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A survey of pedagogical approaches and quality mechanisms used in education programs for mental health professionals

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The provision of high-quality education and training that is responsive, relevant, accessible and evidence based is critical if the vision for quality mental health services presented in recent policy initiatives in Ireland is to be fulfilled. This paper reports the findings related to pedagogical approaches and quality assurance mechanisms utilized within mental health education. The study involved canvassing all Higher Education Institutions in Ireland. A total of 227 courses in 31 educational institutes were identified and 149 questionnaires were returned from 129 Course Coordinators. Various quality processes were identified in existing programs; however, formal feedback from service providers, service users and carers was seldom reported. Ongoing evaluation and quality assurance strategies are a key element of governance and there is a need to develop strategies that explore the impact of education programs on mental health education and health outcomes. Recommendations are made in terms of future interprofessional mental health education and practice.

Keywords: Assessment, interprofessional practice, mental health practitioners, quality assurance, teaching

INTRODUCTION

Since the World Health Organization published the document *Learning Together to Work Together* (World Health Organization, 1988), 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, 2001; Department of Health & Children, 2006; McVicar, Deacon, Curran, & Cornish, 2005; National Institute for Mental Health & Royal College of Psychiatrists, 2005; Sainsbury Centre for Mental Health, 1997). Interprofessional collaboration has been advocated as a means of enhancing quality patient care and health outcomes (Curran, Sharpe, & Forristall, 2007; Institute of Medicine, 2003; Mental Health Commission, 2005) by synergistically maximizing each professional's contribution (Hoffman, Rosenfield, Gilberry, & Oandasan, 2008; Reeves, Goldman, Sawatzky-Girling, & Burton, 2008). As the composition and mission of mental health teams alters, there is an increased need for shared values and accountability that 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 10 essential shared capabilities (ESCs) framework (Department of Health, 2004; NHS Education for Scotland, 2007). The framework details the knowledge and skills that all staff working in mental health services should achieve, which includes 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. In terms of education and training, the ESCs' quality and standards assessment tool has been developed (Centre for Clinical and Academic Workforce Development, 2005). Moreover, an important Canadian study, investigating interprofessional mental health education initiatives, identified collaborative mental health care as "key to enhancing the mental health services provided to consumers, their families and their caregivers in the community." However, the authors identify specific challenges including a lack of knowledge and skills in collaborative mental health care and highlight the importance of interprofessional education (IPE) and training to enhance the provision of quality mental health services in the future (McVicar et al., 2005). In Ireland,

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with the focus now on primary and community care, and the development of interprofessional mental health teams, the need for healthcare 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 the policy document *Vision for Change* (Department of Health & Children, 2006).

BACKGROUND

Quality and IPE

IPE involves influencing attitudes, knowledge, skills and behavior (Duffy, 2008). Although interprofessional team working is being emphasized in health and social care delivery, students traditionally have little formal contact with other professionals during their education experience. The consensus view among academics is that IPE should be encouraged, and a number of pilot initiatives have been developed in mental health settings (Pauze & Reeves, 2010). Although the authors reported some positive outcomes, such as improving the knowledge and skills of professionals providing care to people with mental health problems, there remains the need for research to address the critical issue of how IPE affects changes in professional practice, healthcare processes and client outcomes (Reeves et al., 2008). Other studies discovered that continuing professional development (CPD) training courses were largely attended by nurses compared to other professionals, such as psychiatrists or psychologists (Carpenter, Barnes, Dickinson, & Wooff, 2006; Reeves & Freeth 2006; Reeves, Freeth, Glen, Leiba, Berridge, & Herzberg, 2006), with the involvement of medicine rare at post-qualification level (Ross & Southgate, 2000).

All of the existing studies report the use of a variety of small group learning strategies, such as discussion, role-play and problem-solving groups. Furthermore, other important pedagogical principles and strategies are recognized as fundamental components within IPE, for instance, combining didactic and experiential learning, reflective learning, situated learning, self-directed learning and using both education-based and work-based situations (Hammick, Freeth, Koppel, Reeves, & Barr, 2007). In line with international trends, in Ireland, the Department of Health & 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 IPE for mental health practitioners. Although very little research exists that measures the effectiveness of user and carer involvement on learning and practice, the consensus view internationally is that it should be encouraged (Higgins, Maguire, Watts, Creaner, McCann, Rani, & Alexander, 2011).

