# National Curriculum for Mental Health and Wellbeing Practitioners

## Introduction

Mental Health and Wellbeing Practitioners (MHWPs) are trained to work with adults and older adults with severe mental health problems such as psychosis, bipolar disorder, problems associated with 'personality disorders', bulimia and binge eating disorder. Alongside multi-disciplinary team members they co-ordinate care, supporting collaborative decision-making about care and treatment, in the context of a trauma-informed approach. They also deliver a set of wellbeing-focused psychologically-informed interventions, aligned to cognitive-behavioural principles, based on the best evidence available, that address problems often experienced by people with severe mental health problems. Their work will include carers and families (with consent) to enable connectedness and informal support. Shared decision-making and the interventions will be underpinned by generic therapeutic competences within the NICE-recommended interventions for severe mental health problems[[1]](#footnote-2). They can work across a range of pathways of care including adult community mental health, perinatal mental health and drug and alcohol services. Key to their successful deployment is that their work should focus on severe mental health problems, that they should have excellent supervision and they should be trained to a very high standard in the specific interventions and processes in this curriculum. MHWPs both provide psychological interventions and plan care in partnership with service users (whilst not being designated as care co-ordinators, as this role is being phased out). This means holding a smaller caseload than if they were only care planning.

This curriculum should be read alongside the [Mental Health and Wellbeing Practitioner Guide to Practice](https://www.hee.nhs.uk/our-work/mental-health/new-roles-mental-health/psychological-professions-roles), which sets out more detail on the clinical method and interventions as well as methods of assessing trainee competence that should be used.

### Entry Requirements

The curriculum is designed so that it can be available at both undergraduate (level

6) and postgraduate certificate level (level 7). It is desirable for entrants to have previous clinical or professional experience in mental health, but this is not essential. They should, however, always have a foundational core knowledge of mental health and relevant services (either through lived experience or work experience). Entrants should always have demonstrable interpersonal skills and values consistent with providing hopeful, person-centred care. They should show a commitment to working with people with complex mental health needs. They should hold evidence of academic credit or equivalence allowing entry to either the Level 6 or the Level 7 programme. A degree at 2:2 or above in any relevant subject, or equivalent, should be considered the minimum requirement for entry to the Level 7 programme. This is a demanding programme of study, requiring the development of demonstrable competences in clinical practice, over a relatively short period of time. Learners will need to be robust and adaptable to develop these competences in what can be challenging environments. Lived experience of mental health challenges is a desirable characteristic for entrants at the right stage of recovery, bringing valuable insight to draw on in the clinical role. Additional support form courses and employers will be important for trainees who experience a recurrence of mental health difficulties during the course.

### Learning and Teaching Strategy

The curriculum is based on three components (see below) delivered over 45 days in total. This number of days is essential to meet the learning objectives specified within the curriculum. Although each component has a specific set of foci and learning outcomes, the clinical competencies build on each other and courses are expected to focus *the majority of their teaching activity* on clinical competence development through clinical simulation/role play. Assessment focuses primarily on trainees’ practical demonstration of competencies. Skills based competency assessments are independent of academic level and must be passed. Students can undertake academic assessments at either undergraduate or postgraduate level, depending on their prior academic attainment. Learners are expected to develop competences in both in person and video platform delivery of interventions. The education should be delivered by blended learning (i.e. both in person and remote synchronous taught content and skills practice), recognising that overall student experience is enhanced through in person taught components and skills practice across the whole period of study.

The curriculum includes both theoretical learning and skills practice within the Higher Education Institute and practice-based learning directed by the education provider that extends learning into practice. Over the 3 components comprising a total of 45 days, 30 days are delivered as theoretical learning and skills practice and up to 12 days as directed practice-based learning. Directed practice-based learning tasks include shadowing/observation/joint working, role play/practice with peers/colleagues of assessment and interventions, self-practice of interventions with reflection (i.e. applying techniques to

issues from own life), and directed problem-based learning. Beyond the year’s training the practitioners should have opportunities to embed competences through a period of preceptorship. They should also have access to opportunities to progress within the MHWP role, and beyond it into psychological therapy or clinical psychology training, after a required period of qualified practice.

