voluntary sector. The Ten Essential Shared Capabilities (ESCs) include working in partnership, respecting diversity, practicing ethically, challenging inequality, promoting recovery, identifying people's needs and strengths, user centered care, making a difference, promoting safety and positive risk taking, and personal development and learning.

The Combined Universities Interprofessional Learning Unit (CUILU), building on *The Capable Practitioner* document published by the Sainsbury Centre for Mental Health (SCMH 2001), also developed and evaluated an Interprofessional Capability Framework. The project, funded by the Department of Health (UK), describes under four conceptual domains: ethical practice, knowledge in practice, interprofessional working, and reflection. These are the capabilities that any undergraduate student in health and social care is required to achieve in order to become a capable interprofessional worker. The framework is designed to be used in practice-based learning and was developed and validated by means of a process of collaborative inquiry involving students and practitioners in five practice-based pilot sites. During this process students were, through a mentoring process, facilitated to engage in interprofessional learning within multi-professional teams. The term 'mentor' was used within the CUILU project to encompass the myriad of terms used across the professions to describe the process of teaching, supporting and assessing students in practice environments (CUILU 2004; 2006).

Reviews of Interprofessional Education

Although the consensus view among academics is that interprofessional education should be encouraged, and a number of pilot initiatives have been developed in mental health (Reeves et al. 2001), Cochrane systematic reviews in this area suggests there is limited evidence to base judgments on the effectiveness of IPE because of the flawed design of most studies. The first Cochrane systematic review on the topic, found 89 studies that explored different aspects of interprofessional education, however, due to the strict focus on methodological and outcome criteria of Cochrane reviews, none of the evaluations were sufficiently rigorous to be included (Zwarenstein et al. 2000). Since then two subsequent updated Cochrane reviews have been conducted which has resulted in six studies being included that met the inclusion criteria (Reeves et al. 2001; 2008). Although the authors reported some positive outcomes (improving working culture and patient satisfaction in an emergency department, improved management of care delivered to domestic violence victims and improving the knowledge and skills of professionals providing care to people with mental health problems) they concluded that 'due to the small number of

studies, the heterogeneity of the interventions, and the methodological limitations,' it is not possible to make generalisable inferences about IPE and its effectiveness. The authors, however, do point out that 'the absence of evidence of effect is not evidence of absence of effect' (Reeves et al. 2008: 19). As a result Reeves et al.(2008) highlight the need for more rigorous control studies to be completed, using larger sample sizes. They also advocate the need for research to address the critical issue of how IPE affects changes in professional practice, health care processes and client outcomes.

Reeves (2001) suggest that the 19 mental health interprofessional education studies reviewed for the Cochrane review offer some insights into IPE in mental health. Of the 19 courses reviewed, 15 were published in the United States, and varied from short one or two day courses to education programmes that lasted over a number of months. Details on the participants involved were found to be sketchy, with papers tending to employ terms such as 'psychiatric team' or professional staff. Other more recent studies suggest that courses are largely attended by nurses when compared to other disciplines, such as psychiatrists or psychologists (Carpenter et al. 2006; Reeves and Freeth 2006; Reeves et al. 2006), with the involvement of medicine rare at post-qualification level (Ross and Southgate 2000).

None of the papers reported in Reeves and others review (2001) offered any form of academic qualification or accreditation to participants. All the studies report the use of a variety of small group learning strategies, such as discussion, role play, and problem-solving groups. Interestingly only one study reported involving service users as educators. Although all papers reported positive outcomes, such as use of practice guidelines, better support service for staff, and cost savings from improved collaboration, none of the papers reported changes directly related to client or family care.

Carpenter et al. (2006; 2007) reported on a longitudinal evaluation of an interprofessional postgraduate diploma, designed with an explicit focus on enhancing team collaboration in the delivery of psychosocial interventions. Students reported a substantial increase in knowledge of working in partnership and psychosocial interventions, and welcomed the formal and informal opportunities to learn together and exchange ideas. However, the IPE experience appeared to have little effect on students' positive or negative professional stereotypes. The authors suggest two possible reasons for this. Firstly, students did not view fellow student members as 'typical' of that professional group, therefore did not generalise their positive experience to the professional group as a whole. Secondly, the limited number of psychiatrists and psychologists who attended the programmes afforded students limited opportunity to disconfirm their negative stereotypes of these professional groups.

Barr (2002) suggests that work based interprofessional learning is more likely than college-based teaching to improve the quality of service and bring about direct benefits to clients. Reeves et al. (2006) described a pilot project that offered three weekly workshops to two interdisciplinary community mental health teams (CMHT), with the aim of enhancing their understanding of interprofessional collaboration and improving their collaborative work as a team. While the IPE was well received and improved participants understanding of collaborative working and communication, collaborative action plans were not implemented, and the pilot project was not rolled out to other CMHTs. Participants felt that two key factors constrained the overall impact, a limited involvement of medical staff, which was felt to undermine the value of the workshops, and a lack of senior management support.

Interprofessional Education and Recovery

In line with international trends, Recovery is a central part of the vision for the future of mental health services in Ireland (Department of Health and Children 2006; 2008; Mental Health Commission (Irl) 2006). A review of the literature suggests that there is a drive to enhance all mental health professionals understanding of recovery and recovery principles, and to develop curricula based on the values of rights, relationships, and to respect recovery and responsibility. A number of interprofessional education programmes on recovery are described in the literature (Axiom Market Research and Consultancy 2006; Gordon and Cassidy 2009; Slade et al. 2009; Wood and Wahl 2006). However, in a review of international training on recovery, commissioned by the Scottish Recovery Network, the reviewers noted that although the programmes were 'unanimously inter-professional', evaluations tended to focus on the training itself, with very few addressing the impact of the interprofessional dimension on attitudes or approach to team working in practice (Ask Clyde 2007:31). The need for more medical participation (e.g. psychiatrist) within programmes was also noted, as their involvement in promoting recovery based practice was seen as crucial.

Timing of Interprofessional Education

Although there is consensus in the literature of the need for interprofessional education, the timing of its introduction is controversial. Some believe that IPE should only be introduced when students have a clear understanding of their own professional roles (Mariano 1999; Pirrie et al. 1998), where as others are of the view that opportunities for IPE should be offered to students early in the education, before negative

attitudes, stereotypes and professional separatism, that could effect willingness to collaborate have been developed (Barr 2002; Ker et al. 2003; Leaviss 2000). Offering IPE early in education is considered key to developing mutual understanding and respect for one another's roles, which will provide a basis for professional and wider team working, networking and learning in the future (CUILU 2006; Department of Health (UK) 2001).

Teacher/Facilitator Preparation and Interprofessional Education

Much of the literature on IPE focuses on aspects of design and delivery of programmes, their aims and evaluations. However there is a dearth of literature on the education and training of teacher/facilitators. This may be due to the assumption that the teaching and facilitation skills are the same as unidisciplinary groups. Formal preparation for teacher/facilitators is being advocated in the literature, with some suggesting that preparation be modelled upon the principles advocated by CAIPE (Anderson et al. 2009; Barr 2002; Holland 2002; Lorente et al. 2006). Proponents of additional training and education in this area argue that for successful IPE to take place educators must move outside their knowledge and professional 'comfort zones' (Anderson et al. 2009), have an in-depth understanding of the issues facing students in practice, and be attuned to the professional and political context in which students work. In addition they need to have an understanding of both content and process issues in education (Anderson et al. 2009), as well as the skills to ensure that collaboration in learning takes place (Holland 2002). Anderson et al. (2009) describe the development of a course designed for the education and training of teacher/facilitators on interprofessional education. The course is placed within a suite of masters-level programmes delivered by the University of Leicester's Medical School's Professional development Unit.

Service User and Carer Involvement in Interprofessional Education

In line with international trends, the Department of Health and Children (2006) and the Mental Health Commission (2008) have called for the involvement of people who use mental health services, and carers in the development, delivery and evaluation of interprofessional education for mental health practitioners. This increased involvement is part of a wider commitment to service user and carer involvement in all aspects of health care (Department of Health and Children 2001; 2006; Mental Health Commission 2007; 2008). It is argued that if an ethos of partnership which values the expertise of users and carers is to underpin service delivery, then such partnerships must also be a cornerstone of all mental health education (Tew et al. 2004).

Although very little research exists that measures the effectiveness of users and carer involvement on learning and practice, the consensus view internationally is that it should be encouraged. The evidence that is available from nursing, psychology and social work suggests that involvement of users and carers may impact on service provision and student learning by: increasing students' communication, partnership and advocacy skills (Curran 1997; Simons et al. 2007; Tew et al. 2004; Wood and Wilson-Barnett 1999; Beresford & Croft 2004; Duffy 2008), challenging professional orthodoxies and power (Beresford and Croft 2004; Harper 2002; Rush and Baker 2006; Tew et al. 2004), and enabling practitioners to be more conscious and reflective of the implications of treatments and approaches used (Repper and Breeze 2007; Townend et al. 2008; Wood and Wilson-Barnett 1999). Furthermore, literature suggests that taking on a valued role in education can have various therapeutic outcomes for service users such as raised self-esteem, empowerment and new insight into their problems (Barnes et al. 2006; Repper and Breeze 2007; Walters et al. 2003). Reeves (2001) in his systematic review of 19 courses of interprofessional education in mental health found only one incorporated service users in the delivery of the education programmes. In response to policy requirement in the UK, guidelines for involving users and carers in education and training have been developed (Brooker and Curren 2005; CUILU 2005; Tew et al. 2004).

Interprofessional Education and Clinical Supervision

While no agreed definition of clinical supervision exists among mental health professionals, there does appear to be agreement across disciplines that clinical supervision exists for the welfare of the service user, the competence of the practitioner in training, and ongoing professional development (Bernard and Goodyear 2004; Cutcliffe et al. 2001; Spence et al.2001; Milne 2006; Munson 2002; Bogo & McKnight 2006).

The advantages and disadvantages of the different forms of supervision (for example, individual, group, peer, team and so forth) are well reflected in the literature (Sloan 2006; Creek & Lougher 2008; Bernard & Goodyear, 2009). While the predominant supervision format appears to be dyadic, (Reynolds Welfel & Ingersoll 2001) increasingly more flexible formats within mental health are being proposed (Milne & Oliver 2000; Tisdall & O'Donoghue 2003; Chan et al.2004). However, the prevalent theme is that supervision be provided for in a manner that facilitates optimal access for the mental health practitioner.

In posing the question of multidisciplinary mental health supervision – 'What is the most effective model to provide both discipline-specific supervision and supervision by team members?',the Mental Health Commission (Mental Health Commission 2006:51) acknowledges the complexity of clinical supervision in this context. Research is required to establish which models are most appropriate and effective and from this, an empirically sound theory and model of supervision for mental health professionals in individual and multidisciplinary contexts may emerge (Sloan and Watson 2002). Whichever model is adopted, the 'acid test' of effective clinical supervision is whether it positively impacts on client/service user outcome (Ellis and Ladany 1997; Gonsalvez and McLeod 2008). Notwithstanding the methodological issues associated with many research studies in supervision (Wheeler and Richards 2003), there are some tentative indications of a positive correlation (Bambling et al. 2006; Clifton et al. 2006; Freitas 2002; Milne et al. 2003; Vallance 2004).

Internationally, clinical supervision policies are being implemented in mental health services in many countries. In Australia, the Victorian Government Department of Human Services, (2005) advise that as different disciplines have diverse experience of clinical supervision and as training in clinical supervision will be required (Victorian Government Department of Human Services 2005), a point endorsed across disciplines (Cutcliffe et al. 2001; Falender and Shafranske 2007; Hawkins and Shohet 2007; Whitman et al. 2001), such policies should be incrementally implemented into mental health services. In the UK, many National Health Service (NHS) trusts have also begun to introduce clinical supervision policies for their staff (for example, Worcestershire Mental Health Partnership NHS Trust 2009) and such is the recommendation of the Irish Mental Health Commission (2006).

The benefits of supervision have been referenced in the *Vision for Change Report* (Department of Health and Children 2006) wherein the need for supervision for mental health professionals in Ireland is highlighted. More recently, the discussion document *Clinical Supervision: A Structured Approach to Best Practice* (2008) from the National Council for the Professional Development of Nursing and Midwifery conceptualises supervision as a method of reflective practice and further supports the role of clinical supervision in continuing professional development for optimal client/patient care (National Council for the Professional Development of Nursing and Midwifery 2008).

Barriers to Interprofessional Education

The task of developing and facilitating interprofessional education is not without barriers and challenges. There are a number of barriers identified to the development of interprofessional education. Baldwin and Baldwin (2007:32) suggest that attempts to promote interdisciplinary education are often met with 'systems inertia' and 'disciplinary territoriality'. Others highlight the confusion and lack of understanding around interdisciplinary concepts (Baldwin and Baldwin 2007; Lorente et al.2006), finding time within overburdened curricula, timetabling difficulties, discipline–specific requirements for registration (Cooper et al. 2004; Cooper et al. 2001; Singleton and Green-Hernandez 1998), lack of interdisciplinary role models in education and practice (Baldwin and Baldwin 2007), lack of adequate preparation of academic and clinical lecturers (Anderson et al. 2009), and ensuring joint validation from differing professional regulatory bodies (Glen and Reeves 2004). In times of scarce financial resources, the increase in the number of staff required to facilitate group learning is also seen as a barrier (Rush and Baker 2006). A number of people identify the challenge of overcoming negative faculty attitudes, fears over loss of individual identity (Lorente et al. 2006) and traditional power differentials that are steeped in historical and traditional roles (Baldwin and Baldwin 2007; Lorente et al.2006). Rolls (2002: 318) suggest that 'the problem of "tribalism" embedded in the powerful and often conservative professional bodies, is antithetical to a move towards inter-professional education'. In addition Baldwin and Baldwin (2007) comment that few programmes are able to sustain their initiatives in the absence of prolonged sponsorship and funding.

Summary

There has been a burgeoning interest in interprofessional education and training in recent years. This chapter amplified the importance of effective collaboration between health and social care practitioners in the provision of seamless, responsive, client-centered and evidence-based care. Furthermore, the enhancement of core values, attitudes and competencies are discussed and are considered fundamental to the implementation of current government policy initiatives and the delivery of recovery and community-focused care. Additionally, there is the appreciation of diversity within different professional roles and the dismantling of traditional barriers for effective joint working. The importance of interprofessional training and the preparation of teachers/facilitators is recognised with the need for necessary skills to deliver educational programmes, together with the involvement of service users in the design and delivery of programmes. Some commentators have highlighted the value of interdisciplinary teamwork with practitioners having a

shared vision and the individual, family and carers at the core of mental health care. Additionally, practitioners will need support in terms of clinical supervision in order to carry out the work effectively. Innovative ways that services may plan and deliver care have been proposed such as cascade models together with capability frameworks. However, further systematic research is needed to support such programmes in terms of quality delivery and enhanced patient outcomes. Nevertheless, it seems clear from the review that if health and social care agencies are to provide visionary, achievable and sustainable developments within mental health, then working together to address the challenges would appear to be a crucial part of the process.

Section 3:

Methodology Used in the Study

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Introduction

The terms of reference of the Mental Health Commission tender document had two requirements. Firstly, the research team were to conduct a study to explore current education/training provision for professionals working in mental health services in the Republic of Ireland. Secondly, they had to make recommendations for any future improvements, developments, and sustainability of educational programmes. The title of 'Mental Health Professional' as defined in the tender document referred to professionals from the disciplines of medicine, nursing, social work, psychology, occupational therapy, and speech and language therapy.

Objectives of the Scoping Study

The objectives of the scoping study were to:

a) Identify the current education/training provided to professionals working in mental health services at undergraduate and postgraduate level

b) Document the following:

- best practice examples used in the development and delivery of the programmes
- expertise of the key personnel responsible for the delivery of the programmes
- extent to which multi- and interdisciplinary learning and teaching are included within the programmes

c) Identify the mental health service providers' priorities for future mental health education/training and document what education/training for mental health professional service providers could provide in the future.

Research Design

The overall aim of the research team was to devise a methodological approach that would yield the most reliable information on which to base recommendations. Therefore, the research design for this scoping study was a sequential, exploratory, descriptive design using multiple approaches to data collection.

Eligibility Criteria

Following analysis of the guidelines and acknowledging the list of third-level educational institutions provided by the Mental Health Commission (Appendix 1), the team developed the following eligibility criteria in order to focus data collection. For a course to be included it had to:

- be delivered within a Higher Education Institution in the Republic of Ireland
- be an undergraduate degree leading to professional registration or accreditation, for the mental health professionals listed in the Mental Health Commission Tender document, or be an undergraduate degree for mental health professionals who already held a professional registration (e.g BNS for Nursing)
- be a postgraduate taught course aimed at the mental health professionals identified in the Mental Health Commission Tender document.

- be provided by the Open University and accessible through distance learning to mental health professionals working in the Republic of Ireland.
- be an undergraduate or postgraduate taught programme deemed by the team to merit inclusion, based on the course description published.

Courses were excluded if they were:

- designed specifically for professions other than those identified by the Mental Health Commission
- delivered at a foundation or access level
- consisted of research-based awards, e.g. PhD, MPhil or M.Sc by Research
- not accredited by a third-level educational institution
- offered by professional bodies and not accredited by a third-level educational institution
- were a postgraduate professional training programme for which there was no structured course documentation (e.g. Postgraduate Training in Psychiatry; Medicine – Membership exams for the MRC Psych are taken in London)
- any courses not running in the 2008-09 academic year.

Generating the Sampling Frame

Generating the sampling frame involved the identification of the title of each course deemed relevant to mental health professionals and the name of the relevant Course Coordinator/Director of both undergraduate and postgraduate courses. To ensure comprehensiveness and minimise the risk of courses being omitted, a multi-pronged approach to identifying course provision was employed. Education courses for mental health professionals were identified through:

- a comprehensive search of all third-level education institutions listed by the Mental Health Commission and professional organisations websites
- search of college documentation (e.g. College prospectus)
- request from professional organisations on courses approved (e.g. An Bord Altranais, Irish Medical Council, National Social Work Qualifications Board)
- and direct contact, through email or telephone, with relevant personnel in the third-level educational institutions identified by the Mental Health Commission (Appendix 1) and six educational institutions identified by members of the research team that were not on the Mental Health Commission list (Appendix 2).

During this process the name of the course and the contact details of the Course Coordinator or Course Director were obtained. If courses were considered relevant to mental health professionals, and met the inclusion criteria, the names of the course, name of the institution and contact details for Course Coordinator/Director or Head of Department were entered onto an excel spreadsheet. Where courses were difficult to classify, direct contact was made with key personnel in the relevant institution and further information pertaining to the education programme was elicited.

In situations where the initial web search of educational institutions did not identify any courses deemed relevant to mental health professionals, these colleges were given an opportunity to respond and to clarify the matter as appropriate. 32 colleges were initially contacted either by letter or email to seek verification (Appendix 3 for names of colleges). As this resulted in a low response rate it was followed up by a series of telephone calls and / or second emails. Consequently, some institutions were moved to the main database as their replies confirmed that they had relevant courses not previously identified. Of the 59 educational institutions targeted, 31 institutions were identified as providing relevant education programmes, 23 colleges confirmed that they had no relevant undergraduate or postgraduate courses relating to the study at this time (Appendix 4 for names of colleges).

Finally, to enhance the accuracy of the sampling frame, a letter was sent to each Head of School/Department,[1] outlining the names of the courses identified for their school/department. The letter requested them to verify the accuracy of the list. They were also requested to identify any course that they offered and considered relevant for mental health professionals that may have been omitted by the research team. Questions were also asked about their priorities for future mental health education/training and their ability to provide education in the future. Of the 56 letters sent to Heads of Schools/Department, 27 written responses were returned and two telephone responses were received. This generated an additional four courses, bringing the census sample of courses to 227 and the census sample of Course Coordinators/Directors to 180[2] (Appendix 5 includes a list of the course titles and institutions included in the sample frame).

Data Collection

Data was collected, in two stages, using a combination of surveys and telephone interviews over a ten week period.

Stage 1 of data collection

Stage 1 of the study involved the administration of a postal survey to each Course Coordinator/Director. Questionnaires have advantages over some other methods of data collection in that they are inexpensive, easily administered, and require less effort from the respondent as in-depth individual or focus group interviews (Parahoo, 2006). Since the aim of this research was not adequately addressed by any pre-existing questionnaire, a questionnaire was designed to meet objectives (b) and (c), as outlined above. The questionnaire consisted of a combination of 38 questions, comprising mostly closed questions (Appendix 6). The questions addressed issues such as the level of the award, duration of the course, funding, source of accreditation, target discipline, service user involvement and teaching personnel. They also considered teaching, assessment, and evaluation strategies. In addition, the Course Coordinator was asked to indicate on a Likert scale, ranging from very strong to none, their perception of the emphasis given to certain issues and documents within the course. The options of 'Not applicable' and 'Do not know' were also provided. The issues identified were derived from the literature, and the documents named were considered central to the provision of mental health care. The questionnaire also provided Course Coordinators/Directors with an opportunity to provide examples of best practice, to comment on their priorities for future mental health education/training and on their ability to provide education in the future.

Following review by members of the Mental Health Commission and the research team, the questionnaire was piloted with a sample of seven Course Coordinators/Directors. The pilot included a representation of Coordinators/Directors for undergraduate and postgraduate programmes in nursing and psychology, and included a course aimed at a multidisciplinary audience. Feedback from the pilot study resulted in minor changes being made to the wording of the questionnaire to enhance clarity and comprehension. As there was no methodological reason to exclude pilot participants, they have been included in the main study. The questionnaires were distributed with an accompanying letter (Appendix 6) and a request to return in the stamped addressed envelope supplied, within a two week period.

Stage 2 of data collection

Stage 2 of the process involved collecting data on examples of best practice hence the questionnaire included an open question (Q.37) which asked for examples of best practice used in the development, delivery and assessment of the course. Course Coordinators/Directors were also asked to return a form, with their contact details, if they were willing to be contacted by a member of the research team. The intention was to follow up on examples of best practice in greater detail. Of the 72 Course Coordinators/Directors who gave permission to be contacted, 16 were chosen for follow up, based on some examples of best practice they had provided in response to Q.37 within the questionnaire. Follow up was conducted through an e-letter (Appendix 7). While it was planned to obtain and follow up a cross section of respondents from the different institutions and include at least two examples per discipline, this was not possible for some disciplines. Many questionnaires did not respond in sufficient detail to Q.37 and those that did had to be aligned with the permission forms returned and this greatly reduced the possibilities for inclusion. These aspects were particularly noteworthy for the smaller disciplines within the study group.

1 There were a number of potential courses of relevance to the MHC study identified on a trawl of the Open University (OU) website. Initially the team experienced great difficulty in identifying Course Coordinators/Course Directors for any of their courses. The difficulty was, to some extent, the fact that the OU is based in Milton Keynes, UK, and is a distance-learning institution with many lecturers/facilitators who work on a part-time basis with the OU. In addition, there was difficulty contacting a specific and relevant person to answer individual queries because of the sheer scale of the institution. It should be noted, however, that when contact was made with the relevant person, they were extremely helpful. There was a particular difficulty in identifying specific departmental staff or Heads of Departments. Indeed, the Faculty/School/Departmental demarcation was unclear. For the reasons expressed, the team was of the view that attempting to contact specific department heads, for the purpose of verifying our list or the identification of further courses would be futile.

2 A number of Course Co-ordinators/Directors had responsibility for completing more than one questionnaire for courses within their sphere of responsibility. One Course Co-ordinator had responsibility for eight courses, one had responsibility for five courses, five Course Co-ordinators had responsibility for three courses, 19 had responsibility for two courses and the remaining 161 had responsibility for one course each.

Ethical Considerations

Ethical approval to conduct the study was given by the Research Ethics Committees of the Faculty of Health Sciences in Trinity College Dublin. An information letter outlining the aims, objectives and the confidential nature of the study was sent to all Course Coordinators/Directors with the questionnaire (Appendix 6). Participants were advised that return of the questionnaire would be taken as informed consent. Information gained through access of websites or other published materials does not require consent as this information is in the public domain. Therefore, while public information on the name of the institution, titles of courses, award achieved, and its multidisciplinary nature is provided in the report, the anonymity and confidentiality of the participants/respondents has been protected. However, as the surveys were allocated numerical codes (prior to data entry), to protect the identity of the participants and the organisations, the provision of in-depth details on each course is not possible. Where examples of best practice are identified, permission to name the organisation has been approved by the Course Coordinator/Director.

Distribution of the Questionnaires and Increasing Response Rate

In total, 31 educational institutions were targeted for completion of the questionnaire and 227 courses that fulfilled the inclusion criteria were identified. Of the 227 questionnaires distributed 59 were returned, in the first wave representing 25.9% of the response rate. As the success of the survey was very dependent on a satisfactory response from participants, two reminder letters/emails were sent to encourage a higher return rate. In addition, follow-up telephone calls were also used. This method of follow up resulted in a final response rate of 149 or 65.6%.

Data Entry and Analysis

Data was entered onto the Statistical Package for Social Science (Benjamin and Baker 2000) package Version 16.0 and analysed using descriptive statistics, such as frequency, percentages and ranges. Two questions on the questionnaire asked respondents to indicate the degree of emphasis placed within the courses on various issues and policy documents. In the case of these questions the findings were grouped into the following five clusters: 'No emphasis', 'Little/Weak emphasis', 'Some emphasis', 'Strong emphasis' and 'Very strong emphasis' and analysed to project an overall view of the courses. The analysis of these questions is discussed in the relevant section in the next chapter.

In relation to the open-ended questions and the qualitative comments written, all were transcribed and thematically analysed, using a constant comparison process. To assist with explanation and for illustrative purposes, data is presented using bar charts, figures and tables.

