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Train the trainer toolkit

for a sustainable method of primary care mental health education

Developing people for health and healthcare

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Contents

"Clinicians and commissioners each have an opportunity to make a difference to their patients in primary care by becoming better informed about mental illness and how to identify and manage it"

The purpose of this document

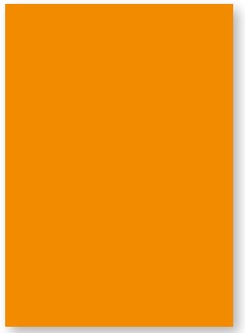
This toolkit has been written to assist providers of primary care services to use a train the trainer method of education to upskill their workforce in mental health and wellbeing. Providers of other services may also find it helpful.

To have a real impact on the quality of care delivered to patients and service users, Health Education England are committed to a number of educational outcomes. The first being that education and training are commissioned and provided to the highest standards, ensuring learners have an excellent experience and that all elements of education and training are delivered in a safe environment for patients, staff and learners[1].

The District Nursing and General Practice Nursing Service Education and Career Framework[2] developed by the Department of Health, Health Education England and Skills for Health include enhanced awareness of mental health issues in their core values, skills and competencies for these disciplines. Their rationale is that many patients experience poor mental health alongside other physical conditions and may need signposting or support to manage their wellbeing.

In this toolkit the importance of educating the primary care workforce in mental health education and the benefits of using a train the trainer approach are defined. The level of training required by different clinicians is briefly described[3]. Real case studies are provided to demonstrate the need for an organised system.

A checklist is given to explain the process of utilising the train the trainer method of education in a clear concise way. Talking to commissioners who have been involved in organising training has helped to shape this. While the examples used in this document relate to mental health, the guidance included will also be applicable to train the trainer education in other subject areas.



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Why mental health education is required in primary care

Experts have reported that one in every four patients seen in primary care in England will need treatment for a mental health problem[4]. Between 2013 and 2014, there were nearly three million adults on the primary care disease registers with depression, and approximately 500,000 with a severe and enduring mental health problem[5]. In 2012, a total of 202 GPs in the United Kingdom reported that 84% of their consultations were attributed to issues with stress and anxiety, and 55% were mental health issues[6].

The **Adult Psychiatric Morbidity Survey (APMS) series**[7] carried out in 2014 from NHS Digital's website found that one adult in six (17%) had a common mental disorder (CMD), signs of drug dependence and probable alcohol dependence were evident in one adult in thirty (3%), and reported rates of self-harming increased in men and women and across age groups since 2007. Young women emerged as a high-risk group, with high rates of CMD, self-harm, and positive screens for post-traumatic stress disorder (PTSD) and bipolar disorder. Most mental disorders were more common in people living alone, in poor physical health, and not employed. Claimants of Employment and Support Allowance (ESA), a benefit aimed at those unable to work due to poor health or disability, experienced particularly high rates of all the disorders assessed.

In 2016 MIND published a **report for Clinical Commissioning Groups**[8]. In it they explain that patients may visit the GP or practice nurse and discuss other concerns that are impacting on or are related to their mental health. They may attend their GP practice frequently before their underlying mental health needs are addressed. The authors of the report recommend a greater focus on mental health in initial training for the primary care workforce and importantly those already working in primary care should receive regular training on mental health. A national survey of practice nurses showed that 82% of respondents thought that they were responsible for managing patients' mental health and wellbeing without having received appropriate training[9]. The authors of the five year forward view for mental health advocate that the training of GPs could be improved to ensure that they are fully supported to lead the delivery of multidisciplinary mental health support in primary care[10]. This suggests that there is a need for providers to have a system to ensure GPs and other practice staff receive regular mental health training relevant to their position.

"One in every four patients seen in primary care in England will need treatment for a mental health problem"

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The benefit of training primary care staff in mental health

Academic literature regarding primary care mental training published in the last three years is limited but positive.