Self-directed study is not counted within the 45 days allocated for the three modules and should be provided by employers in addition. Full time trainees would be expected to have a minimum of 10 additional days for course-related self-directed study across the calendar year. Part time trainees would be subject to suitably adapted arrangements. These days should be timetabled by courses in consultation with services.

##### Supervised and Assessed Practice

The training programme requires trainees to learn from observation and skills practice under supervision while working in fully functioning adult community mental health / integrated primary care services, as well as through the theoretical teaching, skills practice and practice-based learning directed by the Higher Education Institute. Trainees should complete a minimum of 80 clinical contact hours with patients within an adult community mental health service as a requirement of their training (of which 40 hours should be specifically delivering psychologically-informed interventions, 15 should be assessment and 25 should be delivering care planning in partnership). The interventions taught on the course are individual interventions, not groups. Trainees can co-facilitate guided self-help groups with appropriately qualified staff as part of their training experience, and up to 10 of the logged intervention hours may be guided self-help group work.

Trainees should undertake a minimum of 40 hours of clinical supervision of which at least 20 hours should be individual caseload supervision (which ensures a review of entire caseload and opportunity to discuss specific clinical issues in detail to allow appropriate next steps to be decided) and at least 20 hours should be clinical skills supervision (which allows learning of clinical skills through presentation and role play of clinical interactions, and the observation of others doing the same). In addition, clinical skills supervisors should ensure that they observe some full sessions delivered by each trainee, and routinely and regularly use recorded clips to support skills development in supervision. Where clinical skills supervision is provided in groups these should be no larger than 3 trainees per group. Although these represent the minimum requirement to pass the course, **individual caseload supervision of one hour per week should be delivered during working weeks**.

These 80 clinical contact hours and 40 supervision hours are in addition to the 15 practice-based learning days directed by education providers. There should be weekly individual caseload supervision (where the entire caseload is reviewed and action agreed to ensure effective safety-planning, where care-plans are reviewed, and interventions reviewed so that next steps can be decided).

For both Trainee and qualified MHWPs:

1. The Clinical Skills Supervisor (CSS) Must be a qualified psychological professional within the current [taxonomy of occupations](https://www.hee.nhs.uk/our-work/mental-health/new-roles-mental-health/psychological-professions-roles) (excluding assistant psychologists), with training and experience working with adults with severe mental health problems, an extensive understanding of using interventions based on cognitive behavioural therapy principles in clinical practice with this client group. This can include suitably trained and experienced psychologists, clinical associates in psychology, psychological therapists and qualified MHWPs. MHWPs and clinical associates in psychology should have at least two years of post-qualification experience before becoming supervisors of MHWPs. The priority should be that Clinical Skills Supervisors fully understand and themselves be able successfully to deliver the interventions that the MHWPs are learning. CSS must evidence competences in the areas covered by the curriculum:
	1. Engagement and assessment with people with severe mental health problems
	2. Care Planning in Partnership
	3. Wellbeing-focused Psychologically-informed Interventions for Severe Mental Health Problems, based on cognitive behavioural therapy principles, including detailed knowledge and experience of the specific MHWP interventions.
	4. Roth & Pilling Supervision competences (generic, specific and green and blue boxes) [https://www.ucl.ac.uk/clinical-psychology/competency-maps/supervision.html](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.ucl.ac.uk%2Fclinical-psychology%2Fcompetency-maps%2Fsupervision.html&data=05%7C01%7Cadrian.whittington%40nhs.net%7C52770e71fe17424e03cb08dae1a9be9b%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638070416412269411%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=%2FJiUFSYTUc6xUyCI%2BBYK5wi62Oh%2Bk9NeWuZJZ%2FeJ49M%3D&reserved=0)

CSS must attend MHWP supervision training with the training provider, aligned to the UCL competence framework for supervision of psychological therapies. This states that supervisor training should cover generic and specific supervision competences. Experienced supervisors of other groups may just attend the specific competences part to learn more about the MHWP role and interventions, whereas supervisors who have not supervised before should attend the whole training1.