Section 4:

Presentation of Findings on the Quantitative Aspects of the Survey

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Presentation of Findings on the Quantitative Aspects of the Survey

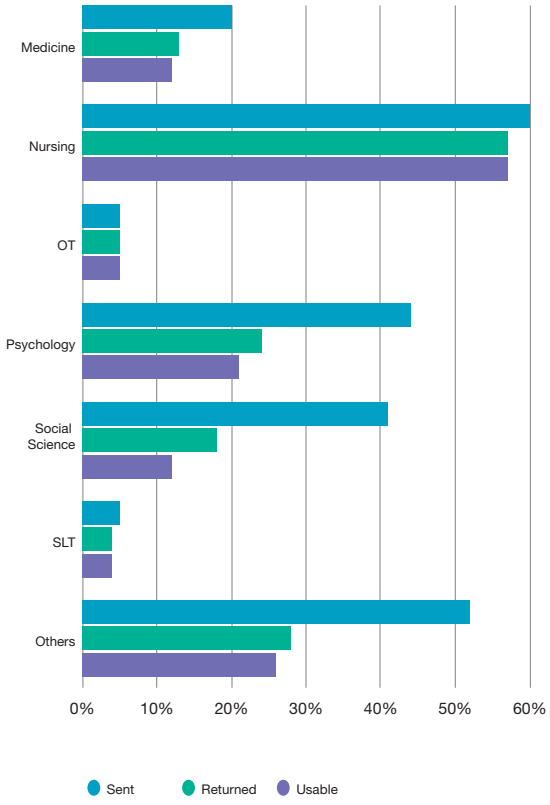
Introduction

This section reports the results from the quantitative questions included in the survey. In total, 149 questionnaires were returned from 129 Coordinators/Directors. This represented a 65.6% return rate for the questionnaires from 72% of the Course Coordinators/Directors targeted. Of these, seven respondents reported that the course was no longer running and five respondents returned blank questionnaires or made contact to say they were of the opinion that their course was not relevant to the study (Appendix 5). Consequently, for the analysis stage, 137 (60%) completed questionnaires were considered.

Profile of the Responses

A very high number of questionnaires were returned by the Course Coordinators/Directors from nursing, occupational therapy, and speech and language therapy departments/schools. The lowest response was from Course Coordinators/Directors within the social science departments. Just over 50% (n=28) of the questionnaires sent to departments categorised as 'others' were returned. These included departments such as education, arts, science, political science, health care management, counselling/psychotherapy and theology.

Figure 1:
Questionnaires sent, returned and usable[3] per department



Analysis of the completed questionnaires shows that the majority (42%, n=57) of the courses considered for the analysis are in the nursing departments/schools. Around 15% (n=21) of the courses are in the psychology departments/schools,

3 In total 12 questionnaires were unusable as they were not completed due to the course no longer running or the respondents being of the opinion that their course was not relevant to the study

followed by medicine (9%, n=12), social science (9%, n=12), occupational therapy (4%, n=5), and speech and language therapy departments/schools (3%, n=4), In addition, 19% (n=26) of courses considered in this study are offered by a number of other departments/schools. There is one course offered across three schools/disciplines: occupational therapy, speech and language therapy, and physiotherapy. Further analysis of the courses returned from psychology departments indicated that 19% (n=4) led to a professional qualification in psychology. In relation to social work, five courses were returned that led to a social work qualification (four from social science and one from a department categorised as 'other'), which represents an 83% response rate from Course Coordinators/Directors of social work programmes. 13 (23%) courses provided by nursing departments allow graduates to apply to have their name entered onto the psychiatric nursing division of the register maintained by An Bord Altranais. Figure 2 shows the distribution of courses according to the Departments/ Schools and figure 3 shows the distribution of courses within the departments coded as 'Other'.

Figure 2:
Distribution of courses according to Department/School

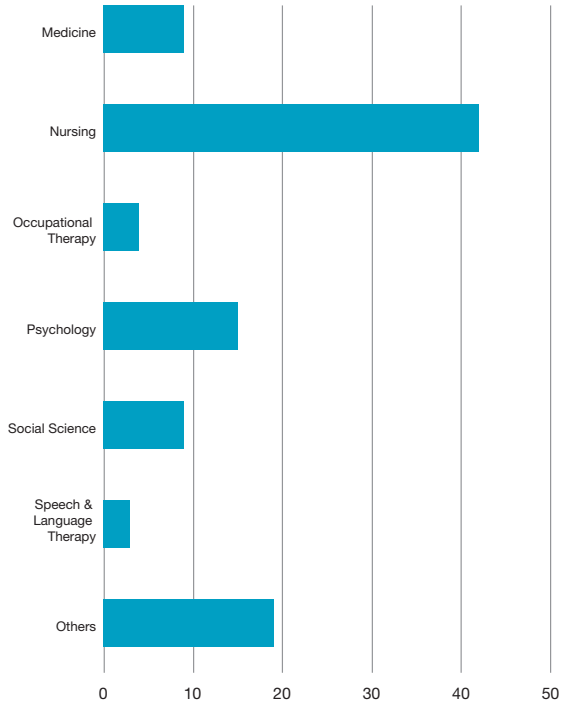
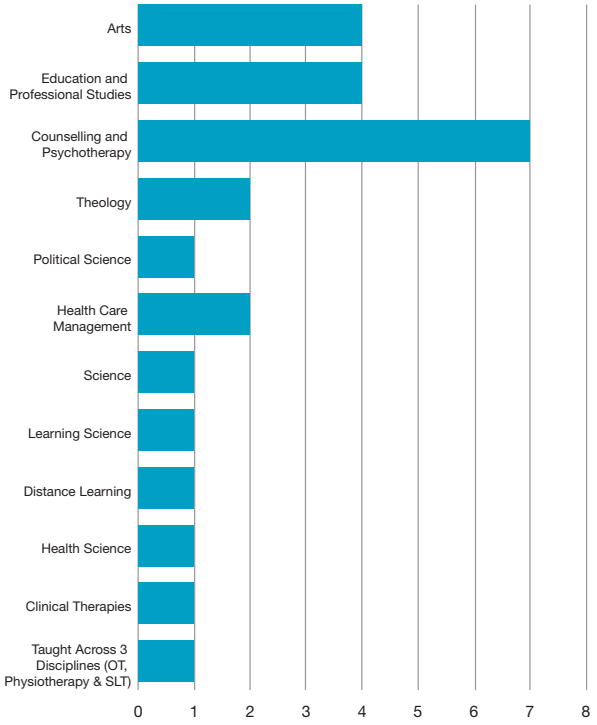


Figure 3:
Distribution of courses coded as 'other'



Level of Award

Analysis of the highest level of award reveals that the majority (39%, n=54) of courses considered within this study are at master's level or level nine of the National Qualifications Authority of Ireland (NQAI) framework (Figure 4). 36% (n=49) of courses are offered at degree level (level eight) and 10% (n=14) are at postgraduate diploma level (usually level nine). Other courses are provided at diploma (1.5%, n=2; level seven), higher diploma (8%, n=12; level eight), and taught doctorate (4%, n=6; level ten) level. In addition, it was noted that 51 courses have a number of exit awards, allowing students to exit with lower qualifications, such as certificate (9%, n=12; level six), diploma (7%, n=9), higher diploma (1.5%, n=2; level eight), postgraduate diploma (18%, n=23), and masters (3%, n=4; level nine).

Figure 4:
Frequency distribution of the highest level of award

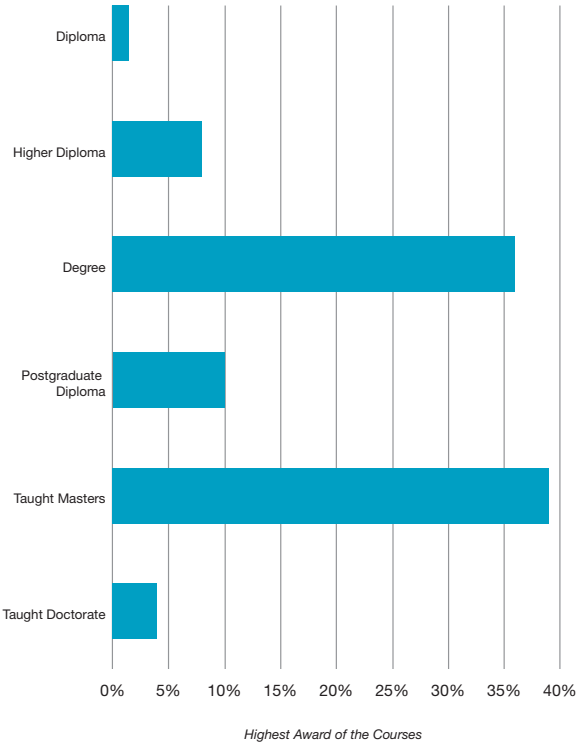
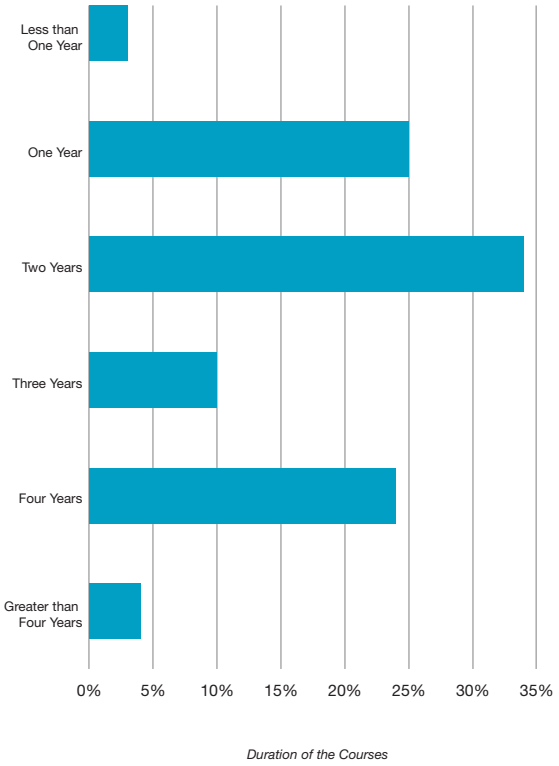


Figure 5:
Distribution of courses according to duration



Duration of the Course

34% (n= 46,) of the courses in this study are of two years duration and in the majority of cases these are taught masters (70%, n=37). Around a quarter of the courses are either of one (25%, n=34) or four years (24%, n=33) duration. The majority of the four year courses (n=28) are undergraduate degrees, with 14 courses residing in nursing departments. Only 10% (n=14) of courses are provided over three years and 4% (n=6) of courses are greater than a four year period. The analysis further reveals that three out of the six courses that are more than four years duration reside within the departments/schools of medicine. Figure 5 shows the distribution of the courses according to duration.

Funding

Most (61%, n=82) of the courses are self-financed from student fees. Others are funded either completely or partly by the Health Service Executive [completely (13%, n=18) or part subsidised (4%, n=6)], the Department of Health and Children [completely (6%, n=8) or part subsidised (1.5%, n=2)] and the Department of Education and Science [completely (7%, n=10) or part subsidised (1.5%, n=2]. Respondents indicated that 5% (n=7) of courses are funded by other sources such as the Nursing and Midwifery Practice Development Units (NMPDU), the probation service and the sponsoring hospital.

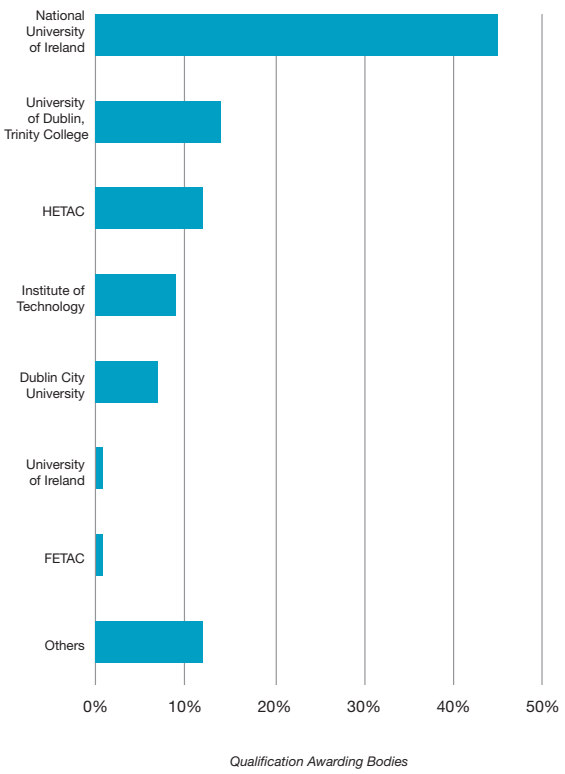
Course Accreditation by Professional Bodies

Information was sought on course accreditation by professional bodies (Q.9). 72% (n=97) of courses are accredited by one of the following professional bodies: An Bord Altranais (n=48), Psychological Society of Ireland (n=15, of which four courses lead to a professional qualification in Psychology), Association of Occupational Therapists of Ireland/World Federation of Occupational Therapists (WFOT) (n=4), Irish Association for Counselling and Psychotherapy (IACP) (n=2), Irish Association of Speech and Language Therapists (IASLT) (n=3), Irish Council for Psychotherapy (ICP) (n=2), Irish Medical Council (IMC) (n=4), and the National Social Work Qualifications Board (NSWQ) (n=5). Fourteen courses (10%) were accredited by other professional bodies such as the Irish College of Psychiatrists in Ireland, Association for Psychotherapy and Psychoanalysis in Ireland (APPI), Behaviour Analyst Certification Board, British Psychological Society, Family Therapy Association of Ireland, Higher Education and Training Awards Council, and the Department of Education. Of the 28% (n= 38) not currently accredited, some of the respondents stated that they are currently in the process of getting accreditation and some would have no professional accreditation currently available in Ireland.

Awarding Body for the Academic Qualification

45% (n=62) of courses have their academic qualifications awarded by the National University of Ireland (NUI). The next highest number is awards from Trinity College Dublin and the University of Dublin, Trinity College[4] (14%, n=19), followed by the Higher Education and Training Awards Council (HETAC) (12%, n=16). Other courses have their awards from Institutes of Technology (9%, n=12), Dublin City University (7%, n=10), and the Further Education and Training Awards Council (FETAC) (n=1). 12% (n=17) of courses receive their awards from other institutions such as Middlesex University, UK; The Open University, UK, the Royal College of Surgeons in Ireland (RCSI), Institute of Public Administration (IPA), St. Patrick's College Maynooth, and the University of Limerick. A graphical representation of these awarding bodies is given in Figure 6.

Figure 6:
Awarding body for the academic qualification

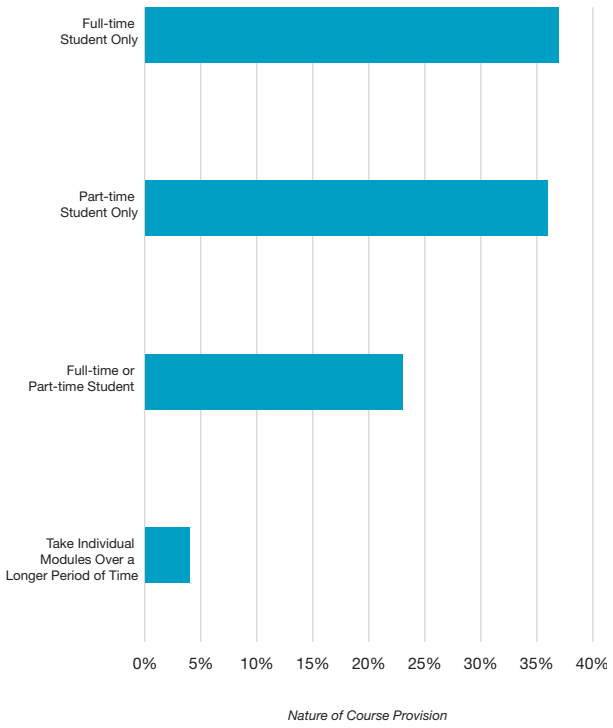


Nature of Course Provision: Frequency, Full-time and Part-time Nature

The majority (88%, n=119,) of courses have one intake of students per year. Around 8% (n=11) of the courses are provided every second year, with only 3% (n=4) enrolling students twice a year. There is one course provided every third year. 37% (n=51) of the courses can be completed as a full-time student and 36% (n=49) of courses are available on a part-time basis only. 23% (n=32) can be completed either as a full-time or a part-time student. It is interesting to note that only 4% (n=5) of the courses have provision for taking individual modules over a longer period of time.

4 Diplomas including Higher Diplomas and Postgraduate Diplomas are awarded by Trinity College Dublin. All other awards (Primary degrees, MSc, PhD) are awarded by The University of Dublin, Trinity College.

Figure 7:
Nature of course provision: full-time/part-time



Unidisciplinary and Multidisciplinary Courses

Analysis shows that of the 137 courses considered in this study, 69% (n=94) are unidisciplinary and the remaining 31% (n=43) are multidisciplinary. A more detailed breakdown on the awards, duration and number of the unidisciplinary and multidisciplinary courses provided by each of the departments/schools is outlined in Appendix 9.

Unidisciplinary courses

Of the 94 unidisciplinary courses available, 52% (n=48) are undergraduate courses and 48% (n=46) are at postgraduate level. 53% (n=50) are provided by nursing departments and the remaining 47% (n=44) are provided by psychology (15%, n=14), social science (8%, n=7), occupational therapy (6%, n=5), medicine (4%, n=4), speech and language therapy (4%, n=4), and departments classified as other (11%, n=10). Further analysis indicates that the courses which lead to a professional qualification in psychology (n=4) and social work (n=5) are all unidisciplinary.

Of the 57 courses within nursing departments 58 % (n=29) are designed specifically for psychiatric nurses, of which 13 allow graduates to apply to have their name entered onto the psychiatric nursing part of the register maintained by An Bord Altranais. The remaining 42% (n=28) are generic nursing programmes, which psychiatric nurses may attend. 52% (n=26) of nursing courses are at undergraduate level and 48% (n= 24) at postgraduate level. The psychology department provides 14 courses, 36% (n=5) at undergraduate level and 64% (n=9) at postgraduate level, of which four postgraduate courses lead to a professional qualification in psychology. Courses within the psychology department are designed for psychologists (79%, n=11), psychotherapists/counsellors (14%, n=2) and guidance and counselling professionals (7%, n=1).

Of the seven courses provided by social science, 71% (n= 5) are at undergraduate level and 29% (n=2) are at postgraduate level. Of the four courses provided by the social science department that led to a professional qualification in social work, two are at undergraduate level and two are at postgraduate level. Courses within the social science department are mostly designed for social workers (86%, n=6) and one (14%) for psychologists. All five (6%) courses provided by the occupational therapy departments are designed for occupational therapists only, of which three (60%) are at undergraduate level and two (40%) are at postgraduate level. Similarly four (3%) courses provided by the speech and language therapy departments are designed for speech and language therapists only, of which three (75%) courses at undergraduate level and one (25%) at postgraduate level. The four (4%) unidisciplinary courses provided by departments of medicine are at undergraduate level and designed to educate doctors. Of the ten (11%) unidisciplinary courses within other departments, six (60%) are at undergraduate level and four (40%) are at postgraduate level. One of the postgraduate courses led to a professional qualification in social work. Courses within the departments classified as others were designed to educate and train psychotherapists/counsellors (50%, n=5), psychologists (20%, n=2), social workers (10%, n=1), psychiatric/mental health nurses (10%, n=1)[5], and others (10%, n=1).

Offering opportunities for disciplines to learn with and from each other, at undergraduate level, is considered by some as

5 This course is provided by a distance learning department

important in fostering mutual understanding and respect for one another's roles. Of the 48 unidisciplinary undergraduate courses in this study, only three courses identified an element of shared learning with another discipline. Two of the courses involved medical students taking some lectures with nursing students and social workers. The other involved speech and language and occupational therapists sharing a module on communication disorders.

Multidisciplinary courses

Of the 43 multidisciplinary courses available 16% (n=7) are provided by nursing departments, 19% (n=8) by medicine departments, 16% (n=7) by psychology departments, 12% (n=5) by social science departments and 37% (n=16) by departments classified as other.

Of the seven multidisciplinary courses provided by nursing departments, one (14%) is at undergraduate and six (86%) are at postgraduate level. Medicine departments provide eight courses and psychology departments provide seven courses, all at postgraduate level. Of the five multidisciplinary courses provided by the social science departments, one (20%) is at undergraduate level and four (80%) are at postgraduate level. Of the 16 (35%) multidisciplinary courses provided by other departments, two (13%) are at undergraduate level and 14 (87%) are at postgraduate level. There were no multidisciplinary courses provided by occupational therapy or speech and language therapy departments.

An analysis of the 43 multidisciplinary course titles reveals that a high percentage of the courses are focused on some aspect of therapeutic engagement (30%, n=13), with others focusing on aspects of management, occupational health, health education and promotion (19% n=8). The remaining multidisciplinary courses (n=22) are focused on clinical therapies, clinical teaching, clinical supervision, health care informatics, mental health practice, rehabilitation and disability, bereavement, and religion, culture and ethics. An overview of the multidisciplinary course titles are provided in Appendix 10.

A more detailed analysis of the 43 multidisciplinary courses in this study indicate that 93% (n= 40) of courses are available to occupational therapists, 84% (n=36) to psychiatrists, psychiatric nurses and psychotherapists, psychologists and speech and language therapists and 74% (n=32) to social workers. 91% (n=39) of the multidisciplinary courses also have provision for attendance of others, such as carers (n=39), complementary therapists (n=39), pastoral care/chaplains (n=39), care assistants (n=38), care officers (n=36), service users (n=34), and others (n=33) who work within mental health and have a primary degree in a relevant course and/or meet the admission criteria. The other category included lawyers, gardaí, teachers, physiotherapists, childcare workers, and prison officers.

A department/school wide analysis was undertaken of the 34 courses that were open to service user attendance. The analysis revealed that ten of the courses are delivered by the social science departments/schools, eight courses are within nursing departments/schools, five are delivered by psychology departments/schools and one within the medical departments/schools. Ten courses are delivered by other departments: arts (n=3), educational and professional studies (n=1), counselling and psychotherapy (n=4), theology (n=1) and health sciences (n=1).

An analysis of student attendance per department/school for the year 2008-09 clearly shows that doctors and nurses more frequently attend courses run by their own departments/schools (Table 1).

Table 1: Number of multidisciplinary courses attended by discipline per department/school in 2008-09						
No of course per Department No of courses attended by	*Medicine (N=8)*	*Nursing (N=7)*	*Psych. (N=7)*	*Social Science (N=5)*	*Other (N=16)*	*Total (N=43)*
Psychiatrists	5	1	0	0	5	**11**
MH Nurses	1	6	3	0	3	**13**
Psychologists	2	2	2	1	4	**11**
Social Workers	3	1	4	1	3	**12**
OTs	2	0	1	0	3	**6**
SLTs	2	1	1	0	3	**7**
Pastoral Care	0	0	1	1	2	**4**
Counsellors/Psychotherapists	2	5	3	0	3	**13**
Others	**6**	**4**	**3**	**3**	**10**	**26**

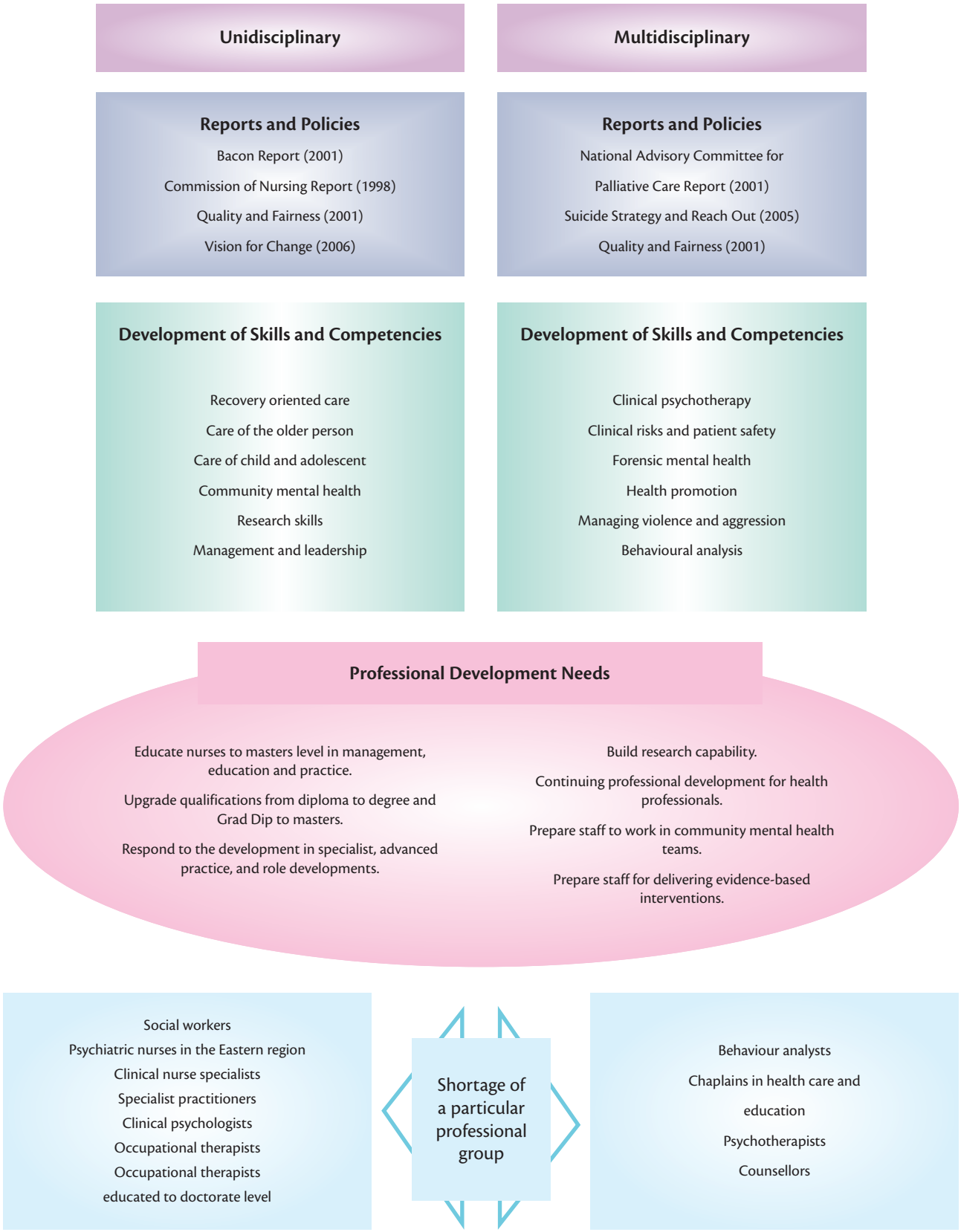
Rationale for Course Development

Respondents were asked to identify if the course for which they were completing the questionnaire was designed to respond to any specific priority. 48% (65) of the respondents indicated that the course was established to meet a particular health service priority. An analysis of the responses indicated that the courses were designed in response to one of the following:

- Reports and policy documents
- A need to develop specific skills and competencies among practitioners
- To meet a specific professional development need
- In response to the shortage of a particular professional group

More detailed information on the health service priorities that led to course development is provided in Figure 8. The priorities are divided and reported in relation to both the unidisciplinary and multidisciplinary courses.

