The ten essential shared capabilities: their background, development and implementation

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Services for people with mental health problems have undergone major structural changes. Although the plan to close long-stay institutions was first announced in 1962, the change did not fully begin to happen until 20 years later. Now, fortunately, practically all the old Victorian hospitals have gone.

Services for people with learning disabilities were similarly congregated into long-stay hospitals until the early 1980s. In this case, however, an important movement emerged that questioned the ways of thinking about and providing services to people with learning disabilities.

This movement or philosophy was described as ‘normalisation’ and was led by Wolf Wolfensberger. Normalisation was described as ‘the use of culturally valued means in order to enable people to live culturally valued lives’ (Wolfensberger, 1980). It stemmed from the hypothesis that a person can be considered ‘deviant’ or devalued when a significant characteristic (a ‘difference’) of theirs is negatively valued by the majority of society. While numerous differences do exist among individuals, these do not constitute ‘deviancy’ unless they are sufficiently negatively value charged in the mind of observers. Different cultures define different types of differences as deviant, but in all cultures they fall into one or more of three broad categories:

(a) Physical differences and bodily impairments that exist from birth, or that occur later because of disease, old age or other reasons.
Wolfensberger (1980) argued that the consequences for people who were perceived as ‘deviant’ from social norms were, in turn, negative. He summarised these as follows:

(a) Devalued people will be badly treated. They will usually be accorded less esteem and status than that given to non-devalued citizens. They are apt to be rejected, even persecuted, and treated in ways that tend to diminish their dignity, adjustment, growth, competence, health, wealth, lifespan etc.

(b) The treatment accorded to devalued people will take forms that express the societal perception of the devalued person or group. For instance, people who may be perceived as risky or dangerous (perhaps for no realistic reason) may be provided in settings that are prison-like.

(c) How a person is treated will, in turn, strongly influence how that person subsequently behaves. Negative expectations are more likely to lead to negative behaviour. ‘On the other hand, the more social value is accorded to the person, the more s/he will usually be encouraged to assume roles and behaviours which are appropriate and desirable and the more will be expected of him/her, and the more she/he is apt to achieve.’

Normalisation, later to be called ‘social role valorisation’, had a great influence on services for people with learning disabilities. It was operationalised into service standards that could be used for evaluation and service design purposes (Wolfensberger & Truman, 1983). In England it was translated into ‘An Ordinary Life’, an approach to service design arguing that people with learning difficulties could live, like anyone else, in ordinary housing, rather than in hospitals or large hostels; that they were individual, with different strengths and needs; and that person-centred planning (called Individual Programme Planning at the time) was essential.

The term ‘normalisation’ was subsequently used indiscriminately, and often wrongly, and is no longer in current usage. The reader will recognise, however, that much of what is in current mental health policy can be traced back to the movement led by Wolfensberger and others. It was, perhaps, easier to apply the principles to people with learning difficulties, whose needs were primarily associated with social and educational challenges. It is interesting to reflect how far the approach was (not) taken up in mental health.

The author was struck, in moving from the field of learning disabilities at the end of the 1980s into the field of mental health, by how the formulation of needs by staff was focused through an illness lens. What ‘patients’ did or said was attributed to their presenting problem or diagnosis; there seemed little reflection...
on them as people, with the same hopes and aspirations as others. This in turn appeared to lead to low expectations from both staff and patients about what the future might hold. An old study carried out by Rosenhan (1973) still had resonance: it described how stooges who faked symptoms in order to be admitted to psychiatric hospital, but who resumed normal behaviour on admission, were not discharged quickly as what they did was perceived by staff to confirm their diagnosis. The researcher concluded that once a person had a label or diagnosis of mental illness, that diagnosis appeared to define them; they could not be listened to as an ordinary person and other aspects of their lives, such as physical illness, family and work issues, were not addressed appropriately.