1. The Caseload Supervisor (CLS) can be any qualified Mental Health professional with training and experience working with adults with severe mental health problems.  CLS must evidence:
	* + 1. UCL Supervision competences (generic, specific and green and blue boxes)  [https://www.ucl.ac.uk/clinical-psychology/competency-maps/supervision.html](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.ucl.ac.uk%2Fclinical-psychology%2Fcompetency-maps%2Fsupervision.html&data=05%7C01%7Cadrian.whittington%40nhs.net%7C52770e71fe17424e03cb08dae1a9be9b%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638070416412269411%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=%2FJiUFSYTUc6xUyCI%2BBYK5wi62Oh%2Bk9NeWuZJZ%2FeJ49M%3D&reserved=0)
2. CLS must attend MHWP supervision training with the training provider[[2]](#footnote-3).
3. For supervision of MHWP trainees in practice supervisors should be approved against these criteria by both education provider and service professional lead for psychological professions (accountable ultimately to the Chief Psychological Professions Officer; CPPO).

##### Equality, Diversity and Inclusion

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

* 1. Trainees need to be equipped with understanding of equality and diversity in a broader sense too, in that individuals can experience disadvantage due to a wide range of factors, such as geographic location, educational opportunities and economic factors. Structural and organisational practice needs to actively address inequity of access and strive for equality and cultural competence.
	2. Courses should include equality, diversity and inclusion issues within all teaching, with a specific focus on:
		1. Reducing inequity of access to and outcomes of mental health services, across all protected characteristics and other characteristics associated with inequity.
		2. Deploying reasonable adjustments to support access to and effectiveness of services where patients are disadvantaged for reasons of protected characteristics, autism, learning disability or other intersecting factors.
		3. Seeking to eliminate all forms of discrimination from the experience of the mental health patients and staff.
		4. Achieving cultural competence in order to provide culturally informed interventions.

##### Expert by Experience Involvement in Training

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

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

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

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

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

Trainee lived experience of mental health problems should be welcomed, acknowledging the need for inclusive and flexible approaches that support success.

##### Course Structure

The curriculum for the education of Mental Health and Wellbeing Practitioner (MHWP) is organised into three components (see below). Components can be organised according to local module structure requirements by training providers to comply with their academic timetable and tailored to suit local needs. It is expected that the delivery of the three components may overlap rather than be taught sequentially. For example, some interventions should be taught early in the course, and Component 2 and 3 will typically be delivered concurrently.

The first part of the course should be front-loaded with a block of teaching at the start to ensure a good grounding in fundamental clinical skills is acquired early in the trainee's employment, including active listening skills, alliance building and managing strong emotions through validating.

Courses should run as a one-year course (if full time) or up to two years (if adapted for part-time staff). Part time options should be offered for trainees working a minimum of 0.6 wte, as these can widen participation by attracting a wider group of entrants. Adapted training should cover the same taught content in Year 1 but extend the practice-based learning requirements and assessments across 18 to 24 months depending on the trainee's wte in practice. Additional supervision, personal tutoring and skills classes will also be required in Year 2 to ensure effective application of taught content in practice.

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

The curriculum will form the basis of course accreditation with the British Psychological Society.

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

### Component 1 Aims

This component introduces MHWPs to severe mental health problems and teaches how to engage and form collaborative alliances with service users, carers and families. It teaches how to assess (including person-centred risk assessment and safety-planning conversations in the context of severe mental health problems), and arrive at a collaborative, simple formulation which can guide the planning of care and/or psychologically informed interventions to be delivered by the MHWP. It will highlight the value of successful engagement as an end in its own right. There is a significant focus on core clinical skills.