Figure 8:
Priorities/needs that led to course development



Professional/experiential backgrounds of lecturers/teachers

In general, psychologists (58%, n=78) appear to teach on most of the courses. Mental health nurses (40%, n=53), psychotherapists/counsellors (37%, n=50), psychiatrists (24%, n=32), social workers (19%, n=26), occupational therapists (11%, n=15), and speech and language therapists (9%, n=12) teach on less than half the courses. Around 37% (n=50) of the courses involve several other professionals including business lecturers, sociologists, educationalists, ethicists, barristers, physiotherapists, anthropologists, and nurses from disciplines other than psychiatry and midwives. In addition, some mentioned the inclusion of people who were working in senior management positions in clinical practice. Only a quarter of the courses have service users involved in teaching (25%, n=33), and very few courses have carers (13%, n=17) or pastoral care/chaplaincy (7%, n=9) involved in teaching. A department level analysis of professional/experiential backgrounds of lecturers/teachers indicates that service users are not involved in courses delivered by departments/schools of medicine. Chaplains and carers are also under-represented as teachers in a number of departments. A further analysis of the four courses leading to a professional qualification in psychology indicated that three (75%) of the courses include lecture input from psychiatrists and psychotherapists/counsellors and one (25%) of the courses has input from speech and language therapists, service users, carers and social workers. Of the five courses leading to a social work qualification, four courses (80%) had input from service users and one course (20%) had input from carers and psychiatrists.

Table 2 and Table 3 provide a breakdown of the professional/experiential backgrounds of lecturers/teachers on courses per department and on the unidisciplinary and multidisciplinary courses.

Table 2: Professional/experiential backgrounds of lecturers/teachers per department

Department Lecturers/Teachers	Medicine (N=12)	Nursing (N=57)	OT (N=5)	Psych. (N=21)	SoSc. (N=12)	SLT (N=4)	Other (N=26)	Total (N=137)
Carer	2	9	1	2	0	0	3	**17**
Pastoral care chaplaincy	0	5	0	1	0	0	3	**9**
Psych nurse	4	42	1	2	0	0	4	**53**
Psychiatrist	7	9	0	4	0	3	9	**32**
Psychologist	7	21	3	21	3	3	20	**78**
Psychotherapist/ Counsellor	4	19	0	10	2	1	14	**50**
OTs	3	2	5	0	0	1	4	**15**
SLTs	1	4	0	1	0	3	3	**12**
Service user/client	0	17	2	2	4	3	5	**33**
Social worker	3	8	1	2	7	0	5	**26**
Others	**6**	**27**	**0**	**4**	**3**	**3**	**7**	**50**

Table 3: Professional/experiential backgrounds of lecturers/teachers on unidisciplinary and multidisciplinary courses				
Professional/experiential backgrounds of lecturers/teachers	**Unidisciplinary N=94**		**Multidisciplinary N= 43**	
	No.	(%)	No.	(%)
Carers	13	14	4	**9**
Pastoral care/chaplaincy	4	4	5	**12**
Mental health nurses	41	44	12	**28**
Psychiatrists	17	18	15	**35**
Psychologists	47	50	31	**71**
Psychotherapists/Counsellors	28	30	22	**51**
Occupational therapists	11	12	4	**9**
Speech and language therapists	6	6	6	**14**
Service users	25	27	8	**19**
Social workers	17	18	9	**21**
Others	**32**	**34**	**18**	**42**

Keeping Abreast of Policy, Service and Practice Developments

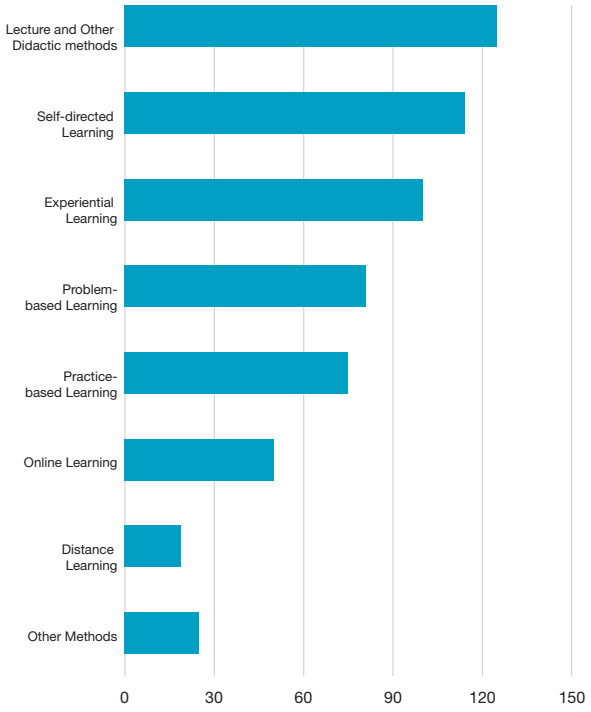
In order to understand how lecturing/teaching staff remain up-to-date with developments in policy, service, and practice, respondents were asked to indicate this by selecting from a list of items on the questionnaire. Analysis indicates that lecturers for most of these courses are expected to keep abreast of current policy, service, and practice development through reading policy, research, and theoretical literature (97%, n=130), and through continuing professional development (93%, n=125). In addition, researching issues from practice (77%, n=103), spending time in practice teaching students (56%, n=75,), developing protocols/standards with clinical staff (38%, n=51), carrying a case load (35%, n=47), or spending time with service managers on service and policy development (30%, n=40), are also practices with which lecturing/teaching staff are expected to engage.

Around 15% (n=21) of respondents mentioned other measures such as: engaging in publication, developing active partnerships with service user groups, attending talks by the experts in specific areas, and attending different forms of clinical supervision such as peer consultation and individual supervision. Personal psychotherapy was also mentioned as a resource. Respondents who mentioned clinical supervision or personal psychotherapy were completing questionnaires for courses in counselling/psychotherapy and/or applied psychology.

Teaching Methods

The most commonly used teaching methods reported were the lecture format and other didactic methods (92%, n=125). Self-directed learning (83%, n=114) and experiential learning (73%, n=100) are also widely used. More than half of the courses made use of problem-based learning (59%, n=81) and practice-based learning (55%,n=75). However online learning (37%, n=50) and distance learning (14%, n=19,) are used in fewer courses. 18% (n= 25) of courses reported using other teaching methods including action learning, blended learning, and case-based learning, simulation, microteaching, task-based learning, student presentation and use of clinical skills laboratories.

Figure 9: Teaching Methods Used on the Courses



Further analysis of the teaching methods used indicates that there is very little difference between unidisciplinary and multidisciplinary courses. Surprisingly, the lecture method continues to feature strongly in multidisciplinary courses with no appreciable difference in the use of experiential methods or problem-based learning.

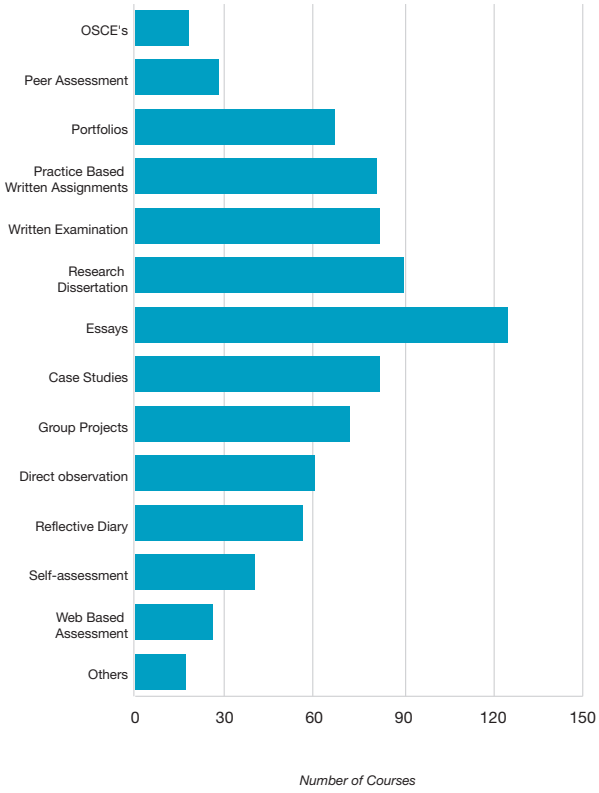
Assessment Methods

Essays are widely used in assessing students on the majority of courses (91%, n=125). Other commonly used assessment methods are research dissertation/thesis (66%, n=90), case study (60%, n=82), written examinations (60%, n=82), practice-based/work based written assignments (59%, n=81), group projects (53%, n=72), and portfolios (49%, n=67). Several assessment methods such as the direct observation of competence in practice (44%, n=60), reflective diaries (41%, n=56), self-assessment (29%, n=40), peer assessment (20%, n=28), web-based assessment (19%, n=26), and Objective Structured Clinical Examinations (OSCE's) (13%, n=18) are used in less than half the number of courses. In addition, 12% (n=17) of courses reported using other assessment methods such as classroom/clinical presentations, poster presentation, computer-assisted examination, minor thesis and research proposals, online discussion board, and supervision reports.

Table 4: Teaching methods used in Unidisciplinary and Multidisciplinary Courses

Teaching Methods	Unidisciplinary N=94		Multidisciplinary N= 43	
	No.	(%)	No.	(%)
Distance Learning	11	12	8	**19**
Experiential Learning	68	72	32	**74**
Lectures/Other Didactic Methods	85	91	40	**93**
Online Learning	33	35	17	**40**
Practice-Based Learning	49	52	26	**61**
Problem-Based Learning	53	56	28	**65**
Self-Directed Learning	78	83	36	**84**
Other Methods	**15**	**16**	**10**	**23**

Figure 10: Assessment Methods Used in the Courses



A further analysis of assessment methods used revealed that similar assessment methods are used on the unidisciplinary and multidisciplinary courses, with the exceptions of direct observation of competence in practice and Objective Structured Clinical Examinations (OSCE's), which are infrequently used on the multidisciplinary courses.

Table 5: Assessment Methods Used in Unidisciplinary and Multidisciplinary Courses					
Assessment Methods	**Unidisciplinary N=94**		**Multidisciplinary N= 43**		**Total (N=137)**
	No.	(%)	No.	(%)	**No.**
Case study	56	60	26	61	**82**
Observation of competence in practice	49	52	11	26	**60**
Essays	86	92	39	91	**125**
Group projects	44	47	28	65	**72**
OSCEs	16	17	2	5	**18**
Peer assessment	19	20	9	21	**28**
Portfolios	51	54	16	37	**67**
Practice-/work-based written assessments	59	63	22	51	**81**
Reflective diaries	38	40	18	42	**56**
Research dissertation/thesis	58	62	32	74	**90**
Self-assessment	29	31	11	26	**40**
Web-based assessment	18	19	8	19	**26**
Written examinations	61	65	21	49	**82**
Other methods	**10**	**11**	**7**	**16**	**17**

Practice Placements/Supervised Sessions

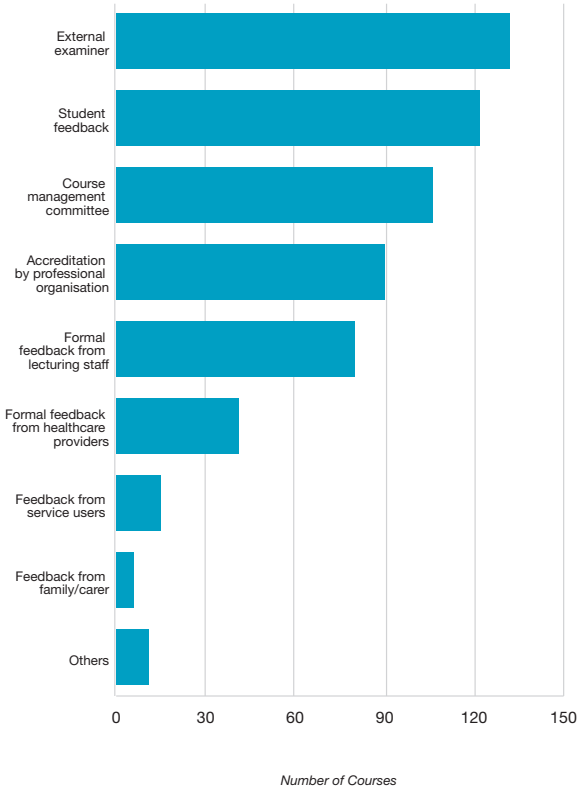
60% (n=81) of the courses reported that the students are required to complete practice placements/supervised sessions as part requirement of the course. A more detailed breakdown of the practice placement requirements per department/school are provided in Table 6.

Quality Assurance Mechanisms

Most of the courses utilise external examiners (96%, n=132) and formal feedback from students (89%, n=122) as the quality assurance mechanism. The course management committee (77%, n=106), accreditation by professional organisations (66%, n=90), and formal feedback from lecturing staff (58%, n=80) are also commonly used quality assurance mechanisms. However formal feedback from health service providers (30%, n=41), service user/client groups (11%, n=15), and family/carers (4%, n=6) are used in fewer courses. Around 8% (n=11) of the courses also use other quality assurance mechanisms such as informal and formal feedback from clinical supervisors/consultation staff and informal feedback from health service providers.

Table 6: Practice placement requirements by the courses within the departments/schools		
Departments/ Schools	**Placement Required**	
	Number	%
Medicine (N=12)	7	58
Nursing (N=57)	41	72
Psychology (N=21)	9	43
Occupational Therapy (N=5)	3	60
Social Science (N=12)	6	50
Speech and Language Therapy (N=4)	3	75
Others (N=26)	12	46
Total= 137	**81**	**60**

Figure 11:
Quality Assurance Mechanisms used on the Courses



Service User Involvement

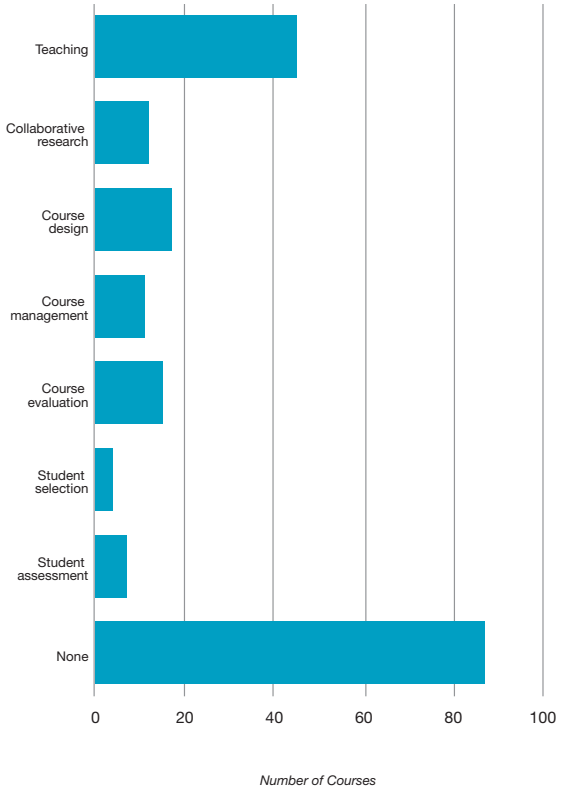
Of the 137 courses considered in this study, service users are only involved in 37% (n=50) of courses. A department/school level distribution of service users' involvement on courses reveal that the social science, occupational therapy, and speech and language therapy departments appear to have more service user involvement when compared to other departments. Four (80%) out of five professional courses in social work indicated service user involvement suggesting high commitment to service user involvement within social work education. In comparison, only one (25%) of the four professional courses in psychology included service users on the educational team. Of the 29 courses designed specifically for psychiatric nurses, 19 (66%) had service users involvement.

Table 7: Service User Involvement on the Courses per Department/School

Departments/Schools	Number of courses service users are involved with	Percentage
Medicine (n=12)	5	42
Nursing (n=57)	24	42
Occupational therapy (n=5)	3	60
Psychology (n=21)	4	19
Social science (n=12)	8	67
Speech & language therapy (n=4)	2	50
Others (n=26)	4	16
Total	**50**	

Of those 50 courses that service users are involved in, 90% of their involvement focuses on providing inputs or teaching about their experiences (n=45).[6] Service users are far less involved in other aspects of educational developments, such as course design (34%, n=17,), course evaluation (30%, n=15,), collaborative research (24%, n=12), course management (22%, n=11), student assessment (14%, n=7), and student selection (8%, n= 4).

Figure 12: Service user involvement on the courses



Of the 87 (63%) respondents that indicated that the courses currently do not have any service user involvement on the course, 47% (n=41) indicated that they had some intention to include service users in various aspects of the programme in future. Future involvement ranged from course design (21%, n=17), course evaluation (17%, n=13), collaborative research (14%, n=11), teaching (13%, n=10), course management (8%, n=6,) student selection (3%, n=2), and student assessment (6%, n=5). In addition, 6% (n=5) mentioned involving the service user in other aspects of educational developments, such as making DVDs on service users' stories for teaching purposes. However, it is important to note that 53% (n= 46) of respondents indicated that there was no plan to involve service users on the programme.

6 In a previous question respondents reported that service users were involved as teachers in 33 courses. In this question, the response on service user involvement in teaching increased to 45. The difference in reported numbers may be due to respondents including service user involvement in clinical teaching on this question.

Table 8: Department/school level distribution of student numbers targeted and admitted in the year 2008-09					
Department/School	**Target met**	**Target not met**	**Exceeded target**	**Missing values**	**Total**
Medicine	6	6	0	0	12
Nursing	16	35	4	2	57
Occupational therapy	0	3	2	0	5
Psychology	9	5	3	4	21
Social science	4	3	3	2	12
Speech and language therapy	1	1	2	0	4
Others	5	12	2	7	26
Total	41 (30%)	65 (47%)	16 (12%)	15 (11%)	137

Recruitment and Target Numbers

Questions 28 and 29 requested information on target numbers for recruitment and admission rates for the academic year 2008-09. 89% (n=22) of respondents provided information to these questions and 11% (n=15) did not. Comparison between target number and admission for the year 2008-09 reveals that in total, 30% (n=41) of courses met the target number and 12% (n=16) of courses actually exceeded the target number. However, 47% (n=65) of courses did not manage to attract sufficient students to meet their target. All of the courses leading to a professional qualification in Psychology and Social Work indicated that they had met the target number. Table 8 shows a department/school level distribution of student numbers targeted and admitted in the year 2008-09 and Table 9 shows the distribution of student numbers targeted and admitted within unidisciplinary and multidisciplinary courses.

It is interesting to note that of the 65 courses that did not meet their target number for student recruitment, 65% (n=42) were at postgraduate level and 56% (n=24) of these were courses delivered within nursing departments.

Emphasis Given to Theoretical and Clinical Issues Within Curricula

Question 17 requested respondents to indicate on a Likert scale, ranging from 'Very strong' to 'None', their perception of the emphasis given within the curriculum, to thirty theoretical and clinically focused issues derived from the literature. These issues were deemed important in the education of mental health professionals. Initially a frequency and percentage score for each item listed was calculated. Table 10 provides an overview of the scores for each item.

Table 9: Target Number and Admissions for the year 2008-09 within Uni/Multidisciplinary Courses					
Department/School	**Target met**	**Target not met**	**Exceeded target**	**Missing values**	**Total**
Unidisciplinary	27	45	11	11	94
Multidisciplinary	14	20	5	4	43
Total	41	65	16	15	137

Table 10: Emphasis placed on theoretical and clinical issues within curricula across disciplines

	Very Strong	Strong	Some	Weak or little	None	N/A	Don't know	Missing
Biological perspectives on mental health issues	3 (2%)	28 (21%)	51 (38%)	24 (18%)	11 (8%)	17 (13%)	0	**3 (2)**
Care pathways	7 (5%)	32 (24%)	44 (33%)	16 (12%)	14 (11%)	17 (13%)	3 (2%)	**4 (3%)**
Clinical supervision	38 (29%)	26 (20)%	21 (16%)	10 (8%)	18 (14%)	17 (13%)	2 (1.5%)	**5 (4%)**
Clinician self-care	27 (20%)	31 (23%)	29 (22%)	13 (10%)	12 (9%)	20 (15%)	2 (1.5%)	**3 (2%)**
Ethics	40 (30%)	61 (45%)	22 (16%)	3 (2%)	3 (2%)	6 (4%)	0	**2 (1.5%)**
Evidence-based practice	61 (46%)	42 (32%)	13 (10%)	6 (4%)	3 (2%)	8 (6%)	0	**4 (3%)**
Family/carer support	14 (10%)	38 (28%)	39 (29%)	16 (12%)	10 (7%)	16 (12%)	2 (1.5%)	**2 (1.5%)**
Gender sensitive care	6 (4%)	36 (27%)	43 (32%)	20 (15%)	11 (8%)	16 (12%)	3 (2%)	**2 (1.5%)**
Group facilitation skills	28 (21%)	33 (24%)	42 (31%)	11 (8%)	9 (7%)	10 (7%)	2 (1.5%)	**2 (1.5%)**
Human rights	28 (21%)	42 (31%)	39 (29%)	9 (7%)	4 (3%)	12 (9%)	1 (0.7%)	**2 (1.5%)**
Legal issues	21 (16%)	37 (28%)	40 (30%)	13 (10%)	4 (3%)	16 (12%)	2 (1.5%)	**4 (3%)**
Malpractice/ negligence	17 (13%)	22 (17%)	50 (38%)	15 (11%)	10 (8%)	18 (14%)	1 (0.8%)	**4 (3%)**
Marginalised groups	14 (10%)	33 (25%)	40 (30%)	24 (12%)	8 (6%)	14 (10%)	1 (0.7%)	**3 (2%)**
Mental health promotion	21 (16%)	33 (25%)	38 (28%)	17 (13%)	6 (5%)	18 (13%)	1 (0.7%)	**3 (2%)**
Multi-agency working	23 (17%)	35 (26%)	36 (27%)	13 (10%)	9 (7%)	16 (12%)	2 (1.5%)	**3 (2%)**
Multidisciplinary working	35 (26%)	42 (31%)	34 (25%)	5 (4%)	7 (5%)	13 (10%)	0	**1 (0.7%)**
Person-centered care	49 (36%)	34 (25%)	24 (18%)	9 (7%)	7 (5%)	12 (9%)	0	**2 (1.5%)**
Psychoeducation	23 (36%)	35 (26%)	36 (27%)	13 (10%)	9 (7%)	16 (12%)	2 (1.5%)	**3 (2%)**
Psychological perspectives	34 (25%)	38 (28%)	26 (19%)	7 (5%)	12 (9%)	14 (10%)	3 (2%)	**3 (2%)**
Quality mechanisms/quality assurance	21 (16%)	47 (35%)	28 (21%)	13 (10%)	7 (5%)	17 (13%)	1 (0.7%)	**3 (2%)**
Recovery approaches	22 (17%)	26 (20%)	37 (28%)	10 (8%)	13 (10%)	20 (15%)	5 (4%)	**4 (3%)**
Risk and risk management	18 (14%)	34 (26%)	41 (31%)	11 (8%)	12 (9%)	16 (12%)	1 (0.8%)	**4 (3%)**
Safety and clinical governance	19 (14%)	32 (24%)	36 (27%)	13 (10%)	15 (11%)	17 (13%)	1 (0.8%)	**4 (3%)**
Self-help/peer support	21 (16%)	27 (20%)	36 (27%)	13 (10%)	17 (13%)	18 (14%)	1 (0.8%)	**4 (3%)**
Service users/clients perspectives	35 (26%)	27 (20%)	28 (21%)	16 (12%)	9 (7%)	17 (13%)	2 (1.5%)	**3 (2%)**
Sexuality	11 (8%)	25 (19%)	47 (35%)	20 (15%)	11 (8%)	17 (13%)	3 (2%)	**3 (2%)**
Social perspectives on mental health problems	9 (22%)	37 (28%)	35 (26%)	8 (6%)	8 (6%)	14 (11%)	2 (1.5%)	**4 (3%)**
Spirituality	5 (4%)	23 (17%)	42 (32%)	23 (17%)	23 (17%)	14 (11%)	3 (2%)	**4 (3%)**
Therapeutic relationships communication/	47 (35%)	33 (24%)	21 (16%)	10 (7%)	6 (4%)	16 (12%)	2 (1.5%)	**2 (1.5%)**
Transcultural issues	13 (10%)	29 (22%)	5 (42%)	14 (10%)	7 (5%)	14 (10%)	1 (0.7%)	**2 (1.5%)**

Table 11: Department wide distribution of emphasis placed on theoretical and clinical issues identified					
Department	**Very Strong**	**Strong**	**Some**	**Weak**	**None**
Medicine (n=12)	2 (17%)	5 (42%)	2 (17%)	2 (17%)	1 (9%)
Nursing (n=57)	8 (14%)	30 (53%)	8 (14%)	6 (11%)	5 (9%)
Occupational therapy (n=5)	2 (40%)	2 (40%)	1 (20%)	-	-
Psychology (n=21)	2 (10%)	7 (35%)	4 (20%)	5 (25%)	3 (10%)
Social science (n=12)	-	7 (58%)	3 (25%)	-	2 (17%)
SLT (n=4)	1 (25%)	2 (50%)	1 (25%)	-	-
Others (n=26)	-	14 (54%)	5 (19%)	5 (19%)	2 (8%)
Total (N=137)	15 (11%)	67 (49%)	24 (18%)	18 (13%)	13 (10%)

To enable further analysis each option was given a score ranging from five to zero ('Very strong' = 5; 'Strong' = 4; 'Some emphasis' = 3; 'Weak emphasis' = 2; and 'None' = 1). Courses with a very strong emphasis on the 30 items listed could achieve a maximum score of 150 for this question. In order to get a clear understanding on the emphasis, the scores were classified as 'None' (0-30), 'Weak' (31-60), 'Some' (61-90), 'Strong' (91-120) and 'Very Strong' (121-150).