Services for people with mental health problems in the early 1990s were still largely hospital based, with some small Community Mental Health Teams emerging as well as primary care links. A methodology known as ‘SEARCH’ conferences was developed to bring people with mental health problems, their families, practitioners and managers together to:

(a) explore what futures people wanted for themselves
(b) compare this with how things were at present
(c) identify what needed to happen to achieve those desirable futures

The outcomes of these conferences, replicated up and down the country, were largely the same. People wanted:

(a) access to services at all times (24 hours a day and at weekends)
(b) help focused at home or locally
(c) services that addressed key issues in their lives: home, work, education
(d) assistance in regaining their ability to manage their own lives, through psychological approaches

These messages, and other national and international studies, influenced the development of new models of care, which were finally formalised in the National Service Framework for Mental Health (Department of Health, 1999) and the NHS Plan (Department of Health, 2000), in which Assertive Outreach, Early Intervention and Crisis Resolution/Home Treatment Teams were made national targets or ‘must dos’.

In many parts of England, a great deal of service redesign was underway. In Staffordshire, for instance, as part of the closure of St Matthews Hospital there was a radical programme of bed reduction and the establishment of locality teams specialising in primary care support, therapy and crisis response. All key stakeholders had influenced the service design and there was a high expectation of improved outcomes for service users and their families. Unfortunately, feedback from service users about the new services was that although the buildings and structures had changed, the expectations of them by staff and the way they felt they were treated had not.
Staff had moved into new roles; there had been very few retirements and redundancies. Training had been provided, largely orienting staff to their new teams, roles and settings. The training and development was only available for a few weeks during the period of transition. Some teams, with inspirational leaders and managers, began to operate them differently, with ongoing supervision and support; but the majority did not.

Over the same period, the Care Programme Approach (CPA), introduced in 1991, was hitting problems and was being carried out as a bureaucratic rather than a person-centred approach to assessment and care planning. Initiatives sprang up, however, such as the development of the Avon Mental Health Measure (see www.mind.org.uk) to enable service users to lead their own assessments and deliver meaningful objectives for their care plans. In the author’s patch, a piece of work was commissioned to facilitate the engagement of service users and carers in the assessment and care planning process of CPA.

An important finding in the evaluation of this work was that service users were anxious about and therefore reluctant to articulate their aspirations, which may, for example, have been to get a job or to come off medication. They felt that this would not be taken seriously by staff and may even have been used as evidence of ‘lack of insight’. This was echoed by the views of some staff. It clearly illustrated the importance of the need for an open dialogue between practitioners and service users; and for practitioners to re-evaluate their expectations of the views and contributions of the person on the other side of the desk.

It is ironic that what service users and carers describe as the gaps in staff skills are not generally perceived by staff themselves to be a problem. A training need analysis in Staffordshire, for example, of primary and secondary care staff of all professional backgrounds across health and social care, which also asked service users and carers what they most found wanting in staff, showed that staff felt the need for more skills in risk assessment and dealing with crises. Service users and carers described the need for more listening skills, being treated with respect and as a partner in the care process. This was still a common finding in 2007 across newly qualified as well as experienced practitioners in health and social care.

The report Pulling Together: The Future Roles and Training of Mental Health Staff (Sainsbury Centre for Mental Health, 1997) provided a timely position statement, highlighting the need for ‘core’ and ‘distinctive’ competences for all mental health staff. While identifying the importance of considering the needs of service users and carers, and highlighting concern about staff attitudes and values, particularly in inpatient care, these did not figure strongly in staff’s proposed core competences.