Some papers discuss the perceived need for training. A systematic review of the recognition and management of perinatal depression and anxiety by general practitioners suggested that more standardized training could help to improve recognition and management practices[11]. A survey of 100 primary care physicians and 100 psychiatrists concluded that clinicians in the United Kingdom should undergo training regarding depression[12]. A national audit of 390 practice nurses found that 98% would like to attend a course related to mental health and wellbeing[13]. A survey of 155 community pharmacy staff following a training programme showed a desire for mental health education[14].

Several papers describe the effect of training programmes. Webster et al[15] trained practice nurses to deliver a psychosocial intervention within a collaborative care framework for people with depression and long-term conditions. Patients perceived the practice nurse (PN) being available to listen as valuable. Barriers were competing practice priorities, perceived lack of time and resources, and lack of engagement by the whole practice team. The authors concluded that there is a need for formal supervision of PNs. A GP training programme on referrals for people at high clinical risk or first episode of psychosis carried out in 48 practices resulted in a significant increase in referrals to the two specialized teams and a significant increase in direct referrals to the teams from GPs[16]. A cascaded training programme for perinatal mental health resulted in 400 perinatal mental health champions educating over 3000 health visitors with many new services being developed as a result[17]. One study trained twenty community matrons in CBT-based skills training and provided supervision[18]. Their knowledge and understanding of CBT-based techniques significantly improved following training, although did not always seamlessly translate into effective practice. The authors recommend the community matrons share their positive practice among peers to maximise the perceived value of this approach. Seven GP practices in four localities were provided with mental health training for all staff which included elements of knowledge transfer, systems review and active linking[19]. Staff who had engaged with the training programme reported increased awareness, recognition and respect for the needs of patients from under-served communities. The authors received reports of changes in style and content of interactions, particularly amongst receptionists, and evidence of system change. In addition, the training programme encouraged signposting to community agencies within the practice locality. A modular programme of mental health and wellbeing was delivered to practice nurses by mental health nurses who were trained as educators[20]. The educators were supported by attending action learning sets. The programme also included e-Learning modules. The authors concluded that using the train the trainer approach gave the practice nurses a different point of view and the mental health nurses gained an appreciation of the practice nurses' workload and skills.

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The train the trainer approach

Train-the-trainer (TTT) refers to a programme of education where practitioners receive training on a defined subject and instruction on how to train, monitor, and supervise other professionals[21].

The TTT approach is based on two theories. Firstly, the adult learning theory[22] which advocates that the best learning resources are those that come from peers, and secondly on the diffusion of innovation theory[23] which states that people adopt new information better through their trusted social networks. TTT programmes combining face-to-face training sessions with additional e-Learning modules have been used extensively in medical education and found to be more effective when compared with solely traditional instructor-based training[24 25].

When used well, the benefits of using TTT are:

- knowledge is retained – learners pay more attention when they are required to teach the subject themselves
- learners become experts and/or champions – teaching is an effective method of learning and gaining motivation
- teaching builds leadership skills
- using practitioners as trainers is less costly than using external educators
- there is a competent in-house trainer available to follow up with the delegates until the new skills become a habit, and to teach new staff
- learning is effective when the teacher is known to the learner
- a culture of teaching promotes skill retention in the organization
- convenience – training can be organized around the clinicians' working day and in their own locality
- training can be arranged with a variety of staff to encourage greater team work, awareness and understanding of each other's role
- training can be customized to meet the needs of the local population
- it is a sustainable method[26].

Using the TTT approach will not be effective if:

- practitioners identified as trainers are not capable or willing to teach
- new trainers are not supported to train others (i.e. not given time, recognition, supervision, administrative assistance)
- the organization has no system in place to deliver the training
- the trainers do not have an opportunity to be updated to keep the training fresh[26].

NHS England and Health Education England support innovative methods of training. NHS England have invested in the development of pilot training hubs, where groups of GP practices can offer inter-professional training to primary care staff, extending the skills base within general practice and developing a workforce which can meet the challenge of new ways of working[27]. Health Education England's local offices are implementing the training hub initiatives that allow some variation in approach through a common operating model across England[28].

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Selecting the right training

The Department of Health commissioned and funded the **Mental Health Core Skills Education and Training Framework** which was developed in collaboration by Skills for Health, Health Education England (HEE) and Skills for Care.