Analysis revealed that of the 137 courses in the study 11% (15) courses have a 'very strong' emphasis and 49 % (67) of the courses have a 'strong' emphasis within the curriculum on the issues identified. 18% (24) of the courses have 'some' emphasis, with 13% (18) indicating a weak emphasis. In addition 10% (13) courses placed no emphasis on these issues in the course curriculum. A department level analysis of the courses that had no emphasis indicate that they were within the departments of medicine (1), nursing (5), psychology (3), social science (2), and other (2). Further analysis of the courses indicate that six courses were focused on educating professionals for roles in education or management, and three courses were focused on issues such as ethics, social research, philosophy and psychological studies. The non-clinical focus of these courses may account for the lack of emphasis. Table 11 provides an analysis of emphasis by department. A departmental analysis of the number of courses that place a very strong emphasis within curricula is included in Appendix 11.

Emphasis Placed on Policy and Legal Documents

Respondents were requested to indicate on a Likert scale, ranging from 'Very strong' to 'None', their perception of the emphasis given to a number of policies/documents deemed important in the education of mental health professionals (Q.18). Similar to Question 17 a frequency and percentage score for each item listed was calculated. Table 13 provides an overview of the scores for each item.

An analysis of courses leading to professional qualifications in social work and psychology are represented in Table 12.

Table 12: Analysis of the emphasis on the theoretical and clinical issues identified within course leading to a professional qualification in psychology and social work					
Department	**Very Strong**	**Strong**	**Some**	**Weak**	**None**
Social work (n=5)	-	1(20%)	4(80%)	-	-
Psychology (n=4)	-	-	3(75%)	1(25%)	-

Table 13: Frequency and percentage of degree of emphasis given to the policy and legal documents

Document	Very Strong	Strong	Some	Weak or little	None	N/A	Do not know	Missing
A Recovery Approach within the Irish Mental Health Services (Mental health Commission, 2006)	19 (14%)	17 (13%)	33 (25%)	14 (10%)	17 (13%)	30 (22%)	4 (3%)	3 (2%)
Criminal Law Insanity Act (Government of Ireland, 2006)	6 (5%)	6 (5%)	40 (30%)	24 (18%)	23 (17%)	31 (23%)	3 (2%)	4 (3%)
Excellence in Mental Health Care Records Guidance (Mental Health Commission, 2005)	7 (5%)	19 (14%)	34 (25%)	22 (16%)	18 (13%)	31 (23%)	3 (2%)	3 (2%)
Mental Health Act 2001 (Government of Ireland, 2001)	14 (10%)	25 (19%)	41 (30%)	10 (7%)	13 (10%)	29 (22%)	3 (2%)	2 (1.5%)
Mental Health Commission Codes of Practice (Mental Health Commission, 2006)	7 (5%)	19 (14%)	42 (31%)	16 (12%)	17 (13%)	30 (22%)	3 (2%)	3 (2%)
Mental Health Commission Rules (Mental Health Commission, 2006)	3 (2%)	17 (12%)	38 (28%)	24 (18%)	20 (15%)	29 (22%)	3 (2%)	3 (2%)
Quality Framework: Mental Health Services in Ireland (Mental Health Commission, 2005)	12 (9%)	26 (19%)	36 (27%)	15 (11%)	12 (9%)	29 (22%)	4 (3%)	3 (2%)
Universal Declaration of Human Rights (UN, 1948)	13 (10%)	21 (16%)	41 (31%)	23 (17%)	10 (8%)	24 (18%)	2 (1.5%)	3 (2%)
Vision for Change: Report of the Expert Group on Mental Health (Department of Health and Children, 2006)	31 (23%)	23 (17%)	26 (19%)	12 (9%)	14 (10%)	25 (19%)	3 (2%)	3 (2%)

To enable further analysis each option was given a score ranging from five to zero ('Very Strong' = 5; 'Strong' = 4; 'Some emphasis' = 3; 'Weak emphasis' = 2; and 'None' = 1). Courses with a very strong emphasis on the nine items listed could achieve a maximum score of 45 for this question. In order to get a clear understanding on the emphasis, the scores were classified as 'None' (0-9), 'Weak' (9-18), 'Some' (18-27), 'Strong' (27-36) and 'Very Strong' (37-45). Of the 137 courses considered for this study, only 10% (n=13) of courses placed a very strong emphasis and 26% (n=35) placed a strong emphasis on the policy documents within curricula. 25% (n=34) of courses have some emphasis, with 10% (n=13) of courses having a weak emphasis. In addition, 31% (n=42) of courses placed no emphasis on these documents. A department-level analysis indicates that between 25% and 60 % of courses in all departments place weak or no emphasis on the documents identified. A departmental analysis of the number of courses that place a very strong emphasis within curricula is included in Appendix 12.

Table 14: Department wide distribution of emphasis placed on various policy and legal documents					
Department	**Very Strong**	**Strong**	**Some**	**Weak**	**None**
Medicine (n=12)	2 (17%)	2 (17%)	4 (33%)	1 (8%)	3 (25%)
Nursing (n=57)	9 (16%)	19 (33%)	10 (18%)	4 (7%)	15 (26%)
Occupational therapy (n=5)	1 (20%)	1 (20%)	1 (20%)	-	2 (40%)
Psychology (n=21)	1 (5%)	3 (14%)	4 (19%)	3 (14%)	10 (48%)
Social science (n=12)	-	5 (42%)	1 (8%)	1 (8%)	5 (42%)
SLT (n=4)	-	1 (25%)	2 (50%)	1 (25%)	-
Others (n=26)	-	4 (15%)	12 (46%)	3 (12%)	7 (27%)
Total (n=137)	13 (10%)	35 (26%)	34 (25%)	13 (10%)	42 (31%)

Table 15: Analysis of the emphasis placed on the various policy and legal documents within course leading to a professional qualification in psychology and social work					
Department	**Very Strong**	**Strong**	**Some**	**Weak**	**None**
Social work (n=5)	-	-	5 (100%)	-	-
Psychology (n=4)	-	2 (50%)	1 (25%)	1 (25%)	-

An analysis of courses leading to professional qualifications in Social Work and Psychology are represented in Table 15.

Summary

There was a very high response rate (66%) to the questionnaire and all targeted disciplines were represented. A very high number of questionnaires were returned by the Course Coordinators/Directors in the disciplines of social work, nursing, occupational therapy, and speech and language therapy.

Analysis of the highest level of award demonstrated that the majority of courses considered within this study were offered at masters level and for the greater part, these were taught masters. The majority of courses were self-financed with others being either completely or partially subsidised mainly by the HSE, the Department of Health and Children and the Department of Education and Science and the remainder were funded from other sources. Responses indicated that the majority of courses held accreditation with a professional body with some in the process of gaining accreditation. Most courses have one student intake per year though some vary their intake. There was an even distribution between full and part-time courses, however very few courses had provision for taking individual modules to achieve the award.

When asked to indicate the rationale for course development, just under half indicated that the course was established to meet a specific health service need. Other courses were designed to respond to initiatives in report and policy documents or competency development for practitioners or to meet a specific professional development need.

Regarding unidisciplinary or multidisciplinary foci of courses, two thirds identified themselves as discipline specific and the remainder as the latter. Multidisciplinary courses were largely provided at postgraduate level, located in a variety of departments and were available to all mental health professionals that were the focus of this study. In addition, over half of the courses were open to a range of other allied health professionals and carer and service users who met the admission criteria.

With reference to admissions and target numbers, less than one third achieved their target intake for 2008-09, with just under half not successfully meeting their targets. Over half of the courses with difficulty achieving their targets were at postgraduate level, and a substantial proportion of these were within nursing schools/departments. All courses leading to professional qualifications in psychology and social work indicated that they had achieved the target numbers.

An analysis of student attendance on the multidisciplinary courses per department/school for the year 2008-09 revealed that doctors and nurses tend to attend courses run by their own departments/schools.

From the courses surveyed, there appears to be a wide distribution of lecturing staff from all professional backgrounds teaching on the programmes. In addition, a quarter of the courses have service user involvement but few accommodate carer involvement in teaching. Teaching staff are expected to keep up-to-date with policy, service and practice developments through reading, research, policy and theoretical literature, continuing professional development, and researching issues in practice. However, spending time teaching students in practice, carrying a case load or spending time on service, and clinical developments are less frequently used strategies. Attending clinical supervision was identified by a very small cohort, and these came from respondents completing questionnaires for courses in counselling, psychotherapy and applied psychology.

While the didactic and lecture format was favoured as a teaching method, self-directed and experiential learning approaches were also employed. Both problem- and practice-based learning strategies were detailed by more than half the courses but very few indicated that online or distance learning was utilised. A variety of assessment methods were specified by courses and with the exceptions of direct observation of practice and OSCEs, these involved some form of written assignments. Some courses require a placement or supervised sessions for students.

In terms of quality assurance mechanisms, most courses have an external examiner and receive formal feedback from students. Various other mechanisms were detailed as utilised including feedback from professional accreditation bodies, management committees and lecturing staff. However, formal feedback from health service providers, service users or carers were infrequently reported.

Service users were involved in 37% of the courses surveyed by providing teaching about their experiences. Few were involved in other educational aspects of the courses, such as course design and evaluation, and the selection or assessment of students. Of those who indicated that there was no service user involvement, nearly half expressed their intention to include service users in educational provision at some point in the future.

Analysis of the question on the degree of emphasis given within the curricula to theoretical and clinical issues deemed important in education of mental health professionals indicated that 10% of courses placed no emphasis, and 13% indicating a weak emphasis on these issues were identified.

Question 18 requested information on the degree of emphasis placed on policy and legal documents deemed important. Analysis of this question indicated that the documents are poorly emphasised within curricula across all courses and within all departments. Only 36% of courses placed either a very strong or strong emphasis on the policy documents within curricula. In addition, 31% of courses placed no emphasis on these documents.

Section 5:

Presentation of Findings on the Qualitative Aspects of the Survey

Section 5:

Presentation of Findings on the Qualitative Aspects of the Survey

Introduction

This section reports the findings of questions that requested qualitative responses to the questions asked in the survey (Q.33-36 on the questionnaire). These questions related to information on whether or not respondents perceived their school/department was in a position to develop other education/training courses for mental health professionals, and questions related to what respondents saw as priorities for education and barriers to future developments. The letter sent to Heads of School/Department gave a further opportunity to comment in this regard and the findings of both are merged within this section. In addition, areas of best practice as identified by the respondents are included in this section.

Future Course Development

In total 73% (n=90) of the respondents completed the question (Q.34) that requested information on whether they are in a position to develop other education/training courses for mental health professionals. Responses included reference to education programmes ranging from certificate to doctorate level. In addition, some respondents mentioned their availability to develop and deliver continuing professional development courses. The remaining 27% (n= 34) of respondents indicated that there are several barriers to developing new educational programmes for mental health professionals.

The barriers reported are mainly lack of funding, lack of resources, restriction on releasing staff from work to attend the course, too many similar courses elsewhere, lack of an interdisciplinary centre in the college, and increased workload on the teaching faculty. Three (2%) respondents reported that they have ceased delivering a particular mental health programme in the last three years (Q.33) but the reasons for doing so were not given.

The education and continuing professional development programmes that respondents indicated they would be in a position to develop and deliver are listed on table 16.

Priorities for the Education of Mental Health Professionals in the Future

Respondents were asked to identify the top three priorities for the education of mental health professionals in the future. In total 107 Course Coordinators/Directors and 23 Heads of Department returned responses to this question. The priorities identified ranged across a wide variety of clinical, educational, and financial issues. An overview of the key issues identified is presented under the following nine categories:

Table 16: List of courses that may be developed in the future for mental health professionals

Level	Focus
Diploma	Solution Focused Behaviour Therapy Clinical Psychotherapy
Higher diploma	Mental Health Psychotherapy Studies
Postgraduate diploma	Communication Abilities and Disability in People with Mental Health Disorders Child and Adolescent Mental Health Cognitive Behaviour Therapy Eating Disorders
Masters	Adolescent Mental Health Care of Older People Dementia Mental Health Nursing Health Care Practice Psychoanalytic Psychotherapy Psychoanalysis Supervision of Professional Practice
Doctorate	Applied Behaviour Analysis Supervision of Professional Practice Psychotherapy
Continuing professional development	Addiction Assessment and Treatment of People with a Diagnosis of Personality Disorder Anger Management Learning Disability and Mental Health Motivational Interviewing Neuroscience and Mental Health Psychopharmacology and Mental Health Risk Assessment and Management Working with Depression and Anxiety

Table 17:
Key priorities for education in the future

Development of competencies
Interdisciplinary/multidisciplinary education Recovery / social inclusion
Service user involvement
Clinical supervision/personal development
Models of education delivery
Research and evidence-based practice
Funding
Community-based approaches

Development of competencies

All respondents mentioned the need for education to focus on the development of competencies in a number of key areas, and listed subject areas for the development of education programmes (Appendix 13). In this regard, the following areas were mentioned: psychotherapeutic interventions, recovery and social inclusion, needs of specific client groups, new models of service delivery, multicultural awareness, and leadership and management.

Many of the respondents mentioned some aspect of psychosocial or psychotherapeutic interventions, such as the need for education in 'therapeutic relationship skills', 'counselling skills', 'solution-focused therapy skills', 'cognitive behaviour skills' and 'family therapy skills'. Emphasis was placed on the need to include some aspects of these skills for all professionals working in mental health, at undergraduate and postgraduate level.

Development of knowledge and competencies in the area of recovery, social inclusion and advocacy was also identified as a priority for education. Respondents expressed the view that professionals needed education on the recovery and advocacy philosophy and thinking, in order that 'recovery orientated practices' or a 'solution-focused recovery approach' could be developed and implemented.

Education on the needs and care of the following specific client groups was also identified: acute mental health, older people and people experiencing dementia, children and

adolescents, complex family needs, and physical health needs of service users.

Some respondents indicated that further education was needed to inform staff of changes in policy and legislation. Respondents expressed the view that there was a need for education on new models of service delivery, the development of 'needs-led services', 'legislative changes' and the development of education programmes that focused on creative approaches towards community working.

'Multi-cultural training', 'working trans-culturally', 'cross-cultural awareness' and 'human rights' education were other areas listed as educational priorities among some respondents.

Respondents who listed leadership and management as their priority for the future identified education in the areas of 'leadership development', 'change management', 'governance', and 'supervision and management' as their top priorities.

Interdisciplinary/multidisciplinary education

Respondents were of the view that the development of 'interprofessional learning' and 'multidisciplinary' education and training programmes were a top priority for the education of mental health professionals in the future. Respondents were of the view that more opportunities for interdisciplinary learning needed to be developed at undergraduate as well as postgraduate level and that education programmes need to be based on a models such as the UK's *New Ways of Working* (DoH (UK) 2005) or *Ten Essential Capabilities* (Department of Health (UK) 2004). Interdisciplinary/multidisciplinary education was viewed as a means of enhancing 'collaborative working', 'interdisciplinary working' and 'team engagement'.

Recovery and social inclusion

Both of these important aspects of client welfare have been addressed through various publications, particularly in the last two years. Again, this area was of particular note to the Heads of Schools/Departments as well as within the questionnaires returned by the Course Coordinators/Directors.

Service user and carer involvement

Many of the respondents stressed the importance of developing 'meaningful collaborative partnerships with service users' and identified the involvement of service user and carer involvement in course design and development as a top priority for the education of mental health professionals. Respondents acknowledged the importance of keeping practice 'client centered' and including service users and carers in planning services and education, while others identified the need to develop 'collaborative research with service users and carers' as priorities for the future. The development of well-designed evaluation strategies for programmes, with the inclusion of service user outcomes, were other specific priorities identified by respondents in the area of service user involvement.

Clinical supervision/personal development

Some of the respondents identified self-care or support as a priority for the education of mental health professionals in the future. 'Education about self-care' and a 'thorough understanding of internal psychic processes of oneself, others and organisation' was viewed as essential for effective therapeutic care and practice. Within this category the importance of 'clinical supervision', 'personal psychotherapy' and 'personal development' were highlighted.

Models of education delivery

Some respondent's mentioned the need to develop more user friendly models of education delivery, such as online learning, distance learning and 'stand alone' modules. A small number of respondents mentioned the need to develop practice components to education programmes, where students would get the opportunity to 'observe practice' and work with a mentor. Some respondents commented on the need to ensure that courses developed were 'clinically relevant' and taught by 'lecturers having clinical experience'. Many of the respondents identified the need for more courses at 'advanced practice', 'masters' and 'doctorate' level to increase the critical mass of mental health professionals' working in practice areas educated to these levels.

Research and evidence-based practice

Respondents expressed the view that there was an urgent need to increase research capability and develop 'competent researchers' within health professionals working in mental health as important. In addition, respondents stressed the need for more research into mental health issues, and more 'collaborative research' with service users. 'Dissemination of findings' and the 'implementation of research findings into practice' were also seen as key priorities. In addition, a number of respondents identified the importance of 'evidence-based approaches' and 'research' underpinning all education programmes.

Funding

The availability of sufficient funding was also viewed as a priority for the education of mental health professionals in the future. Participants expressed the view that without adequate funding and investment into education, continuous professional development, service development and research, that many of the current initiatives would cease.

Community Based Approaches

This aspect was mentioned particularly by the Heads of Schools/Departments on their responses. Respondents clearly recognised the need for competent practitioners to deliver the comprehensive roll out of the *Vision for Change* policy document. In this regard, they emphasised the need for clinicians to be knowledgeable about the ramifications and implications for mental health care delivery within the community and home setting.

Table 18: Course Coordinator and Head of Department priorities for the future education of mental health professionals.			
Priorities for the future	**Priority 1**	**Priority 2**	**Priority 3**
Development of competencies	24 (18%)	33 (27%)	14 (13%)
Interdisciplinary/ multidisciplinary education	19 (15%)	26 (21%)	24 (22%)
Recovery/ social inclusion	12 (9%)	19 (16%)	13 (12%)
Service user involvement	20 (15%)	8 (7%)	13 (12%)
Clinical supervision/personal development	15 (12%)	7 (6%)	16 (15%)
Models of education delivery	18 (14%)	9 (7%)	8 (8%)
Research and evidence-based practice	5 (4%)	8 (6%)	10 (9%)
Funding	9 (7%)	7 (6%)	4 (4%)
Community-based approaches	8 (6%)	5 (4%)	5 (5%)
Total	130 (100%)	122 (100%)	107 (100%)

Examples of Best Practice

As indicated previously Course Coordinators/Directors were asked to identify in the questionnaire (Q.37) facets of best practice used within the course and requested to return a form, with their details, if they were willing to be contacted by a member of the research team to elaborate further their response. The majority of the comments on the questionnaires in relation to best practice were stated in phrases rather than in sentence format (Appendix 14 provides a summary of the emergent themes). In total 72 Course Coordinators/Directors returned the form agreeing to be contacted. The research team re-examined the qualitative comments on the corresponding 72 questionnaires, however, as stated many of the Course Coordinators/Directors did not provide sufficient information within the questionnaire on examples of best practice to warrant follow up. Of those Course Coordinators/Directors who provided some information, 16 best practice comments were selected for follow up. The examples of best or innovative practices are identified under the following six themes:

Table 19:
Best practice themes

Service user involvement
Interdisciplinary learning
Dissemination of course material
Initiatives in teaching, assessment and delivery
Links to practice
Clinical supervision and personal analysis/therapy

Theme 1: Service User Involvement

BSc (Hons) in Psychiatric Nursing , Dublin City University

The School of Nursing, DCU, has over recent years employed two people with personal experience of using mental health services. The justification of employing „experts by experience' in the world of academia has been demonstrated through student evaluations, with a significant number of students valuing the inclusion of the lecturer's real life experiences as an aid to understanding the complex topic of mental health. Bringing together the worlds of theory and practice through the lived experience has brought dividends to the ethical and practical dimensions involved in the education of mental health nursing students

PG Dip in Nursing (Mental Health, Community and In-Patient Acute Care) NUIG

The development of the Postgraduate Diploma in Nursing (Mental Health, Community and In- Patient Care) was underpinned by the philosophy of user involvement. In designing the curriculum the Curriculum Steering Group formed partnerships and collaboration with all stakeholders including academics, mental health service users and local mental health care providers. The partnership approach facilitated and ensured that the curriculum was designed to the mutual satisfaction of academics and the people who use and work within mental health services. Service users are involved in both teaching and course management, and attend all the programme committee meetings.

Bachelor of Social Work (BSW) and Masters in Social Work , UCC

The mental health teaching on social work programs does not emphasise psychopathology. Focus is on developing holistic understandings of mental health by looking at people's experiences of distress in the context of their lives. To achieve this, and in an effort to contribute to a more democratic, user-centred approach to mental health care the concept of 'practitioner' has been broadened to include „experts by experience'. Service users are involved in the areas of: teaching, conference organisation, student selection (undergraduate programme since 2006) and course accreditation (undergraduate programme). A group of five service users, as part of a „service user forum', worked with the course team in preparation for the 2009 accreditation of the BSW program and met with the accreditation panel in February 2009.

Theme 2: Interdisciplinary learning

PG Dip /MSc in Mental Health (Child, adolescent and family strand) Trinity College Dublin

This programme is a multidisciplinary programme. Students on the programme come from different disciplines including nursing, medicine, social work, legal, psychology, psychotherapy, the prison service and voluntary agencies. The programme provides a forum for the range of professions to develop the knowledge and skills to critique key issues in relation to mental health practice, policy and research, while enhancing collaboration between all disciplines concerned.

Educational input for this programme is provided by the range of stakeholders including members of the multidisciplinary team, service users, and carers. Service users are involved in teaching about own experience, service users led research and peer support. Service providers, service users and academics are also involved in supervision and clinical assessments. A representative from the service user's executive is a member of the school ethics committee where students on this course send their proposals for research.

BSc (Hons) Speech and Language Therapy, NUIG

This course has a module entitled module „Communication and Mental Health'. The aim of the module is to introduce students to the field of mental health and in particular the role of the speech and language therapist as a member of the multi-disciplinary team in the management of individuals with communication disorders associated with psychopathology. This module also has an interdisciplinary component as occupational therapy students also attend the lecture component to this module.

Bachelor of Social Work, UCC

Inter-disciplinary seminars are held with Social Work & Occupational Therapy students. These seminars are facilitated by service users who use interactive methods, drawing on personal accounts of recovery, and multidisciplinary interaction around case studies. The seminars provide opportunities for reflecting on the various skills different professionals bring to care from both user and inter-professional perspectives.

Theme 3: Dissemination of course materials

MSc in Healthcare Management, RCSI / Institute of Leadership and Healthcare Management
On this course podcasting is utilised to support other teaching methods such as lectures and tutorials. The podcasts are short inputs on a range of topics and benefit students, as they can access and listen to this material at their convenience. Students are also encouraged to „broad scan', knowing a „little about everything' around the course and its material in order to be able to connect more fully with people. This is perceived as allowing for the provision of a more holistic approach to the course and course material.

BSc (Hons) Psychiatric Nursing, Dundalk Institute of Technology.
Podcasting has recently been introduced on this course in an attempt to address a much wider audience about nursing issues. Students can listen to podcasts on the web and download them to an IPod and listen on the move. The podcast team with responsibility for developing and co- ordination is composed of nursing students and a nurse lecturer. Under the direction of the nurse lecturer, the recording of sessions are edited and returned in a shorter version. The podcast is accessible to students on a website or through group email. The podcasts are interactive as the students are asked to provide feedback to the team.

Bachelor of Nursing Science (Psychiatric Nursing), NUIG
Text Messaging (Short Messaging Service/SMS) has been integrated within the undergraduate and postgraduate mental health nursing programmes as a strategy to improve communication and support mechanisms between students and tutors. Benefits, as reported by students, have included direct access to the programme tutor for advice and support during clinical placement 1and project work.

Theme 4: Initiatives in teaching, assessment and delivery

Diploma in Psychology (conversion for postgraduate students), Open University

The unique aspect of the programme is that it is the only distance-learning programme of its kind in the Republic of Ireland. Few such courses allow students to study part-time, over an unspecified period of time. The programme achieves that aim, which means that students proceed at their own pace, taking components of the programme as and when they can. An additional aspect of the programme is that students undertake project work through a variety of methods, including face-to-face tuition, day schools, telephone tuition, correspondence tuition and online project work.

BSc (Hons) Speech and Language Therapy, NUIG

This course includes a module on communication and mental health. The assessment for the module comprises of a Group Project presentation to a panel of two experts and two practitioners, with 10 minutes of questions from the panel. The focus of the presentation is on Speech and Language in mental health and its role vis a vis the Vision for Change. The second aspect of assessment is an individual review of 3 relevant journal articles relating to Speech and Language in mental health care.

MSc Quality and Safety in Healthcare, RCS1

On this programme guests from quality and safety specific associations/roles are invited to present e.g. Clinical Incident Scheme, Quality & Risk, Clinical Audit, Accreditation etc so that the participants hear first-hand the most up-to-date information and application of current policies. A representative from the Patient Advocacy Group is invited to teach on the programme. As a part of the programme students engage in debates and representatives from HIQA, ISHAB, Quality & Risk and a CEO are part of the judging panel. This gives the participants the skills to be able to put forward their arguments in a focused and evidence-based way. Students also work in pairs to design posters on a quality and safety topic.

Theme 5: Linking education to practice

BSc Occupational Therapy, Trinity College Dublin

Students on the programme are required to produce a piece of work in their final year on the 'study of occupation', which requires a description of the supports for occupational engagement with a particular client they worked with during placement experience. The project requires evidence of the clients perspective and the student therapist perspective at initial, mid and end stage in the working relationship over a placement length of approx 9 weeks. The assignment requires the student to describe the context of the placement, including mission statement, stated values, and the social and cultural context in which the service is embedded. Self assessment is also part of this as the student has to review the process and critique their own work.

PG Dip Nursing (Mental Health), UCC

One of the aims of this course is to equip the students with leadership and change management skills to implement this change in a planned and professional manner. Both the programme and the assessments are very practice focused to enhance evidence based practice. Within this programme there is a module on practice development, and students as part of the module are required to develop and implement a change in practice, in their clinical area, based on the best evidence. On the positive side, students feel more confident when implementing changes and in some instances students have gone on to develop nurse led services, for example in the area of substance abuse. Students on the course are supported by a clinical and practice facilitator. This has aided their development and provided support to advance their skills and implementing change. It has also served to build and maintain the relationship between college and service. The Post Graduate Management Committee has ensured continued links with service users to ensure service needs are being addressed.