Around this time, recovery was beginning to be talked about in mental health circles. Its origins were largely in North America and an early definition (Anthony, 1993), described how ‘a person with mental illness can recover even though the illness is not “cured”.’ (Recovery) is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness.’ This movement was led and championed by service users, but met with early scepticism from the professions.
The National Service Framework for Mental Health implementation process at a national level included the establishment of a Workforce Action Team (WAT). The WAT commissioned work, including the Capable Practitioner Framework from the Sainsbury Centre for Mental Health in 2001, Mental Health National Occupational Standards from Skills for Health, and a national mapping of education and training. This showed significant gaps in pre- and post-qualification training of all staff. Significant omissions included user and carer involvement, mental health promotion, values- and evidence-based practice, working with families, multidisciplinary working and working with diversity. The WAT final report outlined all of the above and other aspects of workforce development and, significantly, recommended the need for the new role of ‘Support Time and Recovery Worker’ (STR). The purpose of the role was to do as it said on the tin, specifically addressing what service users said they wanted from staff: time to be listened to, support to try things out, and to achieve a life that had value and meaning for the person.

In 2002, the National Institute for Mental Health in England (NIMHE) was established. Its role was to help implement mental health policy at a local level. It took the form of a few national programmes: workforce, social inclusion, delivering race equality, acute inpatient care, and the establishment of eight Regional Development Centres to work with local stakeholders, including service users and carers.

The NIMHE National Workforce Programme started its work in 2003 and chunked its work into six key areas:

(a) workforce planning  
(b) recruitment and retention  
(c) new ways of working – for the existing workforce  
(d) new roles – to bring new people into the workforce  
(e) education, training and development – to create capable practitioners  
(f) leadership – to facilitate organisational change and development

This was published in a Mental Health Workforce Strategy in 2004 (Department of Health, 2004a).

A key imperative for the education, training and development aspect of the programme was to prioritise the development of a ‘core curriculum’ or ‘core skills’ for the entire workforce based on the gaps from the Workforce Mapping Report. Furthermore, inquiry reports into untoward incidents had frequently criticised poor risk assessments or inappropriate management of violent behaviour, as well as poor communication and coordination between agencies. In considering how to approach these priorities, the NIMHE National Workforce Programme and the Sainsbury Centre for Mental Health (in a collaborative workforce support unit) reviewed the Capable Practitioner Framework and consulted service users and carers, practitioners, academics and managers specifically about the key gaps in core skills.
It came as no surprise that the frequently expressed concerns of service users and carers were reiterated once again, echoed to some extent by practitioners. Values underpinning skills, knowledge and behaviour were highlighted as the ‘must do’ aspect. This complemented the work being developed on values-based practice by Woodbridge and Fulford (2004). It was therefore agreed that service user and carer concerns should form the basis of our subsequent work at the National Workforce Programme: the Ten Essential Shared Capabilities.

Development of the ten essential shared capabilities

In defining our work, we wanted to use language carefully. The term ‘core’, as linked with competences, has been used to mean ‘shared across all’ as well as ‘specific to one profession’. We therefore decided to use the term ‘shared’ from the outset. We discussed whether we should use the word ‘competences’, but competences were much more detailed than we wanted and, in any case, Mental Health National Occupational Standards were already in development. We preferred broader descriptions of values-based practice, which would build on the well-received Capable Practitioner Framework, to enable the whole of the workforce to see the wood for the trees. So we opted for the word ‘capabilities’. Finally, we wanted to emphasise the importance of the shared capabilities, so ‘essential’ was the final part of our description: Essential Shared Capabilities (ESC). We did not know at the outset that there would end up being 10!

The Ten Essential Shared Capabilities were developed into a framework for the whole of the mental health workforce, which was published in 2004 (Department of Health, 2004c). They are summarised as follows:

(a) ‘Working in Partnership. Developing and maintaining constructive working relationships with service users, carers, families, colleagues, key people and wider community networks. Working positively with any tensions created by conflicts of interest of aspiration that may arise between the partners in care.’

People who use services need to be viewed as partners in care rather than passive recipients of services. Practitioners will need the ability:

- to explain in an understandable way their professional role and any parameters they work within
- to communicate with all stakeholders involved in an individual’s care
- to engage service users in a collaborative assessment process
- to acknowledge the part that families and carers play in the service users’ support network and be able to engage them as partners in care
- to communicate across disciplines, professional and organisational boundaries

(b) ‘Respecting Diversity. Working in partnership with service users, carers, families and colleagues to provide care and interventions that not only make
a positive difference but also do so in ways that respect and value diversity including age, race, culture, disability, gender, spirituality and sexuality.