The evidence that is available from nursing, psychology and social work suggests that the involvement of users and carers may impact on service provision and student learning by increasing students' communication, partnership and advocacy skills (Beresford & Croft, 2004; Curran, 1997; Duffy, 2008; Simons, Tee, Lathlean, Burgess, Herbert, & Gibson, 2007; Tew, Gell, & Foster, 2004; Wood & Wilson-Barnett, 1999); challenging professional orthodoxies and power (Beresford & Croft, 2004; Harper, 2002; Rush & Baker, 2006; Tew et al., 2004) and enabling practitioners to be more conscious and reflective of the implications of treatments and approaches used (Repper & Breeze, 2007; Townend, Tew, Grant & Repper, 2008; Wood & Wilson-Barnett, 1999). Furthermore, existing 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 insights into their problems (Barnes, Davis, & Rogers, 2006; Repper & Breeze, 2007; Walters, Buszewicz, Russell, & Humphreys, 2003).

Clinical supervision, as a mechanism for quality assurance, may influence the quality of services being provided. Clinical supervision exists for the welfare of the service user, the competence of the practitioner in training and ongoing professional development (Bernard & Goodyear, 2009; Bogo & McKnight, 2006; Cutcliffe, Butterworth, & Proctor, 2001; Milne, 2006; Munson 2002; Spence, Wilson, Kavanagh, Strong, & Worrall, 2001). The benefits of supervision have been referenced in the Irish government's report *Vision for Change* (Department of Health & Children, 2006), wherein the need for supervision for mental health professionals is highlighted. More recently, the discussion document *Clinical Supervision: A Structured Approach to Best Practice* from the National Council for the Professional Development of Nursing and Midwifery has conceptualized supervision as a method of reflective practice and further supports the role of clinical supervision in CPD for optimal client/patient care (National Council for the Professional Development of Nursing & Midwifery, 2008). However, further systematic research is needed to support such programs in terms of quality delivery and enhanced patient outcomes. Nevertheless, it seems clear 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.

This study explored the current education and training opportunities for mental health professionals working in the Republic of Ireland. This paper reports on the teaching, assessment and quality assurance mechanisms identified and used in professional mental health education.

METHODS

The aim of this study was to explore the education and training available to professionals working in mental health services in the Republic of Ireland. The research design was an exploratory descriptive design using postal questionnaires for data collection. The questionnaire, designed specifically for the study, consisted of 38 questions that addressed issues such as level of award, course duration, funding, accreditation, target professionals, service user involvement, quality mechanisms, professional development and teaching, assessment and evaluation strategies. The instrument was

developed by the research team and was piloted among seven course coordinators/directors.

Sampling

All Higher Education Institutes (HEIs) and professional organizations websites and other documentation were accessed. Requests were made to professional organizations to provide information on approved courses. Direct contact was made, through letter or telephone, with third-level educational institutions. In total, 227 courses from 31 educational institutions were identified as fulfilling the inclusion criteria for the study. The criteria included delivery within a HEI in the Republic of Ireland; undergraduate degrees leading to professional registration of accreditation; postgraduate taught courses aimed at mental health professionals.

Data collection

The questionnaire was distributed to each course coordinator at the identified educational institutions and asked to return the questionnaire in the stamped addressed envelope supplied within a 2-week period. Ethical approval to conduct the study was given by the Research Ethics Committees of the Faculty of Health Sciences within the University.

Response rate. Reminders, in the form of letters or emails, were sent to encourage a satisfactory return rate. Follow-up telephone calls were also used. In total, 137 questionnaires were returned from 129 coordinators/directors. This represented a 60% return rate for the questionnaires. Sixty-nine percent ($n = 94$) of the courses were uniprofessional and the remaining 31% ($n = 43$) were interprofessional in nature. A higher proportion of questionnaires were returned from nursing, occupational therapy (OT) and speech and language therapy (SLT) departments. The lowest number was from social sciences departments. Over 50% ($n = 28$) were returned from departments categorized as "others." These included departments such as education, arts, political science, healthcare management, counseling/psychotherapy and theology (Figure 1).

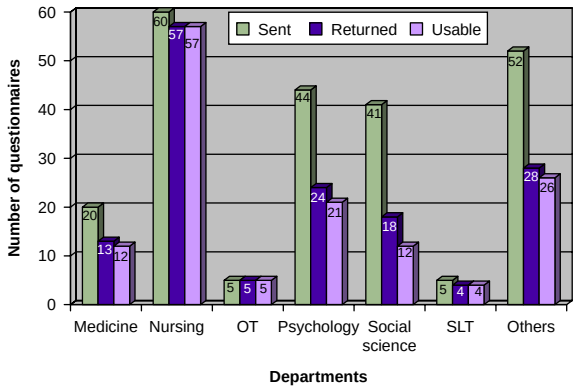

Figure 1. Questionnaires sent, returned and usable per department.