Master of Health Sciences (Nursing), NUIG

The programme involves 4 core modules, 3 of which require the students to apply/use their specialist practice to guide the assessments they submit. For example, the research they undertake will be in their area, and their analysis of ethical practice would be focused on their area of practice. There are also 4 optional modules they can take, 2 of which are contract learning modules where the student identifies their own learning objectives and outcomes related to practice and policy within their specialist area.

MSc in Applied Psychology, TCD

This course has been designed to have relevance to applied and professional psychology. A range of optional modules has been devised in order to provide students with suitable subject matter for study that will enhance and develop knowledge and applied practice in their chosen arena of professional and career development. The core focus of the course as a whole is on facilitating students in developing knowledge and skills surrounding evidence-based practice under the aegis of the scientist-practitioner model. The course is situated professionally in the domain of Early Professional Development for applied psychologists. It is aligned with occupational standards in professional psychology, and develops many of the required skills and knowledge components of the competency model in terms of its learning outcomes. The nature of delivery of the course (within timetabling and resource constraints) allows the vast majority of students to continue working as Assistant Psychologists, or in positions where they can apply their professional skill sets within appropriate domains and with relevant populations. The nature of this employment enhances the quality of research completed as part of the course for the dissertation; indeed, the benchmark target for this element of the course is that the study should result in a peer-reviewed publication.

Theme 6: Clinical Supervision and Personal analysis

MA Psychoanalytic Psychotherapy, Independent College

The focus of this Masters programme is on clinical practice. One of the requirements of the programme is that students undertake personal analysis for the two-year duration of the course. Analysis provides a space for the student to work through personal issues in order that their work with clients is kept free from the student's difficulties/issues, which can be of some significance especially at the beginning of training. It also enables the student to engage with the theory at an intellectual and a personal level. The belief is that the theory without experience of the clinical on a personal level is empty and devoid of meaning. In addition to supervision of casework by the course team, students are required to be engaged in external clinical supervision, to further allow them to discuss their client work. Students' casework, in addition to the personal analysis and supervision, contributes to the mark that the student will obtain. Students who do not engage in analysis or supervision during the course are deemed not to have completed the course.

Summary

Many of the respondents in this study outlined their commitment to the development of various courses for mental health professionals from certificate through to doctorate level. Respondents to this study highlighted their key priorities for the future education of mental health professionals and the majority of these highlight a commitment to best practice in education. Increased interdisciplinary/multidisciplinary education and the development of competencies among professionals were the two most popular priorities identified by respondents. Other top priorities included: increased service user involvement, more community based approaches, committing to recovery/social inclusion, increased research and evidence based practice, developing clinical supervision/personal development, and utilisation of models of education delivery. However, it is clear that the prospect of future course development for mental health professionals may be hampered by a lack of funding and resources.

Some respondents identified a number of areas of best practice in education on their courses including: service user involvement, interdisciplinary learning, dissemination of course material, initiatives in teaching, assessment and delivery, links to practice, clinical supervision, and personal analysis. While it is clear that there are currently a number of courses including areas of best practice, what is more evident is the ongoing commitment of the respondents to developing best practice within their respective courses, highlighted through their top priorities for the education of mental health professionals in the future.

Section 6:

Discussion and Recommendations

Section 6:

Discussion and Recommendations

Introduction

This section provides a discussion of the findings of the study and offers some key recommendations for improvements, developments, and sustainability of education programmes. The discussion and recommendations are addressed under five main headings: course developments to meet contemporary and future needs, interprofessional education, service user/carer involvement, clinical supervision, and evidence-based practice. In addition the limitations of the study are discussed, in order that the findings are interpreted in context.

Course Developments to Meet Contemporary and Future Needs

Mental health practitioners are facing some of the greatest challenges ever encountered. Throughout Europe, mental health services are shifting from an institutional model towards a comprehensive, integrated, community-based mode of delivery. Similar to mental health services in other European countries, the Mental Health Services in Ireland are also undergoing unprecedented levels of change and are responding to the recommendations of the national policy document *A Vision for Change: Report of the Expert Group on Mental Health Policy* (Department of Health and Children 2006) and the reforming Mental Health Legislation (Government of Ireland 2001). Recent policy initiatives and guidance documents have continuously emphasised the provision of a quality service, highlighting the need to develop a holistic, seamless, socially inclusive, recovery- and empowering-oriented service, which fosters active partnerships between service users/carers and professionals (Department of Health and Children 2006; 2007; 2008; Mental Health Commission (Irl) 2005; National Economic and Social Forum 2007). Prominence is also placed on future services that are delivered in the context of the best available evidence and interdisciplinary working (Department of Health and Children 2006; Mental Health Commission 2006; 2007).

Increasingly there is recognition that the education and development of the workforce is a critical step in the provision of the kind of care envisioned. Having a high quality, well educated and motivated workforce is key for the successful implementation of the directives outlined in *A Vision for Change: Report of the Expert Group on Mental Health Policy* (Department of Health and Children 2006) and *The Quality Framework for Mental Health Services in Ireland* (Mental Health Commission 2007). One of the quality markers identified, by users of mental health services, in the document *Quality in Mental Health - Your Views* was the need for services to be delivered by highly-skilled multidisciplinary teams (Mental Health Commission 2005). The emphasis on staff expertise is also reiterated by the Mental Health Commission in *The Quality Framework for Mental Health Services in Ireland.* Theme Seven of this document identifies staff skills, competencies and expertise as the key enablers required if service users are to experience a quality mental health service (Mental Health Commission 2007). Practitioners working with people who experience mental health problems not only require core values, attitudes, knowledge, and competencies, but they also need the ability to apply these in practice, across a range of clinical contexts. Therefore, the provision of high-quality education and training that is responsive, relevant, accessible, and evidence-based is critical, if the modernisation agenda, and the vision for quality mental health services articulated in all of the recent publications, is to be realised. Findings from this study suggest that while there are a variety of courses for professionals working in mental health to choose from there are still a number of gaps in education provision.

The respondents in this study have identified a number of priority areas for future development in education, including: development of competencies, interdisciplinary/ multidisciplinary education, service user involvement, recovery/social inclusion, and community-based approaches. Primarily, respondents were of the view that contemporary MDT members require specific knowledge and expertise in therapeutic approaches/interventions that are less dependent on the traditional medical model of care, and expertise in

working with both the person and family in the context of interprofessional working. Education on the needs and care of the following specific client groups was also identified: acute mental health, older people and people experiencing dementia, children and adolescents, complex family needs, multiculturalism, and physical health needs of service users. In addition, respondents flagged a range of issues that challenge course delivery. These include funding challenges, recruitment issues (particularly at postgraduate level), and developing new modes of course delivery.

While it is evident that there is some degree of flexibility in course delivery (including a range of exit points from postgraduate courses), currently many courses, particularly at postgraduate level, do not have a part-time option for students. Few courses utilise online, blended or distance learning. In relation to continuing professional development, it is interesting to note that 61% of courses are self-financing and this may suggest a high degree of individual motivation to complete courses. Distance-learning approaches would enable the student to continue to work full-time with less cost incurred from campus-based education e.g. accommodation, travel. Indeed these approaches may foster a greater culture of life-long learning (Graham 2005). As the Bologna process seeks to establish an integrated European Higher Education Area (EHEA) by 2010, the issue of transferability of learning across Europe needs to be considered.

Teaching staff are expected to keep up-to-date through reading and researching issues in practice. However, the findings of this study suggest that spending time teaching students in practice, carrying a case load or spending time on clinical developments are less frequently used strategies. In terms of quality assurance mechanisms, most courses have an external examiner and receive formal feedback from students. However, formal feedback from health service providers, service users or carers were infrequently reported. It is also worthy to note that, although a high number of courses have placed a strong emphasis on the theoretical and clinical issues deemed important in education of mental health professionals, this was not the case in relation to the policy and legal documents listed. Here respondents seemed less sure of their relevance, with 41% of courses having a weak or no emphasis.

Recommendations for Course Development:

- While the current and future priorities for mental health training and education have been identified in this report, a long-term strategic plan is indicated. Further consultations among all the relevant stakeholders (e.g. HEIs, HSE, MHC) are required for educational partnerships to develop an interprofessional approach to education and training of mental health professionals to be more fully explored and implemented.

- The HSE in partnership with HEIs and the MHC should develop an education strategy that will identify educational needs at local and national level.

- In the current economic climate, training and education for mental health care professionals must continue to be developed in an integrated manner and in liaison with health care providers and professional bodies.

- Course development needs to take place in line with contemporary service requirements, aligned to service policy and needs, and take cognisance of those priorities identified by the respondents in this study.

- There is a need for more imaginative ways to marry health service needs as regards maintaining contemporary skills, with the individual needs of students. HEIs should be encouraged and supported in the development of a variety of flexible learning approaches and methodologies. The creation and delivery of stand alone modules could offer students a greater degree of flexibility towards Level Eight and Level Nine programmes of study. Online and blended learning would facilitate students to engage in programmes through the process of distance learning and enable students to access learning materials at their convenience.

- Education programmes need to be underpinned by a recovery and social inclusion philosophy of practice, and greater emphasis placed on policy and practice documents that are fundamental to service development and delivery.

- Ongoing evaluation and quality assurance strategies are a key element of governance. In addition to the current evaluation and quality practices identified in the study there is a need to develop strategies that explore the impact of education programmes on service provision and health outcomes, incorporating the perspectives of service providers, service users and carers.

- As less than half of courses succeeded in filling their entire course places, this information needs to be carefully examined locally and nationally in relation to course viability and resource effectiveness.

- Postgraduate pathways for certain disciplines, such as SLT and OT need to be explored and developed if there are to be sufficient numbers interested in working in the area of mental health in the future.

- It is essential that student learning, both at undergraduate and postgraduate level should receive adequate funding and other supports.

- Although not the focus of this study, there is a need to explore provision of short continuing professional development courses, either within the HEI or within clinical sites. This may involve the HEIs strengthening links with care providers and delivering programmes on an outreach basis.

Interprofessional Education

Proponents of IPE view it as a means of cultivating the necessary attitudes, knowledge and skills to promote effective team working required for client benefit (Barr 2002; Carpenter 1995; Hoffman et al. 2008). Shared learning is said to 'cultivate an ethos of co-operation between disciplines and provide opportunities for enhanced understanding of each other's roles in health care delivery' (Government of Ireland 2000:61). The expectation is that learning together will foster mutual respect and enhance understanding of professional roles and responsibilities, and consequently each professional discipline will practice more efficiently and effectively towards the ultimate goal of improved patient care and client outcomes (Freeth et al. 2005; Mental Health Commission 2006; Singleton and Green-Hernandez 1998).

Offering IPE early at third level is considered key to developing mutual understanding and respect for one another's roles, which will provide a basis for professional and wider team working, networking and learning in the future. Findings from this study suggest that shared learning is very underdeveloped at undergraduate level. Although a number of multidisciplinary programmes exist at postgraduate level, and are located in a variety of departments, they are primarily focused in very specialist areas such as psychotherapy, management, health promotion and education. An analysis of student attendance on the multidisciplinary courses per department/school for the year 2008-09 revealed that doctors and nurses have a propensity to attend courses run by their own departments/schools. Although some experiential learning approaches are used within these courses, the lecture and written examination continue to be the primary method of teaching and assessment.

Strategic embedding of interprofessional learning requires a high degree of collaborative planning and resources, as well as individual and institutional commitment. The imperatives that exist for each professional discipline to meet professional training requirements, in respect of course content and minimum periods of instruction, can be particularly challenging. Therefore attention needs to be given to structures and processes required to facilitate interprofessional teaching, learning and assessment.

Recommendations for interprofessional education:

- In order to promote an educational culture with respect to interprofessional learning, adequate financial resource must be committed to support this change.

- HEIs, in partnership with service providers, need to identify core elements of education programmes, at both undergraduate and postgraduate level, that are applicable to all professions and suitable for interprofessional education.

- HEIs, in partnership with service providers, need to develop work-based interprofessional learning initiatives.

- HEIs and service providers need to engage in a consultative dialogue with accreditation organisations and professional bodies so that their requirement and needs are acknowledged from the outset. The development of a single inclusive validation framework in the long term may be worthy of consideration.

- Professional accrediting bodies need to adopt a facilitative approach to interprofessional education and enable both HEI's and service providers' autonomy to develop creative and innovative programmes to meet the challenges of today's health care environment.

- Alongside the need to engage in dialogue with professional organisations and accrediting bodies there is a need to prepare teachers for IPE. It may be naïve to assume that lecturers/teachers can teach on IPE programmes without preparation, therefore we recommend that consideration be given to providing education on both the development of IPE curricula and the skills necessary to facilitate IPE and assess learning outcomes. In the absence of this, educators may simply resort to a multidisciplinary model of education, where people sit and learn in the same environment, but not 'from' or 'about' each others roles and contributions.

- Educators need to move away from the traditional didactic lecture approach to a greater emphasis on facilitation and small group learning. This necessitates a greater emphasis being placed within curricula on interactive and discovery styles of learning, such as action-learning sets and problem- or enquiry-based learning.

- It cannot be assumed that providing opportunities for practitioners to learn collaboratively in higher education institutions will result in collaborative

Table 20: Ladder of service user involvement	
Level 1: No involvement	Curriculum planned and delivered with no consultation or involvement.
Level 2: Limited involvement	Service users/carers invited to 'tell their story' but no opportunity to participate in shaping the course.
Level 3: Growing involvement	Service users/carers contribute regularly to at least two of the following: planning, delivery, student selection, assessment, management, or evaluation. However, key decisions on curricula are made in forums in which service users/carers are not represented. Payment is made at the normal lecturer rate but there is no consistent support, supervision or training available.
Level 4: Collaboration	Service users/carers contribute to key decisions on all matters of curriculum and are involved as full team members in at least three of the following: planning, delivery, student selection, assessment, management, or evaluation. There is regular provision of training, supervision and support, and positive steps are taken to encourage service users/carers to access programmes as students.
Level 5: Partnership	Service users/carers and teaching staff work together systematically and strategically across all areas- and this is underpinned by an explicit statement of values. All key decisions are made jointly. Service users and carers are employed as lecturers on secure or long-term contracts. Positive steps are taken to encourage service users/carers to join programmes as learners even if not in a position to achieve qualifications.

interprofessional team work in practice. Therefore to ensure there is no dissonance between education and practice, health service providers need to continue to promote the concept of interprofessional collaboration within practice.

- There is also a need for further rigorous evaluation studies on the impact of IPE on practice, health care processes, and client and family outcomes.

Service User and Carer Involvement

Meaningful involvement of service users and carers requires a broad strategy that encompasses users and carers being involved in the planning, design, delivery, evaluation and management of programmes, the teaching and assessment of students in both the classroom and practice area, and the recruitment and selection of students (Barnes et al. 2000; Barnes et al. 2006; Brooker and Curren 2005; Tew et al. 2004; Townend et al. 2008). Tew et al.(2004:54) describes the following five levels of service user involvement in education.

Findings from this study indicate that in the vast majority of courses (63%), curricula are planned and delivered without consultation or input from service users/carers, in other words involvement is at level 1 of Tew et al.'s (2004) ladder of involvement. However, there is evidence that this is changing and some courses are at an early stage of development and gradually progressing to level 2 and 3, with many respondents indicating an eagerness to move this agenda forward. Achieving effective service user and carer involvement demands commitment, time, strategic planning as well as the financial resources and infrastructures to support such an initiative. Unless service user and carer involvement becomes part of the process of accreditation, commissioning and funding of courses, their involvement will remain at a limited level and participation at the level of full partnership will largely remain an aspiration.

Recommendations for service user involvement:

- HEIs in partnership with the service user groups, health service providers, and professional bodies need to develop an overall strategy for the involvement of service users/carers in education. This strategy needs to address issues such as educational preparation, support and payment of service users/carers, as well as a strategy for evaluation.

- HEIs should review their philosophy/mission statements to ensure that they are underpinned by an explicit statement of values supporting service user/carer involvement in educational programmes in their institution/school/department.

- HEIs should collaborate with each other and service user/carer groups in the development and delivery of training for service users and carers who are contributing to programmes.

- HEIs need to broaden the scope of service user involvement beyond teaching into more areas of education, including assessment and student selection.

- Professional bodies with responsibility for guiding or accrediting curricula in mental health education have an important role in promoting service user/carer involvement and should include service user and carer involvement as one of the criteria for accreditation.

Clinical Supervision

Clinical supervision has had a relatively long tradition in psychiatry (Clarke 1993), clinical and counselling psychology, (Bernard and Goodyear 2004; Fleming and Steen 2004), social work (Kadushin 1985) and more recently in nursing (Butterworth 1992), occupational therapy (Fone 2006), and speech and language therapy (Geller 2002). The reported benefits of clinical supervision among health professionals, as detailed in the cross-disciplinary study by Strong et al. (2002), relate to professional development, support, assistance with organisational issues, greater discipline identity and development of new skills in the practitioner. Greater adherence to quality assurance measures and best practice principles were also noted. These findings have been endorsed in the literature and in summary refer to enhanced clinical competence (Dudley and Butterworth 1994; Fone 2006; McCrea and Brasseur 2003; Scaife 2001; Wheeler and Richards 2007) and enhanced well-being (Fone 2006; Howard 2008; Sloan and Watson 1997; Veeramah 2002).

These benefits have been reflected in the findings of this study. 63% of respondents placed 'some' to 'strong' emphasis on clinical supervision in their curricula and developing competency in clinical supervision was seen by some as a priority. Supervision was conceptualised by some as a form of self-care and as a means to remain up-to-date on policy and practice developments. A number of supervision formats (individual, team, group) were indicated and supervision was highlighted as an example of best practice. It is interesting to note that while clinical supervision is a cross disciplinary activity, most references to supervision came from the counselling/psychotherapy and applied psychology domains. This may be indicative of the centrality of clinical supervision for trainees in these areas. In the case of counselling and psychotherapy, it may also refer to the supervision mandate of relevant professional associations.

Recommendations for Clinical Supervision:

- There is a necessity for an agreed definition of clinical supervision to be developed for mental health practitioners.

- A service-wide clinical supervision policy should be developed for professionals working in mental health and adequate resources made available for the implementation of such policies and procedures.

- Key competencies for supervision in mental health need to be identified and specialised training should be made available for those who provide supervision.

- Research in this area is clearly indicated to establish the efficacy of clinical supervision with respect to client/patient outcomes and to develop, pilot and evaluate models and formats of supervision that are congruent with best practice in mental health provision.

Research and Evidence-based Practice

Increasingly, calls for research and evidence based practices (EBP) within mental health education and provision are evident in the literature (Cape and Barkham 2002; Craik et al. 1998; Forchuk 2001; Goodheart et al. 2005). Findings from this study resonate with the literature in this regard. Increasing research capability for mental health practitioners and opportunities for collaborative research were viewed by the majority of respondents as a pressing concern. Evidence-based practice was seen by many as a necessary requirement in education provision. Opportunities for the application of research findings to clinical practice and clinical practice-based research into mental health issues were also of significance to many of the respondents. The study team also noted, in the early stages of the data collection process, a considerable number of 'academic/research' PhDs but there was a dearth of clinical doctorates available and being marketed.

Recommendations for Research and Evidence-based practice:

- HEIs should review their philosophy/mission statements/course literature to ensure that they explicate an active commitment to evidence-based practice and implement pedagogical methods which support EBP education.

- HEIs should promote a research attitude and an increase in research capability for practitioners working in mental health in a manner that is cognizant of the specific practice and research context.

- HEIs, in collaboration with professional bodies that hold responsibility for guiding or accrediting curricula in mental health education, have a vital role in promoting curricula which advance research and evidence-based practice.

- In the absence of clinical PhD's, their development needs to be explored in order to provide progression and support for those wishing to remain in clinical practice

Situational Factors and Limitations

As research is subject to situational factors, the findings and implications of this study need to be interpreted with reference to the following considerations:

There was a high level of response to the survey instrument from Course Coordinators/Directors within mental health nursing, and Course Coordinators/Directors of programmes that led to professional qualifications in Social Work, Psychology, Occupational Therapy, and Speech and Language. A much lower response was achieved from Course Coordinators/Directors of courses that did not lead to a professional qualification.

95% of the Course Coordinators targeted within nursing responded to the survey. This means that 42% of the courses analysed in this survey represent the discipline of nursing and this should be considered in interpreting the findings of this study. Despite the apparently high response rate from mental health nursing, it should be noted that this group also comprised by far the greatest number of courses within the study remit.

The courses included in this study are all provided by HEIs. Other CPD education programmes for mental health professionals may be delivered within the HSE at local level or by the professional training bodies. These programmes are not included in this study.

Findings in this study are reported responses to a survey instrument; analysis of curricula documentation was not undertaken. These may have provided further relevant information on the education provided to mental health practitioners.

Interviews were not conducted with course coordinators/directors due to the short time frame provided for the study. As a result they could not elaborate on responses to questionnaires.

Some courses were suspended for 2008-09 while others had not commenced and these were not considered within the study

The research team recognise that the lack of a Social Work and Speech and Language Therapy professional/s on the study team may have been a limitation. It should however be noted that these were actively sought at the tender stage of the project and during the literature review and data analysis phases. Assistance and advice was provided by social work and speech and language at both the literature review and analysis stage.

Currently, there is not a shared language of mental health concepts across disciplines, and while this is an issue outside of the remit of the study, it may have impacted on how items on the questionnaire were interpreted.

References

An Bord Altranais. 2005. *Requirements and Standards for Nurse Registration Education Programmes*. Edited by 3rd. Dublin: An Bord Altranais.

An Bord Altranais. 2007. *Requirements and Standards for Psychiatric Nurse Post Registration Education Programme* Dublin: An Bord Altranais.

Anderson, E, D Cox, and L Thorpe. 2009. Preparation of Educators Involved in Interprofessional Education. *Journal of Interprofessional Care* 23 (1):81-94.

AOTI. 2008. *Minimum Standards for Practice Education in Ireland, Revised March 2008* Association of Occupational Therapy in Ireland.

Armstrong, D. 2002. The Rise of Surveillance Medicine. In *The Sociology of Health and Illness Reader*, edited by S. Nettleton and U. Gustafsson. Cambridge: Polity Press.

Ask Clyde. 2007. *A Literature Review and Documentary Analysis on Recovery Training in Mental Health practice*: Scottish Recovery Network http://www.scottishrecovery.net/content/.

Axiom Market Research and Consultancy. 2006. *Evaluation of Recovery Based Training for Trainers Pilot*: Axiom Market Research and Consultancy; Scottish Recovery Network and Healthier Scotland Executive. http://www.scottishrecovery.net/content/.

Bacon. 2001. *Current and Future Supply and Demand Conditions in the Market for Certain Professional Therapists*. Dublin: Stationery Office.

Baldwin, D, and M Baldwin. 2007. Interdisciplinary Education and Health Team Training: A Model for Learning and Service. *Journal of Interprofessional Care* 21 (S1):52-69.

Bambling, M, R King, P Raue, R Schweitzer, and W Lambert. 2006. Clinical Supervision: Its Influence on Client-Rated Working Alliance and Client Symptom Reduction in the Brief Treatment of Major Depression. *Psychotherapy Research* 16 (3):317 - 331.

Barnes, D, D Carpenter, and D Bailey. 2000. Partnerships with Service Users in Interprofessional Education for Community Mental Health: A Case Study. *Journal of Interprofessional Care* 14 (2):189-200.

Barnes, M, A Davis, and H Rogers. 2006. Women's Voices, Women's Choices: Experiences and Creativity in Consulting Women Users of Mental Health Services. *Journal of Mental Health* 15 (3):329-341.

Barr, H. 2002. *Interprofessional Educations: Today, Yesterday and Tomorrow. Occasional paper No 1*. London: Learning and Teaching Support Network Centre for Health Sciences and Practice.

Benjamin, L, and D Baker. 2000. History of Psychology: The Boulder Conference. *American Psychologist* 55:233-254.

Beresford, P, and S Croft. 2004. Service Users and Practitioners Reunited: The Key Component for Social Work Reform. *British Journal of Social Work* 34:53-68.

Bernard, J, and R.K Goodyear. 2004. *Fundamentals of Clinical Supervision (3rd ed.)*. Boston, MA: Allyn and Bacon.

Bernard, J, and R. K. Goodyear. 2009. *Fundamentals of Clinical Supervision.* Upper *Saddle River, New Jersey. Merrill*/Pearson Education, Inc.

Bogo, M. and McKnight, K. (2006) Clinical Supervision in Social Work. *The Clinical Supervisor,* 24(1): 49-67

Borden, K, and J Ilvried. 2008. Professional Psychology Education Training Models Sequence and Current Issues. In *Clinical Psychology: Assessment, Treatment, and Research*, edited by D. Richard and S. Huprich. New York: Academic Press.

Borrill, C, M West, D Shapiro, and A Rees. 2000. Team Working and Effectiveness in the NHS. *British Journal of Health Care Management* 6:364-371

Brooker, C , and J Curren. 2005. *National Continuous Quality Improvement Tool for Mental Health Education. Handbook and Implementation Guide*. Lincoln: University of Lincoln CCAWI.

Bruce, E J, and M. J Austin. (2001) Social Work Supervision. *The Clinical Supervisor 19*(2): 85-107

Butterworth, T. & Faugier, J. (eds). 1992. *Clinical Supervision and Mentorship in Nursing*. London: Chapman and Hall.

Buttimer, J. (2006) Preparing Ireland's Doctors to meet the Health Needs of the 21st Century; Report of the Postgraduate Medical Education and Training Group (the "Buttimer Report") DOHC: Dublin

CAIPE. 1997. Interprofessional Education: A Definition. *Centre for the Advancement of Interprofessional Education (CAIPE) Bulletin* 13:3.

CAOT. 2005. *Academic Accreditation Standards & Self Study Guide* Ontario.: CAOT Publications ACE.

Cape, J, and M Barkham. 2002. Practice Improvement Methods: Conceptual Base, Evidence-Based Research, and Practice-Based Recommendations. *British Journal of Clinical Psychology* 41 (3):285-307.

Carpenter, J. 1995. Inter-Professional Learning for Medical and Nursing Students: Evaluation of a Programme. *Medical Education* 29:265-272.

Carpenter, J, D Barnes, C Dickinson, and D Wooff. 2006. Outcomes of Interprofessional Education for Community Mental Health Services in England: The Longitudinal Evaluation of a Post Graduate Programme. *Nurse Education in Practice* 7:315-322.