Recognizing that mental health services may be offered in a broad variety of settings, and support staff and other individuals outside the health and care sectors may be involved in the individual's care, the framework defines the core skills and knowledge required in three tiers. Where the training you have identified does not state the tier, you can ask the provider for the objectives and match them to the requirements listed in the boxes here.

Tier 1 -

people that require general mental health awareness, e.g. reception and administration staff.

The learner will understand the importance of:

- promoting positive relationships including unconditional positive regard
- establishing rapport and building respectful, trusting, honest and supportive relationships
- effective communication with individuals and their family and carers
- being socially connected
- considering language difficulties.

They will be aware that:

- behaviour may be a form of non-verbal communication
- feelings and perception may affect behaviour
- behaviour of others might affect the individual
- there are stereotypes and negative attitudes towards mental health problems which impact on establishing positive relationships
- there are ways to enable participation in communities, social interactions, and to provide information and social support.

Tier 2 -

staff that will have regular contact with people experiencing a mental health problem, e.g. health care assistants, treatment room nurses, practice nurses, advanced nurse practitioners.

Tier 1 learning outcomes plus the following.

The learner will be aware of:

- the relationship between known factors which influence behaviour and reinforce positive relationships
- their own role and responsibilities and from whom assistance and advice should be sought.

They will be able to:

- build a respectful, trusting, non-judgemental relationship by actively listening and avoiding assumptions
- understand common causes of distressed behaviour
- recognise distressed behaviour and provide a range of responses to reassure
- support the individual to develop some simple coping strategies
- understand ways in which illness and emotions can affect communication
- support a person to identify their own short term and longer-term recovery goals through reinforcing a positive relationship.

The London Clinical Network developed an **education and training tool kit** in 2016 which provides a summary of mental health education available for London and other areas. Two examples of TTT commissioned by Health Education England are given in this document, the mental health and wellbeing 'train the trainer' programme delivered by the **Charlie Waller Memorial Trust** and **Connect 5** provided by the Royal Society for Public Health.

Tier 3 -

staff supporting people who may experience a mental health problem, e.g. GPs, practice nurses, advanced nurse practitioners

Tier 1 and 2 learning outcomes plus the following

The learner will be aware of:

- strategies for encouraging individuals to recognise and take responsibility for their own behaviour
- how to create and promote opportunities to practise desired behaviour
- the importance of their position as a positive role model
- relevant research into effective practice promoting pro-social behaviour and confronting challenging behaviour
- the methods available for enabling individuals to change their behaviour (e.g. motivational interviewing, cognitive behavioural methods)
- the effect challenging behaviour has on individuals and others in the vicinity
- methods and styles which may be used in developing, sustaining and enabling moving on from relationships
- how to empower individuals to make effective relationships in the future.

They will be able to:

- identify factors which are known to trigger certain kinds of behaviour in individuals
- take appropriate actions to maintain calmness and safety and enable individuals to find alternative ways of expressing their feelings
- encourage individuals to review their behaviour and interaction with others and assist them to practise positive behaviours in a safe and supportive environment.

Case studies

Mental health and wellbeing ‘train the trainer’ programme delivered by the Charlie Waller Memorial Trust.

The **Charlie Waller Memorial Trust (CWMT)** offers a Tier 3 programme of five face to face modules and **seven e-Learning sessions** (register, then go to mental health awareness and select practice nursing). It is suitable for nurses and other healthcare professionals working in primary care. Training for practitioners identified by organisations to become trainers is provided free of charge. **Contact: sheila.hardy@cwmt.org**

South Lincolnshire CCG

As lots of people seen by practice nurses will have a mental health problem, we at South Lincolnshire CCG wanted to empower practice nurses to feel comfortable talking to patients about mental health and to understand when to escalate care. We felt that patients may benefit from input from the practice nurse rather than being sent straight to the GP or elsewhere. We wanted to help practice nurses to stop people slipping through the net waiting for services. We viewed this prevention as being part of the sustainability and transformation plan.