Data entry and analysis

Data were entered onto the Statistical Package for Social Science (Benjamin & Baker, 2000) package Version 16.0 and analyzed using descriptive statistics, such as frequencies, percentages and ranges in relation to both interprofessional and uniprofessional variables.

FINDINGS

Findings from the analysis of the questionnaires are presented in the following five sections: "professional development," "topics and teaching methods," "assessment of learning," "practice placements and supervised sessions" and "quality assurance mechanisms."

Professional development

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 up to date with current policy, service and practice development through reading policy, research and theoretical literature (97%, $n = 130$), and through CPD (93%, $n = 125$). In addition, researching issues from practice (77%, $n = 103$), spending time in practicing 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 counseling/psychotherapy and/or applied psychology.

Topics and teaching methods

All respondents mentioned the need for education to focus on the development of competencies in key subject areas including psychosocial and psychotherapeutic approaches, recovery and social inclusion, needs of specific client groups, new models of service delivery, multicultural awareness, and leadership and management. Respondents were requested to indicate on a Likert Scale, ranging from "very strong" to "none," their perception of emphasis given to theoretical and clinical topics within the curriculum. Analysis revealed that 60% ($n = 82$) of the courses had a strong or very strong emphasis on the theoretical and clinical components identified; however, 23% ($n = 31$) had little to no emphasis.

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

Table I. Teaching methods used in uniprofessional and interprofessional courses.

	Uniprofessional ($N = 94$)		Interprofessional ($N = 43$)	
Teaching methods	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

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. Some of the courses (18%, $n = 25$) reported using other teaching methods including action learning, blended learning, case-based learning, simulation, microteaching, task-based learning, student presentation and use of clinical skills laboratories. Further analysis of the teaching methods used indicates that there is very little difference between uniprofessional and interprofessional courses. Surprisingly, the lecture method continues to feature strongly in interprofessional courses with no appreciable difference in the use of experiential methods or problem-based learning (Table I).

Assessment of learning

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 (OSCEs) (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.

A further analysis of assessment methods used revealed that similar assessment methods are used on both uniprofessional and interprofessional courses, with the exceptions of direct observation of competence in practice and OSCEs, which are infrequently used on the interprofessional courses (Table II).

Practice placements and supervised sessions

Over half of the courses (60%, $n = 81$) 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 III.

Quality assurance mechanisms

Most of the courses utilized 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 organization (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 group (11%, $n = 15$) and family/carer (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 (see Figure 2).

Table II. Assessment methods used in uniprofessional and interprofessional courses.

	Uniprofessional ($N = 94$)		Interprofessional ($N = 43$)		Total ($N = 137$)
Assessment methods	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

Table III. Practice placement requirements by the courses within the departments/schools.

	Placement required	
Departments/schools	Number	%
Medicine ($N = 12$)	7	58
Nursing ($N = 57$)	41	72
Psychology ($N = 21$)	9	43
OT ($N = 5$)	3	60
Social science ($N = 12$)	6	50
SLT ($N = 4$)	3	75
Others ($N = 26$)	12	46
Total = 137	81	60

DISCUSSION

The findings indicate that IPE is being provided to mental health professionals in Ireland, with courses available in a variety of departments and taught by a diversity of professional staff. However, less than one-third of courses were identified as interprofessional which means that current mental health policy directives are not being met (Department of Health & Children, 2006). While the didactic and lecture format was favored as a teaching method, self-directed and experiential learning approaches were also employed. Problem-based and practice-based learning strategies were used in just over half the courses. A variety of assessment methods were also used within the courses, with the exception of direct observation of practice and OSCEs, which involved some form of written assignment. While these findings reflect an incorporation of more experiential learning strategies and assessment techniques, they still indicate that educators are relying on traditional methods for IPE. Notably, very few indicated that online or distance learning was utilized. As recent literature advocates the use of combined teaching strategies (Hammick et al., 2007; Reeves et al., 2008), it is worthwhile that educators consider incorporating more diverse teaching and learning methods. 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. HEIs should be encouraged and supported in the development of a variety of flexible learning approaches and methodologies.