Carpenter, J, D Milne, C Lombardo, and C Dickinson. 2007. Process and Outcomes of Training in Psychosocial Interventions on Mental Health: A Stepwise Approach to Evaluation. *Journal of Mental Health* 16 (4):505-520.

Chan, F, Berven, N. and K. Thomas. 2004 *Counseling Theories and Techniques for Rehabilitation Health Professionals*. New York. Springer Publishing Co Inc

Cheasty, M, A Clare, and C Collins. 1998. Relation Between Sexual Abuse in Childhood and Adult Depression: Case Control Study. *British Medical Journal* 316 (7126):198-201.

Cherry, D, L Messenger, and A Jacoby. 2000. An Examination of Training Model Outcomes in Clinical Psychology Programs. *Professional Psychology: Research and Practice* 31 (50):562-568.

Cheshire, K, and D Pilgrim. 2004. *A Short Introduction to Clinical Psychology*. London: Sage.

Christie, A. (2005) Social Work Education in Ireland: Histories and Challenges. *Portularia* 5 (1), 111-130.

Clarke, D. 1993. Supervision in the Training of a Psychiatrist. *Australian and New Zealand Journal of Psychiatry* 27 (2):306-310.

Clifton, M, C Dale, and C Bradshaw. 2006. *The Impact and Effectiveness of Inter-Professional Education in Primary Care an RCN Literature Review*, . London: Royal College of Nursing.

Clyne, A, C McCoubray, and V Hamilton. 2008. *Occupational Therapy Competencies,Therapy Project Office*. Dublin: Health Service Executive (HSE),Association of Occupational Therapists Ireland (AOTI), Irish Association of Speech and Language Therapists (IASLT), and the Irish Society of Chartered Physiotherapists (ISCP).

Cooper, H, S Braye, and R Geyer. 2004. Complexity and Interprofessional Education. *Learning in Health and Social Care* 3 (4):179-189.

Cooper, H, C Carlisle, T Gibbs, and C Watkins. 2001. Developing an Evidence Base for Interdisciplinary Learning: A Systematic Review. *Journal of Advanced Nursing* 35 (2):228-237.

Coppard, B, and A Dickerson. 2007. Descriptive Review of Occupational Therapy Education. *American Journal of Occupational Therapy* 61 (6).

Cowman, S. 2009. The European Context. In *Psychiatric and Mental Health Nursing: The Craft of Caring*, edited by P. Barker: Hodder Arnold.

CPLOL. 2007. Revised Minimum Standards for Education: http://www.cplol.eu/eng/Revised_Min_Standards_2007_la.pdf Accessed on 07th/ 05th/ 2009.

Craik, C, C Austin, J Chacksfield, G Richards, and D Schell. 1998. College of Occupational Therapists: Position Paper on the Way Ahead for Research, Education and Practice in Mental Health. *The British Journal of Occupational Therapy* 62 (9):390-392.

Creek, J. and L Lougher. 2008 *Occupational Therapy and Mental Health* (4th. Ed.). Edinburgh, UK: Churchill Livingstone.

Cromby, J, D Harper, and P Reavey. 2008. Mental Health Teaching to UK Psychology Undergraduates: Report of a Survey. *Journal of Community & Applied Social Psychology* 18: 83-90.

CUILU. 2004. *A Framework Containing Capabilities and Learning Levels Leading to Interprofessional Capability*: Combined Universities Interprofessional Learning Unit: The University of Sheffield and Sheffield Hallam University http://www.cuilu.group.shef.ac.uk/capability_framework.pdf.

CUILU. 2005. *Good Practice Guidelines for Patient and Service User Participation in Teaching and Assessing*: Combined Universities Interprofessional Learning Unit: The University of Sheffield and Sheffield Hallam University http://www.cuilu.group.shef.ac.uk.

CUILU. 2006. *Combined Universities Interprofessional Learning: Final Report*: Combined Universities Interprofessional Learning Unit. The University of Sheffield and Sheffield Hallam University : http://www.cuilu.group.shef.ac.uk/CUILU%20Final%20Report.pdf Accessed March 2009.

Curran, T. 1997. Power, Participation and Postmodernism: User and Practitioner Participation in Mental Health Social Work Education *Social Work Education* 16 (3):21-36.

Curran, V, D Sharpe, and J Forristall. 2007. Attitudes of Health Sciences Faculty Members Towards Interprofessional Teamwork and Education. *Medical Education* 41:892-896.

Cusick, A. 1999. Accreditation of Occupational Therapy Educational Programmes in Australia: Time to Do It Our Way? *Australian Journal of Occupational Therapy* 46 (60-74.).

Cusick, A, and L Adamson. 2004. Professional Accreditation of Occupational Therapy Educational Programmes: A Bright or Embattled Future? . *Australian Journal of Occupational Therapy* 51:133-143.

Cutcliffe, J, T Butterworth, and B Proctor. 2001. In *Fundamental Themes in Clinical Supervision*, edited by J. Cutcliffe, T. Butterworth and B. Proctor. London: Routledge.

Department of Health (UK). 2001. *Working Together - Learning Together: A Framework for Lifelong Learning for the NHS*. London: Department of Health (

Department of Health (UK). 2004. *The 10 Essential Shared Capabilities*. London: Department of Health.

Department of Health (UK). 2006. *From Values to Action: the Chief Nursing Officer's Review of Mental Health Nursing.* London: The Department of Health.

Department of Health and Children. 2001. *Quality and Fairness A Health System for You,*. Dublin: Government Publications.

Department of Health and Children. 2006. *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Dublin: Stationery Office.

DoH (UK). 2005. *New Ways of Working for Psychiatrists: Enhancing Effective, Person-Centred Services Through New Ways of Working in Multidisciplinary and Multi-Agency Contexts. Final Report 'but Not the End of the Story'*. London Department of Health. Publication Ref 270394A/B/C.

Dudley, M, and T. Butterworth. 1994. The Costs and some Benefits of Clinical Supervision: An Initial Exploration. *International Journal of Psychiatric Nursing Research* 1 (2):34-40.

Duffy, J. (2008) *Looking Out from the Middle: User Involvement in Health and Social Care in Northern Ireland*. Social Care Institute for Excellence, London.

Ellis, M, and N Ladany. 1997. Inferences Concerning Supervisees and Clients in Clinical Supervision. In *Handbook of Psychotherapy Supervision*, edited by C. Watkins. New York: Wiley.

Falender, C., and E Shafranske. 2007. Competence in Competency-Based Supervision Practice: Construct and Application. *Professional Psychology: Research and Practice* 38 (3):232–240.

Fleming, I, and L Steen. 2004. *Supervision and Clinical Psychology: Theory, Practice and Perspectives*. New York: Brunner-Routledge

Fone, S. 2006. Effective Supervision for Occupational Therapists: The Development and Implementation of an Information Package. *Australian Occupational Therapy Journal* 53:277-283.

Forchuk, C. 2001. Evidence-Based Psychiatric/Mental Health Nursing. *Evidence-Based Mental Health* 4:39-40.

Freeth, D, M Hammick, S Reeves, I Koppel, and H Barr. 2005. *Effective Interprofessional Education: Development, Delivery and Evaluation*. Oxford: Blackwell Publishing.

Freitas, G. 2002. The Impact of Psychotherapy Supervision on Client Outcome: A Critical Examination of Two Decades of Research. *Psychotherapy: Theory, Research, Practice, Training* 39:354-367.

Geller, E. 2002. A Reflective Model of Supervision in Speech-Language Pathology. *The Clinical Supervisor* 20 (2):191 – 200.

Gelso, C. 2006. On the Making of a Scientist-Practitioner: A Theory of Research Training and Education in Professional Psychology. *Training in Professional Psychology* S(1):3-16.

General Medical Council. 1993. *Tomorrows Doctors: Recommendations on Undergraduate Medical Education*. London: General Medical Council.

Glen, S, and S Reeves. 2004. Developing Interprofessional Education in the Pre-Registration Curricula: Mission Impossible? . *Nurse Education in Practice* 4:45-52.

Gonsalvez, C, and H McLeod. 2008. Toward the Science-Informed Practice of Clinical Supervision: The Australian context. *Australian Psychologist*, 43 (2):79-87.

Goodheart, C, and J Carter. 2008. The Proper Focus of Evidence-Based Practice in Psychology: Integration of Possibility and Probability. In *Biennial Review of Counseling Psychology*, edited by W. Walsh. New York: Routledge.

Goodheart, C, R Levant, D Barlow, and J Carter. 2005. [American Psychology Association Presidential Task Force on Evidence-Based Practice]. Evidence-Based Practice in Psychology. *American Psychologist* 61 (4):271-285.

Gordon, J, and J Cassidy. 2009. *Wellness Recovery Action Plan (WRAP) Training for BME Women: An Evaluation of Process, Cultural Appropriateness and Effectiveness*: Scottish Recovery Network http://www.scottishrecovery.net/content/ accessed April 2009.

Government of Ireland. 2000. *Nursing Education Forum: A Strategy for a Pre-Registration Nursing Education Degree Programme*. Dublin: Stationary Office.

Government of Ireland. 2001. *Mental Health Act*. Dublin: Government of Ireland.

Government of Ireland. 2005. *Health and Social Care Professionals Act* Dublin: Government of Ireland.

Government of Ireland. 1998. *Report of The Commission on Nursing: A Blueprint for the Future*. Dublin: Stationery Office.

Government of Scotland. 2006. *Rights, Relationships and Recovery: the Report of the National Review of Mental Health Nursing in Scotland*. Edinburgh: Scottish Executive.

Graham, C. R. (2005). Blended Learning Systems: Definition, Current Trends and Future Directions (pp. 3-21). In C. J. Bonk & C. R. Graham (Eds.), Handbook of Blended Learning: Global Perspectives, Local Designs San Francisco, Ca: Pfeiffer Publishing.

Grant, A. 2002. Generalist versus Specialist Approach to Pre-Registration Nursing Education Implication for the Educational Preparation of Students for First Level Practice in Psychiatric Nursing in Ireland. *All Ireland Journal of Nursing and Midwifery* 2 (6): 48-52.

Gould, N. 2006 An Inclusive approach to Knowledge for Mental Health Social Work Practice and Policy. *British Journal of Social Work* **36**, 109-125.

Gould, N., Huxley, P. & Tew, J. 2007. Finding a Direction for Social Research in Mental Health: Establishing Priorities and Developing Capacity. *Journal of Social Work* **7** (2), 179-196.

Government of Ireland. 2001. Mental Health Act Dublin: Government of Ireland.

Guerandel, A, S MacSuibhne, and K Malone. 2008. Best Evidence Medical Education and Psychiatric in Ireland: a Three Step Framework for Change. *Irish Journal of Psychological Medicine* 25 (4):120-122.

Harper, D. 2002. Involving Users of Services in Clinical Psychology Training. *Clinical Psychology Review* 21:14-19.

Harper, D, J Cromby, P Reavey, A Cooke, and J Anderson. 2007. Don't Jump Ship! New Approaches in Mental Health Teaching to Undergraduates. *The Psychologist* 20 (5):302-304.

Hawkins, P, and R. Shohet. 2007. *Supervision in the Helping Professions (3rd ed.)*

Berkshire, UK: Open University Press.

Health Service Executive. 2007 Medical Education, Training and Research: HSE Strategy. HSE: Dublin.

Hensley .P.H. 2003 The Value of Supervision. *The Clinical Supervisor* 21(1):97-110

Hoffman, S, D Rosenfield, J Gilbery, and I Oandasan. 2008. Student Leadership in Interprofessional Education: Benefits, Challenges, and Implications for Educators, Researchers and Policymakers. *Medical Education* 42:654-661.

Holland, K. 2002. Inter-Professional Education and Practice: The Role of the Teacher/Facilitator. *Nurse Education in Practice* 2 (4):221-222.

Holmes, C 2001. Postdisciplinary in Mental Health-Care: An Australian Viewpoint. *Nursing Inquiry* 8:230-239.

Horder, J 2004. Interprofessional Collaboration and Interprofessional Education. *British Journal of General Practice* 54 (501):242 - 244.

Howard, F. 2008. Managing Stress or Enhancing Well-Being? Positive Psychology's Contributions to Clinical Supervision. *Australian Psychologist* 43 (2):105-113.

Huey, D, and P Britton. 2002. A Portrait of Clinical Psychology. *Journal of Interprofessional Care* 16 (1):69-78.

Hunsley, J. 2007. Training Psychologists for Evidence-Based Practice. *Canadian Psychology* 48 (1):32-42.

IASLT. 2006. *History of Speech and Language Therapy Education in the Republic of Ireland*: Available at : http://www.iaslt.com/Documents/IASLT%20History%20of%20Speech%20and%20Language%20Therapy%20Education%20in%20the%20Republic%20of%20Ireland.pdf Accessed on 07th/ 05th/ 2009

IASSW and IFSW. 2004. *Global Standards for Social Work Education and Training*. Available from www.iassw-aiets.org or www.ifsw.org: IASSW and IFSW.

Irish Association of Social Work . 2009. Continuous Professional Development. IASW: Dublin.

Irish College of General Practitioners. 2004. Criteria for Postgraduate Training Programmes in General Practice. ICGP; Dublin

Irish College of Psychiatrists. 2005. *Psychiatry Training in the Republic of Ireland - A Resource Book for Trainees. http://www.irishpsychiatry.com/trainhbk.pdf Accessed February 2009*

Jacobs, M. 2002. That Psychotherapy and Counselling Trainings Should be Based in Universities. *European Journal of Psychotherapy & Counselling* 5 (4):347- 358.

Kadushin, A. 1985. *Supervision in Social Work (2nd ed.)*. New York: Columbia University Press.

Karandashev, V. 2008. Recent International Developments in the Teaching of Psychology. . Paper read at Third International Conference on the Teaching of Psychology (ITCP), at St. Petersburg, Russia, July 2008.

Karban, K. 2003. Social Work Education and Mental Health in a Changing World. *Social Work Education* **22** (2), 191-202.

Ker, J, L Mole, and P Bradley. 2003. Early Introduction to Interprofessional Learning: A Simulated Ward Environment. *Medical Education* 37:284-255.

Kinderman, P, and S Tai, eds. 2008. *Psychological Health and Well-Being: A New Ethos and a New Service Structure for Mental Health: A Report of the Working Group on Psychological Health and Well-Being*. Leicester, UK: British Psychological Society.

Kutner, J, J Westfall, E Morrisson, M Beach, E Jacobs, and A Rosenblatt. 2006. Facilitating Collaboration Among Academic Generalist Disciplines: A Call to Action. *Annals of Family Medicine* 4 (2):172-176.

Law, J, A Van der Gaag, W Hardcastle, J Beck, A MacGregor, and C Plunkett. 2007. Communication Support Needs: A review of the Literature. *Social Research Findings* 34:168-182.

Leahy, M.M, and M.M Supple. 2002. Education of Speech and Language Therapists in the Republic of Ireland and the UK. *Folia Phoniatrica et logopaedica* 54 (2): 87-90.

Leaviss, J. 2000. Exploring the Perceived Effect of an Undergraduate Multiprofessional Educational Intervention. *Medical Education* 34:483-486.

Levin, E. 2004. Involving Service Users and Carers in Social Work Education. Social Care Institute for Excellence Guide 4. SCIE., London.

Lorente, M, G Hogg, and J Ker. 2006. The Challenges of Initiating a Multi-Professional Skills Project. *Journal of Interprofessional Care* 20 (3):290-301.

Lubinski, R, and C Frattali. 2003. Revisiting the Professional Doctorate in Medical Speech-Language Pathology. *Journal of Medical Speech-Language Pathology* 11 (4):59-63.

Mariano, C. 1999. The Case for Interdisciplinary Collaboration. *Nursing Outlook* 37 (6):285-288.

McCarthy, S, S Newstead, V Karandashev, C Prandini, C Hutz, and W Gomes. 2007. *Teaching Psychology Around the World*. Newcastle, UK: Cambridge Scholars Publishing.

McCrea, E, and J Brasseur. 2003. *The Supervisory Process in Speech-Language Pathology and Audiology*. Boston: Allyn & Bacon.

McCrae, N., Murray, J., Huxley, P. & Evans, S. 2005. The Research Potential of Mental Health Social Workers: A Qualitative Study of the Views of Mental Health Service Managers. *British Journal of Social Work* **35**, 55-71.

Mental Health Commission. 2005. *Quality in Mental Health-Your Views*. Dublin: Mental Health Commission.

Mental Health Commission. 2006. *Multidisciplinary Team Working: From Theory to Practice*. Dublin: Mental Health Commission.

Mental Health Commission. 2007. *Quality Framework: Mental Health Services in Ireland*. Dublin: Mental Health Commission.

Mental Health Commission. 2008. *A Recovery Approach within the Irish Mental Health Service: A Framework for Development* ,. Dublin: Mental Health Commission.

Mental Health Commission (Irl). 2005. *Quality in Mental Health-Your Views. Report on Stakeholders Consultation on Quality in Mental Health Services*. Dublin: Mental Health Commission (Irl).

Mental Health Commission (Irl). 2006. *A Vision for Recovery in the Irish Mental Health Services*. Dublin: Mental Health Commission.

Mental Health Commission (Irl). 2008 *A Recovery Approach within the Irish Mental Health Service: A Framework for Development* ,. Dublin: Mental Health Commission.

Mental Health Nurse Education Taskforce (Australia). 2008. *Final Report: Mental Health in Pre-Registration Nursing Courses*. Melbourne: Mental Health Workforce Advisory Committee.

Milne, D, J Pilkington, J Gracie, and I James. 2003. Transferring Skills from Supervision to Therapy: A Qualitative and Quantitative N/1 Analysis. *Behavioural and Cognitive Psychotherapy* 31:193-202.

Milne, D. 2006. Developing Clinical Supervision Research Through Reasoned Analogies with Therapy. *Clinical Psychology and Psychotherapy* 13:215–222.

Milne, D. and V. Oliver. 2000. Flexible Formats of Clinical Supervision: Description, Evaluation and Implementation. *Journal of Mental Health*, 9:3, 291 - 304

Munson, C. 2002. *Handbook of Clinical Social Work Supervision*. New York: The Haworth Press.

National Board for Nursing, Midwifery and Health Visiting for Scotland. 2000. *Partnership in Developments and Delivery*. Edinburgh: National Board for Nursing, Midwifery and Health Visiting for Scotland.

National Council for the Professional Development of Nursing and Midwifery. 2001a. *Clinical Nurse/Midwife Specialists-Intermediate Pathway 1st Edition*. Dublin: NCNM.

National Council for the Professional Development of Nursing and Midwifery. 2001b. *Framework for the Establishment of Advanced Nurse and Advanced Midwife Practitioner Posts 1st Edition*. Dublin: NCNM.

National Council for the Professional Development of Nursing and Midwifery. 2004a. *Clinical Nurse/Midwife Specialists-Intermediate Pathway 2nd Edition*. Dublin: NCNM.

National Council for the Professional Development of Nursing and Midwifery. 2004b. *Framework for the Establishment of Advanced Nurse and Advanced Midwife Practitioner Posts 2nd Edition*. Dublin: NCNM.

National Council for the Professional Development of Nursing and Midwifery. 2008. *Clinical Supervision: A Structured Approach to Best Practice. Discussion Paper*. Dublin: National Council for the Professional Development of Nursing and Midwifery <http://www.ncnm.ie/files/publications08/Clinical%20Supervision%20Disc%20paper%202008.pdf>.

National Council for the Professional Development of Nursing and Midwifery. 2009. downloaded from www.ncnm.ie.

National Economic and Social Forum. 2007. *Mental Health and Social Inclusion*. Dublin: NESF.

National Health Service Scotland. 2006. *Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland*. Edinburgh: National Health Service Scotland.

National Institute for Health and Clinical Excellence. 2008. Published Clinical Guidelines London, Department of Health. Accessed from NICE website [December 2008] <http://www.nice.org.uk/Guidance/CG/Published>.

Neimeyer, G, and R Goodyear. 2005. Empirical Reflections on Academic Training Programs in Counselling Psychology: Contexts and Commitments. *The Counselling Psychologist* 33:605-609.

Newstead, S, and S Makinen. 1997. Psychology Teaching in Europe. *European Psychologist* 2: 3-10.

NIMH and RCP. 2005. *New Ways of Working for Psychiatrists-Enhancing Effective Person Centred Services Through New Ways of Working in Multidisciplinary and Multi-Agency Contexts*. London: National Institute for Mental Health in England and the Royal College of Psychiatrists.

Noble, C. & Irwin, J. 2009. Social Work Supervision: An Exploration of the Current Challenges in a Rapidly Changing Social, Economic and Political Environment'. *Journal of Social Work* **9**(3):345-358

NQAI. 2004. *National Framework of Qualifications*: National Qualification Authority of Ireland www.nqai.ie

NSWQB. 2003. *Handbook of Accreditation Standards and Procedures for Courses Leading to National Qualification in Social Work (NQSW) Award: Updated 2006*. Dublin: National Social Work Qualifications Board.

Ovretveit, J. 1993. *Co-ordinating Community Care: Multidisciplinary Teams and Care Management*. Buckingham: Open University Press.

Parker, I. . 2002. Universities are not a Good Place for Psychotherapy and Counselling Training. *European Journal of Psychotherapy & Counselling* 5 (4):331 – 346

Payne, M. 2001. Knowledge Bases and Knowledge Biases in Social Work. *Journal of Social Work* 1 (2):133-146.

Pirrie, A, V Wilson, J Elsegood, J Hall, S Hamilton, R Harden, D Lee, and J Stead. 1998. *Evaluating Multidisciplinary Education in Health Care*. Edinburgh: Scottish Council for Research in Education.

Psychological Society of Ireland. 2004. Guidelines on the Accreditation of Courses Leading to a First Qualification in Psychology. Dublin, Ireland. Accessed [November, 2008] from <http//psihq.ie>.

Reeves, S, and D Freeth. 2006. Re-Examining the Evaluation of Interprofessional Education for Community Mental Health Teams with a Different Lens: Understanding Presage, Process and Product Factors. *Journal of Psychiatric and Mental Health Nursing* 13:765-770.

Reeves, S, D Freeth, S Glen, T Leiba, E Berridgge, and J Herzberg. 2006. Delivering Practice-Based Interprofessional Education to Community Mental Health Teams: Understanding Some Key Lessons. *Nurse Education in Practice* 6:246-253.

Reeves, S, M Zwarenstein, J Goldman, H Barr, D Freeth, M Hammick, and I Koppel. 2001. *Interprofessional Education: Effects on Professional Practice and Health Care Outcomes (Review)*: Cochrane Database of Systematic Reviews. Issue 1 Art, No.: CD002213. DOI:10.1002/14651858. CD002213.pub2.

Reeves, S, M Zwarenstein, J Goldman, H Barr, D Freeth, M Hammick, and I Koppel. 2008. Interprofessional Education: Effects on Professional Practice and Health Care Outcomes (Review). *Cochrane Database of Systematic Reviews. Issue 1 Art, No.: CD002213. DOI:10.1002/14651858. CD002213.pub2.*

Repper, J, and J Breeze. 2007. A Review of the Literature on User and Carer Involvement in the Training and Education of Health Professionals. *International Journal of Nursing Studies* 44 (3):511-9.

Reynolds Welfel, E. and E. Ingersoll, (Eds). 2001. *The Mental Health Desk Reference: A Practice-Based Guide to Diagnosis, Treatment, and Professional Ethics.* New York: John Wiley & Sons

Ring, H, D Mumford, and C Katona. 1999. Psychiatry in the New Undergraduate Curriculum. *Advances in Psychiatric Treatment* 5:414-419.

Rodolfa, E, S Ko, and L Petersen. 2004. Psychology Training Directors' Views of Trainees' Readiness to Practice Independently. *Professional Psychology: Research and Practice* 35 (4):397-404.

Rolls, L, E Davis, and K Coupland. 2002. Improving Serious Mental Illness through Interprofessional Education. *Journal of Psychiatric and Mental Health Nursing* 9:317-324.

Ross, F, and L Southgate. 2000. Learning Together in Medical and Nursing Training: Aspirations and Activity. *Medical Education* 34:739-743.

Rush, B, and J Baker. 2006. Involving Mental Health Service Users in Nurse Education through Enquiry-Based Learning. *Nurse Education in Practice* 6:254-260.

Sainsbury Centre for Mental Health. 1997. *Pulling Together: The Future Roles and Training of Mental Health Staff*. London: Sainsbury Centre for Mental Health.

Scaife, J. . 2001. *Supervision in the Mental Health Professions A Practitioners Guide*. East Sussex, UK: Brunner-Routledge.

SCMH. 2001. *The Capable Practitioner*. London: The Sainsbury Centre for Mental Health.

Scofield, M. . 2008. *Best Practice Self-Regulation Model for Psychotherapy and Counselling in Australia: Final Report – Psychotherapy and Counselling Federation of Australia* Department of Human Services, Australia, 2008 [cited December 2008]. Available from <http://www.health.vic.gov.au/pracreg/psychotherapy.htm>.

Sheehan, R. & Ryan, M. 2001. Educating for Mental Practice: Results of a Survey of Mental Health Content in Bachelor of Social Work Curricula in Australian Schools of Social Work. *Social Work Education* **20** (3), 351-361.

Shulman, L. 1995 Supervision and Consultation. In RL Edwards (Ed-in Chief), *Encyclopaedia of Social Work*, (19th ed) pp. 2373–9. Silver Spring, MD: National Association of Social Workers.

Simons, L, S Tee, J Lathlean, A Burgess, L Herbert, and C Gibson. 2007. A Socially Inclusive Approach to User Participation in Higher Education,. *Journal of Advanced Nursing* 58 (3):246-255.

Simpson, A. 2007. The Impact of Team Processes on Psychiatric Case Management. *Journal of Advanced Nursing* 60 (4):409-418.

Singleton, J, and Green-Hernandez. 1998. Interdisciplinary Education and Practice: Has its Time Come? *Journal of Nurse-Midwifery* 43 (1):3-7.

Skehill, C. 2003. Social Work in the Republic of Ireland. *Journal of Social Work* **3** (2), 141-159.

Slade, M, G Luke, and L Knowles. 2009. Methodologies for Evaluating Recovery Training. *Clinical Psychology Forum* 193 (January):10-15.