### Component 1 Learning Outcomes:

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

1. Core knowledge of mental health (including common and more severe mental health problems) and the NHS service context;
2. Engagement with warmth and empathy – active listening and enquiry: questioning styles, developing a collaborative alliance, including adapting engagement style in response to needs of different service users, appropriate use of and limitations to personal disclosure;
3. Supporting the service user to maintain and develop relationships within the community in line with the CHIME factors (Connectedness, Hope, Identity, Meaning and Empowerment);
4. Being with someone in distress – managing affect by listening and validating
5. Professional and ethical practice both in the training programme and in practice;
6. Involvement of families and carers in engagement and assessment (with consent from service users)
7. Cultural competence and anti-discriminatory practice – addressing inequities of access and outcome;
8. Respect for and the value of individual differences in age, sexuality, disability, gender, spirituality, ethnicity and culture;
9. Responding to peoples’ needs sensitively with regard to all aspects of diversity, including working with older people, the use of interpretation services and taking into account any physical and sensory difficulties service users may experience in accessing services.
10. CHIME factors –: understanding their link with wellbeing and recovery;
11. Person-centred risk assessment, safety planning and safeguarding;
12. Confidentiality, consent, and the appropriate involvement of families and carers;
13. The experience and core features of psychosis, bipolar disorder, ‘personality disorder’ and eating disorders, and associated difficulties (including anxiety and depression), and helpful adaptations to engagement in the context of each of these difficulties;
14. Reasonable adjustments to make mental health services autism-friendly, and responsive to service users with substance misuse problems;
15. Understanding the relationship between adversity and presentations of severe mental health problems;
16. Trauma-informed care principles in practice, including the role of attachment and self-compassion;
17. Collaborative assessment and formulation within the ‘5 Ps’ framework of Presenting problem, Predisposing factors, Precipitating factors, Perpetuating factors and Protective factors;

### Component 1 Learning and teaching strategy

Skills based competencies will be learnt through a combination of clinical simulation

in small groups working intensively under close supervision with peer and tutor

feedback and supervised practice through supervised direct contact with patients in

the workplace. Knowledge will be learnt through a combination of lectures,

seminars, discussion groups, guided reading and independent study. Some of the knowledge element may helpfully be supported through the practice-based learning days.

### Component 1 Assessment strategy

1) Standardised role-play scenario(s) where trainees are required to demonstrate

skills in undertaking problem focused assessment and 5 P formulation. This will be video-recorded and assessed by teaching staff using standardised assessment measures that measure skills in engagement, flexibility and ability to stick to task.

2) Academic assignment: trainees should also provide a reflective commentary on

their performance on the above, or an alternative academic assignment could be

set e.g. an exam, case report or essay.

3) Successful completion of the following practice outcomes, to be assessed by

means of a practice outcomes portfolio:

* Demonstrates the common factor competencies necessary to engage effectively and involve families and carers in line with the service user’s and their family’s needs, including maintaining appropriate professional boundaries, actively managing a collaborative working alliance and managing endings
* Demonstrates competence in undertaking assessments across a range of presenting problems
* Demonstrates competence in the generation of 5 P formulations with clients

### Component 1 Duration

The following structure is suggested for this component:

12 days in total, with a minimum of9 days of theoretical teaching, skills practice in intensive workshops and clinical simulations and up to3 days undertaking directed practice-based learning in the service setting.