In terms of quality assurance mechanisms, it is encouraging that the findings show that the vast majority of courses are using various types of evaluation, with external examiners and student feedback used most frequently. Several other mechanisms were used including feedback from professional accreditation bodies, management committees and lecturing staff. Clinical supervision was used only by a very small cohort despite policy recommendations and the clear benefits in terms of professional practice and staff development (Bernard & Goodyear, 2009; Bogo & McKnight, 2006; Department of Health & Children, 2006). Further research is needed to establish the efficacy of clinical supervision with respect to client/patient outcomes and to develop and evaluate supervision methods that are congruent with best practice (Department of Health & Children, 2006; Mental Health Commission, 2008). Formal feedback from health service providers, service users or carers was also infrequently reported. In addition to the current evaluation and quality practices identified in this study, there is a need to develop strategies that explore the impact of education programs on service provision and health outcomes, incorporating the perspectives of service providers, service users and carers (Higgins et al., 2011; Repper & Breeze, 2007). These approaches may address some of the aspirations detailed in the most recent policy documents that highlight future challenges facing higher education in Ireland (Higher Education Authority, 2011).

Although service users participated in teaching sessions by sharing their experiences with students, few were involved in other educational aspects of the courses, such as course design and evaluation, and the selection or assessment of students. It is notable that very few courses involved family members or carers in teaching. This is in stark contrast to directives contained in recent government policy documents

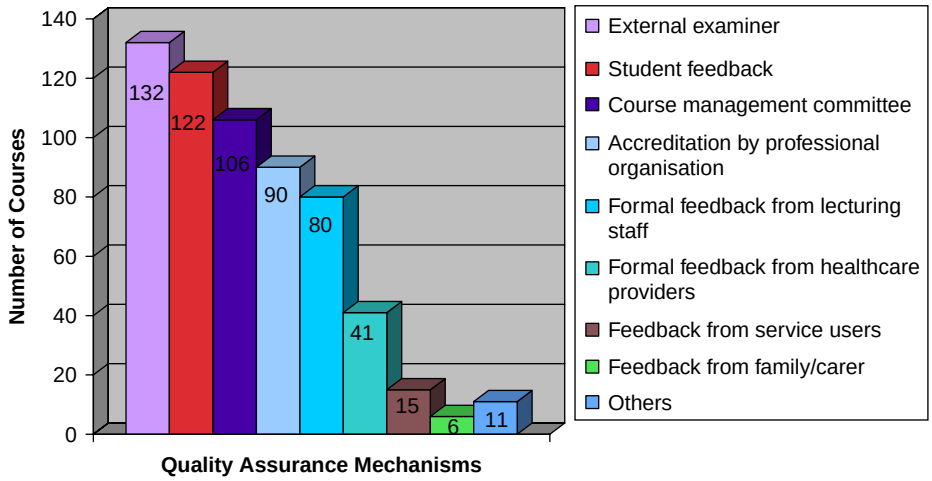

Figure 2. Quality assurance mechanisms used on the courses.

and should be addressed by involving service users, families and carers in all aspects of mental health education provision (Department of Health & Children, 2006; Mental Health Commission, 2008).

As the sample is not representative of all courses in Ireland fulfilling the inclusion criteria, the results are not generalizable. Specifically, there was a particularly high rate of mental health course coordinators in the sample. Furthermore, the courses included in the study are provided by HEIs and CPD courses provided by other organizations, such as professional groups, are not included in the study.

CONCLUDING COMMENTS

Recent research has called for increased use of IPE in healthcare education (Anderson, Cox, & Thorpe, 2009; Baldwin & Baldwin, 2007; Pauze & Reeves, 2010). This study has shown that although some IPE courses are available, there is a need for more diverse teaching strategies, enhanced evaluation techniques and the increased involvement of service users and carers. It is only by addressing these issues that mental health education providers can hope to respond to policy initiatives and guidance documents which have continuously emphasized 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 & Children, 2006; Mental Health Commission, 2008; National Economic & Social Forum, 2007). It is recommended that the Health Service Executive in Ireland, in partnership with HEIs and the Mental Health Commission, develops an education strategy that will support the provision of high-quality education and training that is responsive, relevant, accessible and evidence based. This is critical if the vision for quality mental health services, articulated in all of the recent publications is to be realized.

Declaration of interest

The authors report no declarations of interest. The authors alone are responsible for the writing and content of this paper.

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