Sloan, G, and H Watson. 1997. *Characteristics of a Good Clinical Supervision*. Glasgow: Caledonian University

Sloan, G, and H Watson. 2002. Clinical Supervision Models for Nursing: Structure, Research and Limitations. *Nursing Standard* 17 (4): 41-46.

Sloan, G. 2006. *Clinical Supervision in Mental Health Nursing*. Chichester UK. Wiley & Sons Ltd.

Soffe, J. 2004. Clinical Psychology and Service User Involvement: Our Business? *Clinical Psychology and Psychotherapy* 37:15- 18

Spence, S., Wilson, J., Kavanagh, D., Strong, J and L. Worrall. 2001. Clinical Supervision in Four Mental Health Professions: A Review of the Evidence. *Behaviour Change* 18(3):135–155

Stanhope, V, and P Solomon. 2008. Getting to the Heart of Recovery: Methods for Studying Recovery and Their Implications for Evidence-Based Practice. *British Journal of Social Work* 38 (885-899).

Steiner, J, D Allison, N Ponce, T Styron, E Aklin, and B Wexler. 2008. Teaching an Interdisciplinary Approach to the Treatment of Chronic Mental Illness: Challenges and Rewards. *Academic Psychiatry* 32:255-258.

Stuhmiller, C. 2005. Rethinking Mental Health Nursing in Australia: A Case for Direct Entry. *International Journal of Mental Health Nursing* 14:156-160.

Tait, L, and H Lester. 2005. Encouraging User Involvement in Mental Health Services. *Advances in Psychiatric Treatment* 11:168-175.

Tew, J, C Gell, and S Foster. 2004. *Learning from Experience: Involving Service Users and Carers in Mental Health Education and Training*. Higher Education Academy/NIMHE/Trent Workforce Development: Nottingham.

The College of Psychiatry of Ireland (2009) Interim CPD Handbook; Good Psychiatric Practice in Ireland. CPI: Dublin.

The Irish College of Psychiatry (http://www.irishpsychiatry.ie/postgraduate_training.aspx#HST)

The Psychological Therapy Forum. 2007. *Submission on the Statutory Registration of Counsellors & Psychotherapists in Ireland to the Department of Children and Health, Ireland.* : The Psychological Therapy Forum.

Thompson, S, G Checkley, J Hocking, N Crofts, A Mijch, and F Judd. 1997. HIV Risk Behaviour and HIV Testing of Patients in Melbourne. *Australian and New Zealand Journal of Psychiatry* 31 (4):566-576.

Tisdall. M., and K. O'Donoghue. 2003. A Facilitated Peer Group Supervision Model for Practitioners. In McMaster, K. and Wells, A. (eds). *Innovative Approaches to Stopping Family Violence*, Wellington NZ: Steele Roberts, pp. 221-232.

Townend, M, J Tew, A Grant, and J Repper. 2008. Involvement of Service Users in Education and Training: A Review of the Literature and Exploration of the Implications for the Education and Training of Psychological Therapists. *Journal of Mental Health* 17 (1):65-78.

Vallance, K. . 2004. Exploring Counsellor Perceptions of the Impact of Counselling Supervision on Clients. *British Journal of Guidance and Counselling* 32 (4):559-574.

Veeramah, V. 2002. The Benefits of Using Clinical Supervision. *Mental Health Nursing* 22 (1):18-23.

Victorian Government Department of Human Services. 2005. Clinical Supervision Guidelines: Victorian Mental Health Services Australia <http://www.health.vic.gov.au/mentalhealth/pmc/clinical-super.htm>.

Walsh, I, J Regan, R Sowman, B Parsons, and P.A Mckay. 2007. A Needs Analysis for the Provision of a Speech and Language Therapy Service to Adults with Mental Health Disorders. *International Journal of Psychiatric Medicine* 24 (3):89-93.

Walters, K, M Buszewicz, J Russell, and C Humphrey. 2003. Teaching as Therapy: Cross Sectional and Qualitative Evaluation of Patients' Experiences of Undergraduate Psychiatric Teaching in the Community. *British Medical Journal* 326:740.

Wheeler, S, and K Richards. 2003. *Research on Supervision of Counsellors and Psychotherapists: A Systematic Scoping Search*. Rugby: British Association for Counselling and Psychotherapy.

Wheeler, S, and K Richards. 2007. The Impact of Clinical Supervision on Counsellors and Therapists, Their Practice and Their Clients. A Systematic Review of the Literature. *Counselling and Psychotherapy Research* 7 (1):54 – 65.

Whitman, S, B. Ryan, and D Rubenstein. 2001. Psychotherapy Supervisor Training Differences Between Psychiatry and Other Mental Health Disciplines. *Academic Psychiatry* 25:156-161.

WHO. 1999. *Nurses and Midwives for Health: A WHO European Strategy from Nursing and Midwifery Education*. Copenhagen: World Health Organisation Regional Office for Europe.

WHO. 2005. *Atlas: Psychiatric Education and Training Across the World*. Geneva: World Health Organisation

Wilson, G, Hamilton, B, Britton, F, Campbell, J, Hughes, P. & Manktelow, R. 2005. Approved Social Work Training in Northern Ireland: Using Research to Examine Competence-Based Learning and Influence Policy Change. *Social Work Education* **24** (7), 721-736.

Wilson, G and Kirwan, G. 2007 Mental Health Social Work in Northern Ireland and the Republic of Ireland: Challenges and Opportunities for Developing Practice, *European Journal of Social Work* **10** (2), 175-191.

Wood, A, and O Wahl. 2006. Evaluating the Effectiveness of a Consumer-Provided Mental Health Recovery Education *Psychiatric Rehabilitation Journal* 30 (1):46-53.

Wood, J, and J Wilson-Barnett. 1999. The Influence of User Involvement on the Learning of Mental Health Students. *NT Research* 4 (4):257-270.

Worcestershire Mental Health Partnership NHS Trust. 2009. *Supervision Policy <http://www.worcestershirehealth.nhs.uk/SWPCT_Library/Policies_and_Procedures/Clinical/SupervisionPolicy.pdf>*

World Federation of Occupational Therapists (WFOT). 2005. *Position Statement Occupational Therapy Entry-Level Qualifications*: World Federation of Occupational Therapists.

World Health Organisation. 1988. *Learn Together to Work Together*. Geneva: World Health Organisation.

World Psychiatric Association. 2001. *Core Curriculum in Psychiatry for Medical Students* http://www.wpanet.org/education/core-curric-eng.shtml.

Zwarenstein, M, S Reeves, H Barr, M Hammick, I Koppel, and J Atkins. 2000. *Interprofessional Education: Effects on Professional Practice and Health Care Outcomes (Review)*: Cochrane Database of Systematic Reviews. Issue 3 Art, No.: CD002213. DOI:10.1002/14651858. CD002213.

Appendix 1:

List of universities, institutes of technology, colleges of education, & other third-level institutions provided by the Mental Health Commission

Universities

Dublin City University

National University of Ireland*

National University of Ireland Galway

National University of Ireland Maynooth

Open University in Ireland

University College Dublin

University College Cork

University of Limerick

University of Dublin Trinity College

Institutes of Technology

Athlone Institute of Technology

Cork Institute of Technology

Dublin Institute of Technology

Dun Laoghaire Institute of Art Design and Technology

Dundalk Institute of Technology

Galway-Mayo Institute of Technology

Institute of Technology Blanchardstown

Institute of Technology Carlow

Institute of Technology Sligo

Institute of Technology Tallaght

Institute of Technology Tralee

Institute of Technology Limerick

Miltown Institute

Waterford Institute of Technology

Colleges

Institute of Public Administration

National College of Art and Design

Royal College of Surgeons in Ireland

Shannon College of Hotel Management

St Angela's College Sligo

St Patrick's College Maynooth

Colleges of Education

Froebel College of Education

Marino Institute of Education

Mary Immaculate College University of Limerick

Mater Dei Institute of Education

St Patrick's College Drumcondra

The Church of Ireland College of Education

Other Third-Level Institutions

All Hallows College

American College Dublin

Burren College of Art

Carlow College

Dublin Business School

Griffith College Cork

Griffith College Dublin

Hibernia College

HSI Limerick Business School

Irish Management Institute

Irish Public Administration**

Irish School of Economics Trinity College**

Kimmage Development Studies Centre

Milltown Institute

National College of Art and Design

National College of Ireland

Open Training College

Portobello College Dublin

Royal College of Physicians of Ireland

Royal College of Surgeons of Ireland***

Royal Irish Academy

Tipperary Institute

* The National University is addressed with its constituent colleges

** These colleges do not exist independently

*** The Royal College of Surgeons of Ireland is included under the Colleges list

Appendix 2:

Colleges contacted that were not on the Mental Health Commission list

Academy of Medical Laboratory Science

ATI Training, Leeson Street

Clanwilliam Institute

Independent College

Institute of Technology Letterkenny

PCI College, Dublin

Appendix 3:

Colleges written to as they did not appear to have courses of relevance on their website

All Hallows College*

American College Dublin*

Burren College of Art

Carlow College

Clanwilliam Institute*

Dublin Business School*

Froebel College of Education

Griffith College Cork

Griffith College Dublin

Hibernia College

HSI Limerick Business School

Institute of Technology Blanchardstown

Institute of Technology Carlow

Institute of Technology Cork

Institute of Technology Limerick

Institute of Technology Sligo

Institute of Technology Tallaght

Irish Management Institute

Kimmage Development Studies Centre

Marino Institute Of Education

Mater Dei Institute of Education*

Miltown Institute*

National College of Art and Design

National College of Ireland

Portobello College Dublin

Royal College of Physicians of Ireland

Royal College of Surgeons of Ireland *

Royal Irish Academy

Shannon College of Hotel Management

St Patrick's College

The Church of Ireland College of Education

Tipperary Institute

* Following contact these institutions were added to the master database as they offered courses deemed relevant to the study.

Appendix 4:

Colleges that confirmed that they had no relevant Undergraduate or Postgraduate courses relating to the study at this time

Blanchardstown I.T

Burren College of Art

Carlow College

Froebel College of Education

National College of Art and Design

National College of Ireland

Shannon College of Hotel Management

Griffith College Cork

Griffith College Dublin

Hibernia College

HSI Limerick Business School

Institute of Technology Blanchardstown

Institute of Technology Carlow

Institute of Technology Limerick

Institute of Technology Sligo

Institute of Technology Tallaght

Irish Management Institute

Kimmage Development Studies Centre

Marino Institute Of Education

Royal Irish Academy

St Patrick's College

The Church of Ireland College of Education

Tipperary Institute

Appendix 5:

Names of courses included in the sample frame

College	Course Title
Academy of Medical Laboratory Science	MBA in Health Care Management
All Hallows College	H. Dip/MA in Leadership and Pastoral Care
American College, Dublin	BA Hons in Psychology (Behavioural Science)
Athlone IT	BSc (Hons) Psychiatric Nursing
ATI Training and Education	BA Applied Addiction Studies
ATI Training and Education	BA Counselling and Psychotherapy
Clanwilliam Institute	PG. Dip / M.Sc. Systemic Psychotherapy
DCU	BNS (Hons) in Community Nursing
DCU	BNS (Hons) Oscail Distance Learning
DCU	BNS (Hons) P/T 1yr conversion
DCU	BSc(Hons) Psychiatric Nursing
DCU	Doctorate in Psychotherapy
DCU	H. Dip in Psychiatric/Mental Health Nursing
DCU	Masters in Psychotherapy
DCU	PG. Dip in Counselling and Psychotherapeutic Practice
DCU	PG. Dip/ MSc in Mental Health Care Practice
DCU	PG. Dip/ MSc in Mental Health Nursing Practice
Dublin Business School	BA (Hons) Counselling and Psychotherapy (evening)
Dublin Business School	BA (Hons) in Psychology
Dublin Business School	BA (Hons) Social Studies
Dublin Business School	H. Dip Counselling Psychotherapy
Dublin Business School	H. Dip in Psychoanalytic Studies
Dublin Business School	MA in Addiction Studies
Dublin Business School	MA in Psychotherapy
Dublin Business School	MA Psychoanalytic Psychotherapy.
Dublin Institute of Technology	MA Child, Family and Community Studies
Dun Laoghaire Institute of Art &Design	BSc (Hons) Applied Psychology
Dundalk IT	BSc in Professional Management of Violence and Aggression
Dundalk IT	BSc in Psychiatric Nursing.
Independent College	BA (Hons) Psychotherapy Studies

Independent College	H. Dip in Psychotherapy Studies
Independent College	MA Psychoanalytic Psychotherapy
Institute of Public Administration	MA in Health Care Management.
Institute of Public Administration	Dip in Health Economics
Letterkenny IT	BSc in Psychiatric Nursing
Letterkenny IT	H. Dip in Mental Health
Mary Immaculate College	BA in Psychology
Mary Immaculate College	PG. Dip / MA Applied Behaviour Analysis
Mater Dei Institute of Education	MA Religion and Culture - Ethics For Professionals
Mayo IT,	BSc in Nursing
Mayo IT,	BSc in Psychiatric Nursing.
Milltown Institute	H. Dip/MA Supervisory Practice
NUI Galway	BA Psychological Studies
NUI Galway	BA Psychology
NUI Galway	BSc in Occupational Therapy
NUI Galway	BSc in Speech and Language Therapy
NUI Galway	BSc Psychiatric Nursing
NUI Galway	Doctorate in Clinical Psychology
NUI Galway	Diploma / H. Dip in Health Sciences (Clinical Teaching)
NUI Galway	H. Dip Psychology (Conversion)
NUI Galway	MA in Applied Behaviour Analysis
NUI Galway	MA Social Work
NUI Galway	Master of Health Sciences (Nursing)
NUI Galway	Masters in Health Sciences (Advanced Practice)
NUI Galway	Masters in Health Sciences (Nurse and Midwifery Education)
NUI Galway	MB BCh BAO - Bachelor of Medicine
NUI Galway	MSc (Occupational Health and Safety and Ergonomics)
NUI Galway	MSc Health Psychology
NUI Galway	MSc in Health Sciences (Specialist Nursing)
NUI Galway	MSc Occupational Health & Safety and Hygiene
NUI Galway	PG. Dip/ MA in Health Promotion
NUI Galway	PG. Dip (Mental Health, Community and In-Patient Acute Care).
NUI Galway	PG. Dip in Nursing (Child and Adolescent Mental Health)
NUI Galway	PG. Dip in Nursing (Gerontology)
NUI Galway	PG. Dip in Nursing Studies (Education)
NUI Galway	PhD in Applied Behaviour Analysis
NUI Maynooth	BA Psychology
NUI Maynooth	BSc in Psychology

NUI Maynooth	MSc / Doctorate in Psychological Science (Behaviour Analysis and Therapy)
Open University Ireland	BA (Hons) Social Work (England and Wales)
Open University Ireland	BA (Hons) Social Work (Scotland)
Open University Ireland	BA/BSc (Hons) Criminology and Psychological Studies
Open University Ireland	BA/BSc (Hons) Nursing Studies
Open University Ireland	BA/BSc (Hons) Social Sciences with Policy
Open University Ireland	BA/BSc (Hons) Social Studies with Psychological Studies **
Open University Ireland	BSc (Hons) Computing with Psychological Studies
Open University Ireland	BSc (Hons) Nursing Practice
Open University Ireland	BSc (Hons) Philosophy and Psychological Studies
Open University Ireland	BSc (Hons) Psychology
Open University Ireland	Dip / PG. Dip / MSc in Social Policy and Criminology
Open University Ireland	Dip in Psychology (Conversion for Post Graduates)
Open University Ireland	Diploma in Social Policy
Open University Ireland	MA Social Sciences
Open University Ireland	Master of Public Administration (MPA)
Open University Ireland	MSc in Forensic Psychology and Criminology
Open University Ireland	MSc in Psychology
Open University Ireland	PG. Cert / PG. Dip/ MSc in Advancing Health Care Practice
Open University Ireland	PG. Cert in the Social Sciences
Open University Ireland	PG. Dip In Criminal Justice
Open University Ireland	PG. Dip in Forensic Psychological Studies
Open University Ireland	PG. Dip in Social Research Methods
Open University Ireland	PG. Dip In Social Sciences
PCI College	Advanced Dip in Supervision
PCI College	BSc in Addiction Studies
PCI College	BSc in Counselling & Psychotherapy
RCSI	BSc Nursing
RCSI	BSc Nursing Management
RCSI	Dip Management for Medical Doctors
RCSI	MB BCh BAO, LRCP & SI (5 Year Programme)
RCSI	MB BCh BAO, LRCP & SI (4 Year Modular Medical Programme)
RCSI	MSc /PG.Dip in Quality in Health care Management
RCSI	MSc in Health Care Ethics & Law
RCSI	MSc/PG. Dip in Creative Leadership & Organisational Learning
RCSI	PG. Dip/ MSc Bereavement Studies.
RCSI	PG. Dip/ MSc in Health Care Management
RCSI	PG. Dip/ MSc in Leadership & Management Development

St Angela's College, Sligo	BNS
St Angela's College, Sligo	PG. Dip Master of Health Sciences
St Angela's College, Sligo	PG. Dip Nursing Studies (Community Mental Health)
St Angela's College, Sligo	PG. Dip / MA Pastoral Care / Chaplaincy
St Pats College, Maynooth	H. Dip/M.PS Pastoral Studies
TCD	BA in Psychology
TCD	Bachelor in Social Studies (BES) – Social Work
TCD	BNS (Bachelor in Nursing Studies)
TCD	BSc in Clinical Speech and Language
TCD	BSc in Occupational Therapy
TCD	BSc Psychiatric Nursing
TCD	Dip. in Addiction Studies.
TCD	Doctorate in Clinical Psychology
TCD	H. Dip Psychology (Conversion Course)
TCD	MB BCh BAO
TCD	MSc (Dysphagia, Acquired Communication Disorders, Child Language, Voice and Fluency)
TCD	MSc Applied Psychology
TCD	MSc Applied Social Research
TCD	MSc Clinical Speech and Language
TCD	MSc in Child and Adolescent Psychoanalytic Psychotherapy.
TCD	MSc in Counselling Psychology
TCD	MSc in Drug and Alcohol Policy *
TCD	MSc in Gerontological Nursing
TCD	MSc in Health Services Management.
TCD	MSc in Mental Health
TCD	MSc in Occupational Therapy
TCD	MSc in Psychoanalytic Psychotherapy
TCD	MSc Mental Health (Child, Adolescent and Family Strand)
TCD	MSc Nursing
TCD	MSc Psychology (Applied Behavioural Analysis)
TCD	PG. Dip. / MSc Child Protection and Welfare
TCD	PG. Dip / MSc in Social Work
TCD	PG. Dip in Applied Behavioural Analysis
TCD	PG. Dip in Cognitive Psychotherapy
TCD	PG. Dip/MSc Child Protection and Welfare
TCD	PG. Dip/MSc Clinical Supervision
Tralee IT	BSc (Hons) in Mental Health Nursing.

Tralee IT	H. Dip in Science in Nursing (Gerontological Nursing)
Tralee IT	H. Dip in Science in Nursing in a Specialist Area
Tralee IT	H. Dip in Science in Nursing in Psychosocial Interventions in Mental Health
Tralee IT	MSc in Nursing
Turning Point (DCU accredited)	PG. Dip/Masters in Integrative Counselling and Psychotherapy
UCC	BA (Hons) Applied Psychology
UCC	Bachelor of Social Work
UCC	BSc in Nursing (Psychiatric Nursing)
UCC	BSc in Nursing Studies
UCC	BSc in Speech and Language Therapy
UCC	BSc Occupational Therapy.
UCC	BSocSc
UCC	D. Psyc. Doctorate of Psychology **
UCC	DSocSc (Doctor of Social Science)
UCC	H. Dip Psychology (Conversion Course)
UCC	H. Dip in Safety, Health and Welfare at Work
UCC	MA Forensic Psychology **
UCC	MA in Counselling Psychology **
UCC	MA in Gerontology.
UCC	MA in Group Facilitation.
UCC	MA in Occupational and Organisational Psychology
UCC	Masters in Public Health
UCC	Masters in Social Work
UCC	Masters of Social Science (Social Policy)
UCC	MB BCh BAO (Graduate Entry)
UCC	MB, BCh, BAO Bachelors Degree in Medicine
UCC	MSc in Advanced Health Care Practice
UCC	MSc Nursing Studies (Taught) – Education / Clinical.
UCC	MSc Occupational Health
UCC	MSocSc in Third Sector Management
UCC	PD/MA Behavioural and Cognitive Psychotherapy **
UCC	PG. Dip in Advanced Fieldwork and Supervision (Social Work).
UCC	PG. Cert / Pg. Dip Health Promotion.
UCC	PG. Dip in Guidance and Counselling.
UCC	PG. Dip in Integrative Psychotherapy Studies.
UCC	PG. Dip in Nursing (Mental Health).
UCC	PG. Dip Nursing (Gerontology)
UCC	Professional Doctorate, Occupational Therapy

UCD	BA (Hons) Psychology
UCD	BA Social Science **
UCD	BSc (Nursing) Psychiatric Nursing
UCD	BSc Nursing (Management)
UCD	BSocSc (Hons) *
UCD	D Psych Sc (Clinical Programme)
UCD	Grad Dip in Applied Social Studies
UCD	Grad. Dip in Health Care (Risk Management and Quality)
UCD	Grad. Dip. In Medicine (Forensic Medicine)
UCD	H. Dip in Social Policy *
UCD	H. Dip in Sociology & Social Research *
UCD	H. Dip in Psychotherapy Studies. ICP recognised.
UCD	H. Dip Psych – Higher Dip in Psychology. PSI.
UCD	Master of Social Science (Social Work) Mode A
UCD	MB, BCh, BAO Medicine (Hons)
UCD	Medicine Graduate Entry
UCD	MSc in Child Art Psychotherapy
UCD	MSc in Clinical Practice
UCD	MSc in Cognitive Behavioural Therapy (CBT) for Children & Adolescents
UCD	MSc in Group Analytic Psychotherapy.
UCD	MSc in Nursing (Education)
UCD	MSc in Rehabilitation and Disability Studies
UCD	MSc Nursing (Applied Health Care Management)
UCD	MSc Psychotherapy (Systemic Family Therapy)
UCD	MSc. Psychoanalytic Psychotherapy
UCD	MSocSc (Social Policy Analysis)
UCD	MSocSc (Probation Service)
UCD	MSocSc Health & Illness
UCD	MSocSc(Social Work)
UCD	PG. Cert in Education
UCD	PG. Cert in Medicine (Sexual Assault Forensic Examination) *
UCD	PG. Cert/ PG. Dip/ MSc In Advanced Practice
UCD	PG. Dip in Health Care Informatics
UCD	PG. Dip In Nursing (Gerontological Nursing)
UL	BA Psychology and Sociology.
UL	BSc in Psychology
UL	Doctorate in Clinical Psychology
UL	MA Humanistic and Integrative Psychotherapy Programme

UL	MA Sociology **
UL	PG. Dip / MSc Health Education and Promotion
UL	PG. Dip In Nursing (Rehabilitation of the Older Person)
UL	PG. Dip/MSc in Clinical Therapies (OT/Physio Ther/SLT)
Waterford IT	BA (Hons) Psychology
Waterford IT	BSc (Hons) Psychiatric Nursing
Waterford IT	BSc Nursing Studies
Waterford IT	PG. Dip/ MSc Nursing (Mental Health Nursing)

* Course Directors were of the view that the questionnaire was not applicable to their course

** Courses are no longer running

Appendix 6:

Questionnaire

Provision of Education for Mental Health Professionals

The aim of this survey is to explore the current education and training provision for mental health professionals working in the Mental Health Services in the Republic of Ireland

The questionnaire is comprised mostly of closed questions.

Where indicated, please tick the appropriate box.

In some questions you may tick more than ONE response.

After answering a question, go directly to the next question unless directed otherwise.

The questionnaire should take you 15-20 minutes to complete.

To preserve confidentiality do not write your name anywhere on this questionnaire.

We are hoping to complete the data collection phase for this study within the next two weeks and would therefore be grateful if you could return the completed questionnaire at your earliest convenience to:

Professor Agnes Higgins,

School of Nursing and Midwifery,

Trinity College,

Dublin.