###

**Component 2: Care Planning in Partnership**

### Component 2 Aims

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

### Component 2 Learning outcomes:

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

1. Helpful information giving to service users, families and carers;
2. Shared decision making in practice, based on service user goals;
3. Involvement of families and carers in care planning with service user consent
4. The range of resources available to support wellbeing and recovery in the locality served
5. Understanding the roles in multi-disciplinary teams (within primary care teams and mental health community teams) and working effectively in the team;
6. Understanding the role of employment support in the team;
7. Symptom focused and personal recovery/wellbeing models of mental health;
8. Diagnosis and formulation, how they differ, limitations and benefits;
9. Understanding the role of medication and the competence in providing accurate information about relevant medications to service users, families and carers;
10. Demonstrate awareness and understanding of the power issues in professional /service user and family and carer relationships.
11. Anti-discriminatory practice addressing inequalities of access and outcome across all elements of care planning and delivery of interventions.
12. Demonstrate competence in managing a caseload of people with severe mental health problems efficiently and safely.
13. Collaborative care planning within the multi-disciplinary team, with active safety planning (in response to person-centred risk assessment) and safeguarding and with understanding of the impact of this on service user, family and carers;
14. Use of care planning tools including DIALOG, alongside other measures to track progress with psychological interventions including Goal Based Outcomes and ReQoL-10.
15. Use of clinical information systems and correspondence
16. Reflexive practice and using clinical skills supervision and caseload supervision
17. Self-care and wellbeing for staff and teams

### Component 2 Learning and teaching Strategy

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

### Component 2 Assessment Strategy

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

2) Academic assignment: A Case Report detailing care planning with a service user, linked to relevant theories of mental health and intervention. There must be evidence of appropriate consideration of / engagement with carers and families.

3) Successful completion of the following practice outcomes, to be assessed by

means of a practice outcomes portfolio:

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

### Component 2 Duration

The following structure is suggested for this component:

12 days in total, with a minimum of 9 days of theoretical teaching, skills practice and clinical simulations and up to3 days undertaking directed practice-based learning.

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

### Component 3 Aims

This component enables MHWPs to deliver wellbeing-focused psychologically-informed interventions that support connectedness, hope, identity, meaning and empowerment (CHIME). MHWPs will learn to set collaborative goals with people with severe mental health problems and to deliver six psychological interventions as set out in the MHWP Guide to Practice. The interventions will be applied with appropriate flexibility within the context of a positive collaborative working relationship, whilst maintaining fidelity to the interventions. It will also embed the routine use of patient-reported outcome measures to support collaborative evaluation of progress.

### Component 3 Learning outcomes:

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

1. Collaborative construction of a 5-areas formulation to inform psychologically-informed interventions;
2. Identifying and providing psychoeducation about the impact (helpful and unhelpful) of different thinking styles
3. Collaborative goal setting for wellbeing-focused psychologically-informed interventions
4. Appropriate choice of intervention, when not to intervene, or to pause or end an intervention.
5. Appropriate involvement of families and carers in psychologically-informed intervention
6. Working with motivational difficulties, readiness to change and appropriate adaptations to interventions in light of external factors and/or individual differences impeding progress including but not limited to; learning difficulties and relationship difficulties
7. The effective use of routine sessional patient-reported outcome measures including Goal Based Outcomes and ReQoL-10, as well as any symptom focused measures relevant to a specific intervention
8. Six specific wellbeing-focused psychologically-informed interventions:
	1. Behavioural Activation and Graded Exposure using the “GOALS” programme
	2. Teaching problem-solving skills
	3. Improving sleep
	4. Recognising and managing emotions
	5. Guided self-help for bulimia and binge-eating
	6. Building confidence
9. Relapse Prevention/Staying Well
10. Dealing with endings safely and appropriately;
11. Appreciation of the worker’s own level of competence and boundaries of competence and role

###

### Component 3 Learning and teaching strategy

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

### Component 3 Assessment strategy

1) A recording of a session with a service user delivering one of the specified interventions, rated according to a standardised rating scale

2) A case report of intervention with a service user using one of the specified interventions, linked to relevant theory and critical evaluation.

3) Successful completion of the following practice outcomes, to be assessed by

means of a practice outcomes portfolio:

* Demonstrates the ability to set appropriate goals for intervention collaboratively with service users
* Demonstrates competence in practice to deliver at least three of the specified interventions in the curriculum

### Component 3 Duration

The following structure is suggested for this component:

21 days in total, with a minimum of 15 days to be spent in class in theoretical teaching and clinical simulation and up to6 days undertaking directed practice-based learning.

1. https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks [↑](#footnote-ref-2)
2. In recognition that a service may be served by more than one training provider, where possible, supervisor training should be provided jointly by the training providers. [↑](#footnote-ref-3)