Practitioners will need to:

■ understand and acknowledge diversity
■ understand the impact of discrimination and prejudice on mental health and mental health services
■ demonstrate a commitment to equal opportunities for everyone
■ respond to the needs of people sensitively
■ promote people’s rights and responsibilities and recognise the service users’ rights to privacy, dignity, respect and confidentiality

(c) ‘Practising Ethically. Recognising the rights and aspirations of service users and their families, acknowledging power differentials and minimising them wherever possible, providing treatment and care that is accountable to service users and carers within the boundaries prescribed by national (professional) legal and local codes of ethical practice.’

Practitioners will need to demonstrate:

■ an understanding of and commitment to the legal and human rights of service users and carers
■ an ability to respond to the needs of people in an ethical, honest and non-judgemental manner
■ an ability to encourage active choices and participation in care and treatment

(d) ‘Challenging Inequality. Addressing the causes and consequences of stigma, discrimination, social inequality and exclusion on service users, carers and mental health services. Creating, developing and maintaining valued social roles for people in the communities they come from.’

In order to challenge inequality, practitioners need to:

■ understand the nature of stigma
■ understand the effects of exclusion and discrimination and the role that mental health services play in this process
■ demonstrate an ability to challenge discrimination and communicate concerns to others

This capability has further been developed in the light of what we know about social exclusion and what practitioners can do to promote social inclusion.

(e) ‘Promoting Recovery. Working in partnership to provide care and treatment that enables service users and carers to tackle mental health problems with hope and optimism and to work towards a valued lifestyle within and beyond the limits of any mental health problem.’
Recovery is what people experience themselves as they become empowered to achieve a life that is meaningful in their own terms. Practitioners need to:

■ understand that recovery is a process that is unique to each person
■ understand the essential role of hope in the process
■ accept that recovery is not about the elimination of symptoms or the notion of cure
■ work in a way that is flexible and responds to the expressed needs of the person

(f) ‘Identifying People’s Needs and Strengths. Working in partnership to gather information to agree health and social care needs in the context of the preferred lifestyle and aspiration of service users, their families, carers and friends.’

The focus is to enable people to describe their experience in such a way as to identify their strengths and formulate their needs as a person. Practitioners need to:

■ carry out (or contribute to) a systematic whole systems assessment, focusing on strengths and needs rather than on problems and symptoms

(g) ‘Providing Service User Centred Care. Negotiating achievable and meaningful goals; primarily from the perspective of service users and their families. Influencing and seeking to achieve these goals and clarifying the responsibilities of the people who will provide any help that is needed, including systematically evaluating outcomes and achievements.’

Goals need to be, first and foremost, meaningful to the person for whom they are set; they need to have achievable and measurable steps so that success can be measured or so that the plan can be revised. Practitioners need:

■ to work alongside service users to help them describe their goals as precisely and meaningfully as possible
■ to help the service user identify and use their strengths to achieve their goals and aspirations

(h) ‘Making a Difference. Facilitating access to and delivering the best quality, evidence-based, values-based health and social care interventions to meet the needs and aspirations of service users and their families and carers.’

Much of what is practised in mental health service has no evidence base. In some cases, service users describe those services as helpful, such as alternative therapies. What does have an evidence base (as defined by being included in National Institute for Health and Clinical Excellence guidance), on the other hand, is frequently not implemented. Both of these issues are a source of concern. Practitioners need to:

■ be aware of and seek to implement evidence-based practice
gather information on a regular basis in order to develop evidence from practice

(i) ‘Promoting Safety and Positive Risk Taking. Empowering the person to decide the level of risk that they are prepared to take with their health and safety. This includes working with the tension between promoting safety and positive risk taking, including assessing and dealing with possible risks for service users, carers, family members, and the wider public.’