Code __ __ __ __ __

1. Title of course

2. Which department/ school does the course reside in? (Please tick left hand column as appropriate)

- ☐ Medicine
- ☐ Nursing
- ☐ Occupational Therapy
- ☐ Psychology
- ☐ Social Science
- ☐ Speech and Language Therapy
- ☐ Other (Please specify)

3. What is the highest level of the award for this course? (Please tick left hand column as appropriate)

- ☐ Certificate
- ☐ Diploma
- ☐ Higher Diploma
- ☐ Degree
- ☐ Postgraduate Diploma
- ☐ Taught Masters
- ☐ Taught Doctorate

4. Can students exit the course, prior to its completion, with any of the following lesser awards? Please indicate ALL exit possibilities

- ☐ Certificate
- ☐ Diploma
- ☐ Higher Diploma
- ☐ Degree
- ☐ Postgraduate Diploma
- ☐ Taught Masters
- ☐ None of the above

5. What is the duration of the complete course? (Tick one box only)

- ☐ Less than one year
- ☐ One year
- ☐ Two years
- ☐ Three years
- ☐ Four years

Greater than four ears (Please specify exact duration)

6. Is it possible to complete the course as a; (Tick one box only)

- ☐ Full-time student
- ☐ Part-time student only
- ☐ Full-time or part timepart-time student
- ☐ Take individual modules over a longer period of time

7. How often do you provide the course? (Tick one box only)

- ☐ Once a year
- ☐ Twice a year
- ☐ Every second year

Other (please specify)

8. How is the course funded? (Tick one box only)

- ☐ Course is self financing (student organises own payment)
- ☐ Completely funded by the HSE
- ☐ Part subsidised by the HSE
- ☐ Completely funded by the Department of Health and Children
- ☐ Part subsidised by the Department of Health and Children
- ☐ Completely funded by the Department of Education
- ☐ Part subsidised by the Department of Education

Other (Please specify)

9. Is the course accredited by any of the following professional bodies?

- ☐ An Bord Altranais
- ☐ Association of Occupational Therapists of Ireland/ World Federation of Occupational Therapists
- ☐ Irish Association for Counselling and Psychotherapy (IACP)
- ☐ Irish Association for Counselling Social Studies and Therapy (IACT)
- ☐ Irish Association of Speech and Language Therapists
- ☐ Irish Council for Psychotherapy
- ☐ College of Psychiatry of Ireland/ Royal College of Psychiatrists
- ☐ Irish Medical Council
- ☐ National Social Work Qualifications Board (NSWQ)
- ☐ Psychological Society of Ireland
- ☐ None of the above

Other (Please specify)

10. Which institution awards the qualification?

- ☐ National University of Ireland
- ☐ Higher Education and Training Awards Council
- ☐ Further Education and Training Awards Council
- ☐ Institute of Technology
- ☐ The University of Ireland
- ☐ University of Dublin, Trinity College
- ☐ Dublin City University

Other (Please specify)

11. Was the course set up to respond to any specific Health Service Educational priority? (Tick one box only)

- ☐ Yes
- ☐ No
- ☐ Don't know

12. If yes, what educational priority was it responding to?

13. Is the course designed for a (Tick one box only)

- ☐ Specific discipline
- ☐ Multidisciplinary

14. If designed for a specific discipline, what discipline is the course targeting? (Tick one box only)

- ☐ Psychiatry
- ☐ Psychiatry/ Mental Health Nursing
- ☐ Psychology
- ☐ Psychotherapy/ Counselling
- ☐ Pastoral Care/ Chaplaincy
- ☐ Occupational Therapy
- ☐ Speech and Language Therapy
- ☐ Social Work

Other (Please specify)

15. If designed for multidisciplinary participation, which of the following can attend? Please tick all that apply.

- ☐ Psychiatrists
- ☐ Psychiatric/ Mental Health Nurses
- ☐ Psychologists
- ☐ Occupational Therapists
- ☐ Social Workers
- ☐ Speech and Language Therapists
- ☐ Psychotherapists /Counsellors

Other (Please specify)

16. Which if any of the following groups is eligible to attend the course? Please tick all that apply.

- ☐ Service Users/ Clients
- ☐ Carers
- ☐ Care Assistants
- ☐ Complementary Therapists
- ☐ Pastoral Care/ Chaplains
- ☐ Care Officers
- ☐ None of the above

Other (Please specify)

17. Please rate on the following scale the degree of EMPHASIS, in your opinion, given to the following list of issues within the course.	VERY STRONG	STRONG	SOME	WEAK OR LITTLE	NONE	N/A	DON'T KNOW
Biological perspectives on mental health problems							
Care pathways							
Clinical supervision							
Clinician/ practitioner self care							
Ethics							
Evidence based practice							
Family/ carer support							
Gender sensitive care							
Group facilitation skills							
Human rights							
Legal issues and mental health							
Malpractice/ professional negligence							
Marginalised groups							
Mental health promotion							
Multi agency working							
Multidisciplinary working							
Person centered care							
Psychoeducation							
Psychological perspectives on mental health problems							
Quality mechanisms/ quality assurance							
Recovery approaches							
Risk and risk management							
Safety and clinical governance							
Self help/ peer support services							
Service users/ clients perspectives							
Sexuality							
Social perspectives on mental health problems							
Spirituality							
Therapeutic communication/ relationships							
Transcultural issues							

18. Please rate on the following scale the degree of EMPHASIS, in your opinion, given to the following documents within the course.	VERY STRONG	STRONG	SOME	WEAK OR LITTLE	NONE	N/A	DON'T KNOW
A Recovery Approach within the Irish Mental Health Services (Mental Health Commission, 2006)							
Criminal Law Insanity Act (Government of Ireland, 2006)							
Excellence in Mental Health Care Records Guidance (Mental Health Commission, 2005)							
Mental Health Act 2001 (Government of Ireland, 2001)							
Mental Health Commission Codes of Practice (Mental Health Commission, 2006)							
Mental Health Commission Rules (Mental Health Commission, 2006)							
Quality Framework: Mental Health Services in Ireland (Mental Health Commission, 2005)							
Universal Declaration of Human Rights (UN, 1948)							
Vision for Change: Report of the Expert Group on Mental Health (Department of Health and Children, 2006)							

19. Which of the following teach on the course? Please tick all that apply

- ☐ Carers
- ☐ Pastoral Care/ Chaplains
- ☐ Psychiatric/ Mental Health Nurses
- ☐ Psychiatrists
- ☐ Psychologists
- ☐ Psychotherapists/ Counsellors
- ☐ Occupational Therapists
- ☐ Speech and Language Therapists
- ☐ Service Users/ Clients
- ☐ Social Workers

Other (Please specify)

20. How are lecturers for this programme expected to keep abreast of current policy, service and practice development? Please tick all that apply.

- ☐ Carrying a case load (face to face work with clients)
- ☐ Continuing Professional Development (conference, course attendance)
- ☐ Reading research, policy literature and theoretical literature

- [ ] Researching issues from practice
- [ ] Spending time developing protocols/ standards with clinical staff
- [ ] Spending time in practice teaching students
- [ ] Spending time with service managers on service and policy development

Other (Please specify)

21. What teaching methods are used on the course? Please tick all that apply

- [ ] Distance learning
- [ ] Experiential learning (e.g. role play, group work)
- [ ] Lecture and other didactic methods
- [ ] Online learning
- [ ] Practice- based learning
- [ ] Problem- based learning
- [ ] Self- directed learning

Other (Please specify)

22. What methods of assessment do you employ to determine if students have achieved the course outcomes?

Please tick all that apply

- [ ] Case studies
- [ ] Direct observation of competence in practice
- [ ] Essays
- [ ] Group projects
- [ ] OCSE's (objective structured clinical examinations)
- [ ] Peer assessment
- [ ] Portfolios
- [ ] Practice- based/ work- based written assignments
- [ ] Reflective diary
- [ ] Research dissertation/ Thesis
- [ ] Self assessment
- [ ] Web based assessments
- [ ] Written examinations

Other (Please specify)

23. Are students required to complete practice placements/supervised sessions as part requirement for the course?

- [ ] Yes
- [ ] No

24. What Quality Assurance Mechanisms do you use for the course? Please tick all that apply

- [ ] Accreditation by professional organisation
- [ ] Course management committee
- [ ] External examiner
- [ ] Formal feedback from family /carers
- [ ] Formal feedback from health service providers
- [ ] Formal feedback from lecturing staff
- [ ] Formal feedback from service user/ client group

☐ Formal feedback from students

Other (Please specify)

☐ None of the above

Other (Please specify)

25. Are service users/clients involved with this course?

☐ Yes

☐ No

26. If yes, how are service users/clients involved in the course? Please tick all that apply.

☐ Collaborative research

☐ Course design

☐ Course management

☐ Course evaluation

☐ Selection of students

☐ Student assessment

☐ Teaching on the course

☐ None of the above

27. If no, do you plan, in the near future to involve service users/clients in any of the following ways?

Please tick all that apply

☐ Collaborative research

☐ Course design

☐ Course management

☐ Course evaluation

☐ Selection of students

☐ Student assessment

☐ Teaching on the course

28. What was the overall target number for student's intake this year (2008-2009?)

29. What was the overall number of students who commenced the course this year (2008-2009)

30. How many students successfully completed the course in:

☐ **2006**

☐ **2007**

☐ **2008**

31. If the course is multidisciplinary, how many students commenced the course this year (2008-09)?

- ☐ Psychiatrists
- ☐ Psychiatric/ Mental Health Nursing
- ☐ Social Work
- ☐ Psychology
- ☐ Speech and Language Therapists
- ☐ Occupational Therapists
- ☐ Pastoral Care/ Chaplaincy
- ☐ Psychotherapists/ Counsellors

Others

32. Have you ceased delivering any course for mental health professionals in the last 3 years? If the answer to this question is NO or DON'T KNOW, please go to question 34.

- ☐ Yes
- ☐ No
- ☐ Don't know

33. If the answer to 32 was YES what was the name of the course/s and what was the reason for discontinuing?

34. Are you in a position to develop other education/training courses for mental health professionals in the future?

- ☐ Yes
- ☐ No

If YES (please specify what courses you would be in a position to develop and deliver)

35. If your answer to question 34 is NO, what are the main barriers to you developing education programmes for mental health professionals?

36. What do you see as the top 3 priorities for education of mental health professionals in the future?

1.....

2.....

3.....

37. **We would appreciate if you would be willing to describe any examples of best practice that you consider are used on the course (these examples could relate to any aspect of course development, delivery, assessment, evaluation, advertising etc).**

38. **Should we require clarification or more information on the examples of best practice, would you be willing to consent to a telephone interview?**

☐ Yes

☐ No

If yes, we should be grateful if you would let us know by completing and returning the enclosed pink page.

Thank you for taking the time to complete the questionnaire.

Please return the completed questionnaire by post to Professor Agnes Higgins, School of Nursing and Midwifery, Trinity College, Dublin 2 (ahiggins@tcd.ie)

Appendix 7:

Information letter that accompanied the questionnaire

Dear Colleague,

Title of study: An exploration of the current education/training provided to mental health professionals in the Republic of Ireland.

Thank you for taking the time to read our introductory letter, and we hope that you will consider assisting us with our study. As you may be aware the Mental Health Commission have commissioned a multidisciplinary team, from Trinity College Dublin, to conduct a national study to explore the current education/training provided to mental health professionals in the Republic of Ireland.

Phase one of our study involved the identification of all courses offered by Third Level educational institutions. From information gleaned from websites, professional accreditation organizations, and your Head of Department, we understand that you are the Course Co-Ordinator/Director for a course that provides training for mental health professionals.

We have enclosed a questionnaire that asks you some questions about the course and should be grateful if you would complete it and return it in the SAE provided. The questionnaire should take you approx 15-20 minutes to complete. For some questions you may need to consult with colleagues to access the information.

This research has been granted ethical approval from the Faculty of Health Sciences, Trinity College, Dublin, and is being funded by the Mental Health Commission. While their may be no benefits to you directly, it is hoped that the knowledge generated from the evaluation will provide information on the current education and training provided to mental health professionals in the Republic of Ireland. There is no foreseeable risk to you being involved in this study. At all times your identity will be protected, therefore, we ask that you do not write your name on the questionnaire.

If you wish further information about the study, please do not hesitate to contact me by phone or email.

Yours sincerely

Dr Agnes Higgins
Associate Professor of Mental Health Nursing
School of Nursing and Midwifery
Trinity College
Dublin

ahiggins@tcd.ie

Appendix 8:

E-letter sent to respondents

Dear ….

Thank you for completing the questionnaire recently in relation to our study on Educational Opportunities for Members of the Multi-Disciplinary Team in Mental Health.

The next phase involves highlighting aspects of best practice and you may remember agreeing to be involved in this stage of the study. To this end, the research group would be delighted to hear more about your innovative course that may be included in the final report. Some areas to consider might be teaching methods, assessment strategies, service user involvement or multi-disciplinary involvement in course development or delivery.

We would be grateful if you could provide us with a descriptive account of your programme that demonstrates its unique qualities. We suggest that the précis be no more than approximately 300 words and would appreciate if you could return this to us by Mon 6th April 2009. Once we have received your response a member of the team may contact you to discuss further.

Once again, thank you for your time and interest in our study.

Kind regards,

Gerry Maguire (on behalf of Prof A. Higgins and the Trinity College Dublin Research Team)
Lecturer
School of Nursing and Midwifery
Trinity College
Dublin

Appendix 9:

Overview of unidisciplinary and multidisciplinary courses within the departments/schools

Department/School	*Award*	*Duration*	*Uni/Multidisciplinary*	*Number of Courses*
Medicine	Degree (4)	4 Years	*Specific Discipline*	1
		>4 Years	*Specific Discipline*	3
	Postgraduate Diploma(1)	1 Year	*Multidisciplinary*	1
	Taught Masters (7)	1 Year	*Multidisciplinary*	1
		2 Years	*Multidisciplinary*	5
		3 Years	*Multidisciplinary*	1
Nursing	Diploma (1)	4 Years	*Specific Discipline*	1
	Higher Diploma (6)	Less than 1 Year	*Specific Discipline*	1
		1 Year	*Specific Discipline*	5
	Degree (20)	Less than 1Year	*Specific Discipline*	1
		1 Year	*Specific Discipline*	5
		2 Years	*Specific Discipline*	2
			Multidisciplinary	1
		4 Years	*Specific Discipline*	11
	Postgraduate Diploma (9)	1 Year	*Specific Discipline*	7
			Multidisciplinary	1
		2 Years	*Specific Discipline*	1
	Taught Masters (20)	1 Year	*Specific Discipline*	4
		2 Years	*Specific Discipline*	12
			Multidisciplinary	3
		4 Years	*Multidisciplinary*	1
	Taught Doctorate (1)	>4 Years	*Multidisciplinary*	1
Occupational Therapy	Degree (3)	4 Years	*Specific Discipline*	3
	Taught Masters (1)	2 Years	*Specific Discipline*	1
	Taught Doctorate (1)	>4 Years	*Specific Discipline*	1
Speech and Language Therapy	Degree (3)	4 Years	*Specific Discipline*	3
	Taught Masters (1)	1 Year	*Specific Discipline*	1

Department/School	*Highest Level of the Award*	*Duration of the Course*	*Specific/ Multidisciplinary*	*Number of Courses*
Psychology	Higher Diploma (3)	Less than 1 Year	*Specific Discipline*	1
		2 Years	*Specific Discipline*	1
			Multidisciplinary	1
	Degree (5)	3 Years	*Specific Discipline*	1
		4 Years	*Specific Discipline*	4
	Postgraduate Diploma (3)	1 Year	*Specific Discipline*	1
			Multidisciplinary	1
		2 Years	*Specific Discipline*	1
	Taught Masters (7)	1 Year	*Specific Discipline*	1
			Multidisciplinary	1
		2 Years	*Specific Discipline*	1
			Multidisciplinary	4
	Taught Doctorate (3)	3 Years	*Specific Discipline*	3
Social Science	Degree (6)	3 Years	*Specific Discipline*	2
			Multidisciplinary	1
		4 Years	*Specific Discipline*	2
		>4 Years	*Specific Discipline*	1
	Taught Masters (6)	1 Year	*Multidisciplinary*	3
		2 Years	*Specific Discipline*	1
			Multidisciplinary	1
		4 Years	*Specific Discipline*	1
Others	Diploma (1)	Less than 1Year	*Specific Discipline*	1
	Higher Diploma (3)	1 Year	*Multidisciplinary*	2
		2 Years	*Specific Discipline*	1
	Degree (7)	3 Years	*Specific Discipline*	1
			Multidisciplinary	1
		4 Years	*Specific Discipline*	4
		>4 Years	*Multidisciplinary*	1
	Taught Masters (14)	1 Year	*Multidisciplinary*	1
		2 Years	*Specific Discipline*	1
			Multidisciplinary	9
		3 Years	*Specific Discipline*	1
			Multidisciplinary	1
		4 Years	*Multidisciplinary*	1
	Taught Doctorate (1)	3 Years	*Specific Discipline*	1

Appendix 10:

Multidisciplinary course titles

Department/School	Highest Level of Award	Course Title
Medicine	Postgraduate Diploma (1)	Grad Diploma in Health Care Informatics
	Taught Masters (7)	1. Diploma/H. Dip/MSc in Health Sciences (Clinical Teaching)
		2. MSc in Occupational Health
		3. MSc/PG Dip in Health Care Management
		4. Grad Dip/MSc in Healthcare (Risk Management and Quality)
		5. MSc in Psychoanalytic Psychotherapy
		6. MSc in Child Art Psychotherapy
		7. MSc in Group Psychoanalytic Psychotherapy
Nursing	Degree (1)	BSc Professional Management of Violence and Aggression
	Postgraduate Diploma (1)	Grad Diploma in Counselling and Psychotherapeutic Practice
	Taught Masters (4)	1. MSc in Mental Health
		2. MSc Mental Health (Child, Adolescent and Family Strand)
		3. Graduate Diploma/MSc in Mental Health Care Practice
		4. MSc in Psychotherapy
	Taught Doctorate (1)	1. Doctorate in Psychotherapy
Psychology	Higher Diploma (1)	1. H.Dip Psychology (Conversion Course)
	Postgraduate Diploma (1)	2. PGdip in Integrative Psychotherapy Studies
	Taught Masters (5)	1. Grad Dip/MA Applied Behavioural Analysis
		2. PGdip/MSc. Clinical, Supervision
		3. PGdip/ MSc Bereavement Studies
		4. MSc Psychology (Applied Behavioural Analysis)
		5. PGdip/MSc in Rehabilitation and Disability Studies

Department/School	Highest Level of Award	Course Title
Social Science	Degree (1)	BA (Hons) Social Studies
	Taught Masters (4)	1. MSc Applied Social Research
		2. Masters of Social Science (Social Policy)
		3. MSoc Sc Health and Illness
		4. MSc in Third Sector Management
Other	Degree (2)	1. BA (Hons) Psychology
		2. BSc (Hons) Philosophy and Psychological Studies (B43)
	Higher Diploma (2)	1. HDip in Psychotherapy Studies
		2. H Dip in Psychoanalytic Studies
	Taught Masters (12)	1. HDip/MSc Pastoral Studies
		2. Graduate Diploma/MSc in Health Education and Promotion
		3. PGDip/ MSc Systematic Psychotherapy
		4. PG Diploma/ MSc in Leadership and Management Development
		5. PG Dip/MSc in Clinical Therapies
		6. MA in Health Promotion
		7. MA Religion and Culture-Ethics for Professionals
		8. MA in Psychotherapy
		9. MA Psychoanalytic Psychotherapy
		10. MA Psychoanalytic Psychotherapy
		11. MSc in Advanced Healthcare Practice
		12. MBA in Health Care Management

Appendix 11:

Number/percentage of courses that placed very strong emphasis on the theoretical issues

Departments Issues	Medicine (n=12)	Nursing (n=57)	OT (n=5)	Psychol. (n=21)	Soc. Sc. (n=12)	SLT (n=4)	Other (n=26)
Biological perspectives on mental health problems	3 (25%)	-	-	-	-	-	-
Care pathways	-	4 (7%)	1 (20%)	1 (5%)	-	1 (25%)	-
Clinical supervision	8 (67%)	11 (20%)	1 (20%)	7 35%)	-	2 (50%)	9 (36%)
Clinician/ practitioner self care	3 (25%)	7 (12%)	2 (40%)	3 (15%)	-	2 (50%)	10 (42%)
Ethics	3 (25%)	9 (16%)	2 (40%)	10 (48%)	1 (8%)	2 (50%)	13 (50%)
Evidence based practice	3 (25%)	33 (58%)	4 (80%)	10 (48%)	2 (17%)	3 (75%)	6 (24%)
Family/ carer support	1 (8%)	6 (11%)	1 (20%)	3 (15%)	-	2 (50%)	1 (4%)
Gender sensitive care	1 (8%)	-	1 (20%)	1 (5%)	1 (8%)	-	2 (8%)
Group facilitation skills	2 (17%)	10 (18%)	3 (60%)	4 (19%)	-	2 (50%)	7 (27%)
Human rights	3 (25%)	11 (19%)	2 (40%)	2 (10%)	4 (33%)	-	6 (24%)
Legal issues and mental health	2 (17%)	11 (19%)	1 (20%)	4 (19%)	2 (17%)	-	1 (4%)
Malpractice/ professional negligence	3 (25%)	10 (18%)	1 (20%)	1 (5%)	-	2 (50%)	-
Marginalised groups	1 (8%)	5 (9%)	1 (20%)	1 (5%)	4 (33%)	-	2 (8%)
Mental health promotion	3 (25%)	11 (19%)	-	2 (10%)	1 (8%)	-	4 (17%)
Multi agency working	3 (25%)	10 (18%)	-	3 (14%)	-	3 (75%)	4 (17%)
Multidisciplinary working	4 (33%)	12 (21%)	1 (20%)	4 (19%)	1 (8%)	3 (75%)	10 (36%)
Person centred care	4 (33%)	24 (42%)	4 (80%)	6 (27%)	-	2 (50%)	9 (35%)
Psycho education	2 (17%)	12 (21%)	1 (20%)	5 (24%)	1 (8%)	1 (25%)	2 (8%)
Psychological perspectives on mental health problems	3 (25%)	13 (23%)	1 (20%)	9 (43%)	-	1 (25%)	7 (27%)
Quality mechanisms/ quality assurance	3 (25%)	10 (18%)	1 (20%)	4 (19%)	-	1 (25%)	2 (8%)

Departments Issues	Medicine (n=12)	Nursing (n=57)	OT (n=5)	Psychol. (n=21)	Soc. Sc. (n=12)	SLT (n=4)	Other (n=26)
Quality mechanisms/ quality assurance	3 (25%)	10 (18%)	1 (20%)	4 (19%)	-	1 (25%)	2 (8%)
Recovery approaches	1 (8%)	14 (25%)	1 (20%)	1 (5%)	3 (25%)	1 (25%)	1 (4%)
Risk and risk management	4 (33%)	11 (19%)	1 (20%)	1 (5%)	-	1 (25%)	-
Safety and Clinical Governance	4 (33%)	8 (14%)	1 (20%)	3 (14%)	-	-	3 (12%)
Self help/ peer support services	1 (8%)	10 (18%)	1 (20%)	2 (10%)	2 (17%)	2 (50%)	3 (12%)
Service users/ clients perspectives	1 (8%)	14 (25%)	3 (60%)	2 (10%)	7 (58%)	3 (75%)	5 (19%)
Sexuality	-	2 (4%)	-	-	-	-	9 35%)
Social perspectives on mental health problems	3 (25%)	11 (19%)	1 (20%)	1 (5%)	6 (50%)	1 (25%)	6 23%)
Spirituality	1 (8%)	1 (2%)	-	-	1 (8%)	-	2 (8%)
Therapeutic communication/ relationships	4 (33%)	22 (39%)	3 (60%)	4 (19%)	-	2 (50%)	12 (46%)
Transcultural issues	-	4 (8%)	1 (20%)	-	3 (25%)	1 (25%)	4 (16%)

Appendix 12:

Number/percentage of courses that place very strong emphasis on the policies/documents

	Medicine (n=12)	Nursing (n=57)	OT (n=5)	Psychol. (n=21)	Soc. Sc. (n=12)	SLT (n=4)	Other (n=26)
A Recovery Approach within the Irish Mental Health Services (Mental Health Commission, 2006)	1 (8%)	12 (21%)	1 (20%)	-	3 (25%)	-	2 (8%)
Criminal Law Insanity Act (Government of Ireland, 2006)	2 (17%)	3 (5%)	1 (20%)	-	-	-	-
Excellence in Mental Health Care Records Guidance (Mental Health Commission, 2005)	-	5 (9%)	1 (20%)	1 (5%)	-	-	-
Mental Health Act 2001 (Government of Ireland, 2001)	-	10 (18%)	1 (20%)	2 (10%)	-	-	1 (4%)
Mental Health Commission Codes of Practice (Mental Health Commission, 2006)	-	6 (11%)	-	1 (5%)	-	-	-
Mental Health Commission Rules (Mental Health Commission, 2006)	-	3 (5%)	-	-	-	-	-
Quality Framework: Mental Health Services in Ireland (Mental Health Commission, 2005)	-	10 (18%)	1 (20%)	-	-	1 (25%)	-
Universal Declaration of Human Rights (UN, 1948)	1 (8%)	5 (9%)	2 (40%)	-	1 (8%)	1 (25%)	3 (12%)
Vision for Change: Report of the Expert Group on Mental Health (Department of Health and Children, 2006)	-	19 (33%)	2 (40%)	5 (24%)	4 (33%)	1 (25%)	-

Appendix 13:

Recommended subject area for development of education/training courses for mental health professionals in future

Acute Care
Addiction Studies
Anger and Aggression
Applied Psychology

Behaviour Management
Brief Solution Focus Therapy

Child and Adolescent Psychiatry
Childhood Sexual Trauma
Clinical Supervision
Cognitive Behaviour Therapy
Communication and Language Abilities
Community Based Interventions
Community Development Approach in Partnership with Service Users
Counselling
Disabilities Associated with Specific Mental Health conditions

Domestic Violence

Eating Disorders

Forensic Mental Health Issues

Group Psychotherapy

Interprofessional Working

Leadership and Management Development
Lifestyle and Emotional Well-Being

Management and Audit

Medication Management
Mental Health in Intellectual Disability
Mental Health Promotion
Multidisciplinary Working

Nurse Prescribing

Occupational Therapy Practice and Mental Health
Patients Rights
Personality Disorder: Assessment and Treatment
Physical Health
Population Health
Post Traumatic Stress Disorder
Practitioner Health and Wellbeing
Psychological Therapies
Psychosocial Interventions
Psychotherapy Supervision Training

Quality Assurance

Recovery
Risk Assessment, Management and Audit

Service Improvement and Practice Development
Stress Inoculation and Stress Management.
Substance Misuse
Suicide/Risk Management
Supervision/ Group Supervision
Systemic Therapy

Therapeutic Communication

Wound Care

Appendix 14:

Emergent themes regarding best practice

Theme

Examples of comments regarding Best Practice

Course content

- Students exposed to social inclusion and recovery models
- Students exposed to human rights approach and equality issues

Course development issues

- Realistic learning outcomes
- Postgraduate Management Committee including both HSE and HEI representation
- MDT approach to course development
- Collaboration with all stakeholders in course development

Service user involvement

- Service users teach 18hrs on a module
- Service users have been involved in student selection
- The use of experts by experience
- Involve service users in meetings/workshops
- Incorporate autobiographical literature on service user experience
- First year students participate in pre-clinical conversation networks with people with aphasia

Assessment methods

- Practice-based assessment / placements
- Capture and value experiential learning
- Participatory research with voluntary/community groups
- Peer/self/panel assessment for presentations
- The student group presentation advocates for the role of SLT's in mental health
- Use of OSCE's on the taught nursing modules
- Assessments allow students to present cases from practice

Course delivery/Teaching methods

- Students in year 4 complete a certificate in Brief Solution Focused Therapy
- Use role-play on the therapeutic communication module
- Use clinical portfolios to integrate theory and practice
- Development in problem-based learning
- Ongoing self-reflective philosophical stance
- Tutorials and one-to-one interface with students
- Students share information, learning with each other in online forum
- Blended learning and experiential approaches
- Parts of modules delivered via e-learning
- Web-based learning

- Increased elective modules
- CNS invited to deliver specialist content,
- Lecturers are all clinicians
- Informed by research led teaching
- Use of technology- Podcast

Support mechanisms available

- Clinical facilitator
- Clinical supervision
- Supervised practice placements
- Reflective practice
- Personal psychotherapy and supervision

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