Risk assessments and risk management are essential, but they can feed into defensive practice if they are not integrated into a person-centred assessment and care planning (CPA) process. Practitioners need to:

- demonstrate the ability to form harmonious working relationships with service users and carers and involve them in risk management strategies

(j) ‘Personal Development and Learning. Keeping up to date with changes in practice and participating in life long learning, personal and professional development for oneself and colleagues through supervision, appraisal and reflective practice.’

Practitioners need to be active participants in their own development and supported by their colleagues and employing organisation to do so. Staff are the most important resource and have the most impact on the experience of people using services. The vast majority come in to services to do the best they can for the people they are working with. The fact that they end up doing things that do not help people is due to a number of factors, including inadequate or outdated training, poor ongoing support and supervision to foster personal growth and self-questioning, and inadequate multidisciplinary working.

Implementing the ten essential shared capabilities

It is one thing to produce a framework for the whole of the workforce; it is quite another to implement it! It was decided to develop learning materials as a first step towards implementation. The NHSU, at the time, agreed to fund the process and the first materials were printed and distributed for field testing in 46 sites across England in 2005. The materials were produced in both paper and CD-Rom versions.

A formal, external evaluation was completed and published (Brabban & Brooker, 2006). 579 learners and 75 facilitators took part in the evaluation and the overall results were highly positive. The key recommendations included:

(a) ‘Experts by Experience’ should be involved in the delivery of specific ESC (Essential Shared Capabilities) modules wherever possible.

(b) Group facilitation is the preferred mode of delivery rather than individual study alone, as it is important for values-based issues to be challenged by peers.
(c) The material needs to be made more relevant to non-clinical staff, by using different case study examples.

(d) 98% of participants used the paper version rather than the CD Rom, so revised materials need to be available in printable form.

(e) The hours of study are likely to be in excess of what was originally estimated (16 hours).

(f) There are opportunities for more in-depth learning through extensive references, to accommodate practitioners from a variety of backgrounds and with different levels of expertise.

In the light of the recommendations, the learning materials were modified and are now available on the website of the Centre for Clinical and Academic Workforce Innovation at the University of Lincoln (commissioned by NIMHE to undertake the work) www.lincoln.ac.uk/ccawi.

Discussions have been held with all of the key professions to ensure that the ESC are addressed within their pre-registration training programmes. They are now referred to explicitly in clinical psychology training, in the College of Occupational Therapists, and by the General Social Care Council for Social Work. They were included in the Chief Nursing Officer’s review of mental health nursing in 2006, which emphasised a commitment to recovery. Active discussions have been held with the Royal College of Psychiatrists and the ESC have been addressed in some undergraduate medical training.

There is a danger, however, that the cross-referencing aspect of training can be a tick-box exercise rather than an in-depth scrutiny of the curricula. A separately funded project, Mental Health in Higher Education (see www.mhhe.heacademy.ac.uk) set up to facilitate interdisciplinary learning in mental health, is actively promoting the ESC with all its academic partners to engage them in a fundamental, root-and-branch review of their curricula.

All employing organisations have been encouraged to integrate the ESC into their training strategies and there are increasingly frequent examples of positive practice.

Building on the ten essential shared capabilities

An induction module is being developed to enable the ESC to become integrated in the time-pressured induction programmes in health and social care organisations.

Additional, more in-depth materials have been developed or are in the process of development to expand on the ESC:

- **Promoting Recovery**: A recovery module on a CD-Rom has been produced, which outlines a two-day programme with associated learning resources: ‘Creating and Inspiring Hope’ – Integrating recovery values and principles into everyday practice.
- **Respecting Diversity**: Race Equality and Cultural Capability (RECC) learning materials have been developed, field tested in four sites nationally and revised; they were published in 2007.

- **Challenging Inequality**: A framework called ‘Capabilities for Inclusive Practice’ has been developed, published in 2007.

- **Identifying People’s Needs and Strengths; Providing Service User Centred Care; Promoting Safety and Positive Risk Taking**: Through the review of the Care Programme Approach (2007/2008), learning materials to cover the assessment, care planning and risk processes will be available in 2008.

**What are the continuing challenges?**

Producing learning materials is only one step. They are now available as an ‘off-the-shelf’ resource for everyone. How they are delivered and facilitated will make the difference. This means that facilitators need to have undergone values-based training. Equally, it is increasingly recognised that service users and carers are a great source of trainers, not only in describing their experience but also as facilitators in their own right. Ways of involving service users and carers is described in a report by Tew, Gell and Foster (2004). This is one way of ensuring that training is values based and grounded in the experience of the person using them.

Training and development still tends to occur in an unsystematic manner, not related to the needs of service users and of the service as a whole. A ‘Learning and Development Toolkit’ for the whole of the mental health workforce (Department of Health, 2007a) has been produced to help local health and social care organisations identify their priorities and develop learning and development strategies.

What people learn and how they put what they have learned into practice is a key challenge for all students, practitioners, educators and employing organisations. It is unhappily all too common for people undertaking training, both at pre- and post-registration levels, to find that their new skills or attitudes do not sit well with existing models of service or with what the team or service has been doing traditionally. Training to provide psychosocial interventions is a case in point and, more recently, training for non-medical prescribing.

Person-centred values, which challenge the culture of many existing services, run the risk of being discouraged in new trainees and converts. This relates back to the earlier point that staff are often unaware that what they do is actually not focused on the needs and wishes of the service user and carer. The suggestion or impression that this is the case can lead to defensiveness and hostility. Indeed, feedback from employers suggests that the ESC are often seen as most appropriate for the non-professionally qualified workforce. While this is heartening on the one hand, it ignores the fact that mental health professionals also need to base their work on these capabilities. The experience of Support, Time and Recovery workers, for instance, shows that the greatest challenge to the
successful implementation of their role is from experienced practitioners, who do not have a full understanding of, or commitment to, their recovery-oriented approach.

In seeking to ensure that we have capable practitioners in the future, therefore, we need to ensure that there are also capable teams and services in which they can work effectively.

### Conclusions and the way forward

The values that should underpin how services are designed and delivered have become clearer over the years. The Ten Essential Shared Capabilities have been specifically developed to articulate the primacy of person-centred values.

Making the ESC core to what practitioners do is not an easy task, as they challenge different professional perspectives. They overarch the medical, psychological and social models and their implications for formulating needs.

Help is at hand, however, in the approach of New Ways of Working (NWW). Work started on this in 2003 and since that time three key reports have been published: *New Ways of Working for Everyone* (Department of Health, 2007b) and its two preceding reports, *New Ways of Working for Psychiatrists: An Interim Report* (Department of Health, 2004b) and *New Ways of Working for Psychiatrists: Final Report – But Not the End of the Story* (Department of Health, 2005). NWW challenges custom and practice; it is about making jobs doable for staff, but it is also about delivering services more effectively to meet the needs of people with mental health problems and those of their carers. All three reports explicitly state that the ESC must underpin what all practitioners need in order to deliver effective New Ways of Working.

The Creating Capable Teams Approach (Department of Health, 2007c) provides a means for multidisciplinary teams to review what they are doing, based on service user and carer needs, to facilitate New Ways of Working and to develop more appropriate education and training for team members. The ESC are used to underpin the preparation of the team for the process.

The Ten Essential Shared Capabilities have considerable validity and present significant challenges to practitioners developing their practice. They make explicit the values that should underpin modern mental health services and what practitioners do to make their efforts more relevant to service users and carers. Who would argue with that?

### References


**Web sites**

Centre for Clinical and Academic Workforce Innovation: www.lincoln.ac.uk/ccawi
New Ways of Working: www.newwaysofworking.org.uk
Skills for Health: www.skillsforhealth.org.uk
MHHE: www.mhhe.heacademy.ac.uk)