We asked CWMT to deliver a straight face-to-face training of ‘module one’ to 18 of our practice nurses. Eight of the nurses who attended wanted to continue with the other four modules and were prepared to become trainers. As no further funding was available they organised the training to take place in their practices and individually negotiated time to attend. Impressed by their drive, we found funding to host the final module. The nurses evaluated all modules as excellent and felt confident to teach their peers. Representatives from the CCG met with the nurses to work out how best to support them to deliver the training. The nurses plan to deliver training in their own practices in short half hour sessions. We plan to support the trainers by hosting group supervision. We are hoping to get a further cohort of nurses trained as trainers. We think that there is a need for funding and buy-in from federations and practice managers in order to make this happen. We feel that we should be able to empower people that want to make a difference.

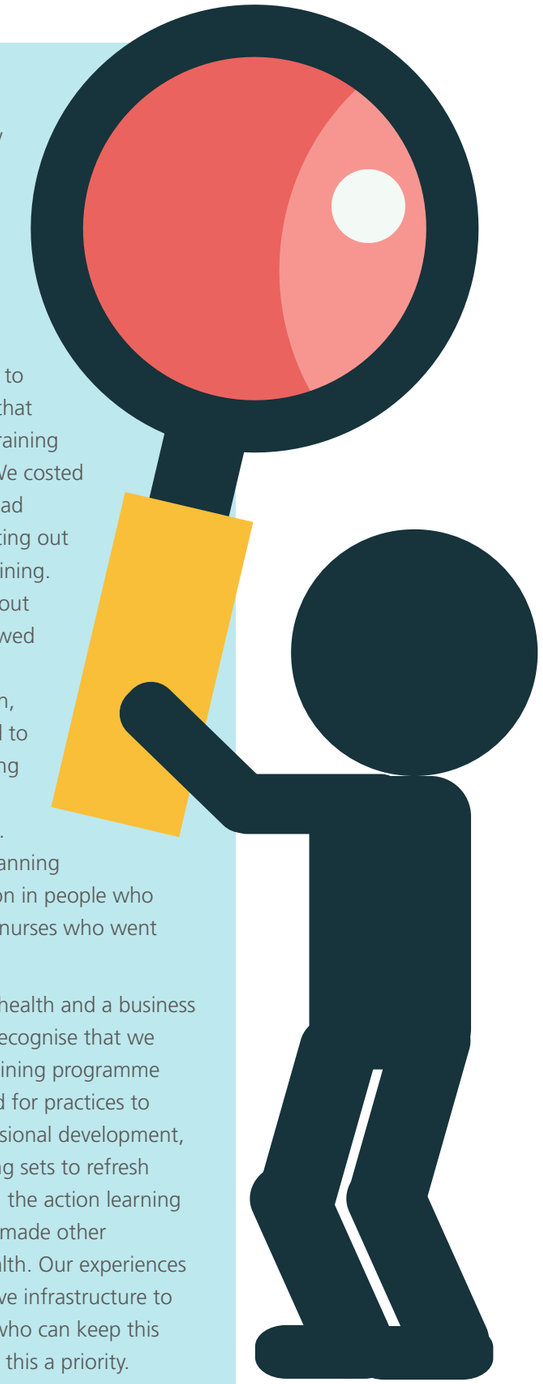
Contact: kerri.bennett@southlincolnshireCCG.nhs.uk

Anonymous CCG

We were driven by the parity of esteem agenda, particularly the issue of people with SMI dying so early and the CWMT training met the agenda. We supported the training of six practice nurses as trainers in 2015. These nurses all evaluated the sessions well and felt confident to deliver the training at the end of the programme.

We chose the train the trainer method of delivery because we knew we would not get enough nurses released by GPs to make a difference, so from a practical perspective thought that training a cohort would be a good start. We also thought training as a trainer was a good skill and the model is sustainable. We costed in backfill but this did not help with release of nurses. We had funding and administration for the training for trainers (sorting out venues etc) and already had a system to provide general training. CCG representatives came and talked to the nurses to find out how they would like to be supported but this was not followed through. This was due to the training agenda being very crowded with other topics such as safeguarding, vaccination, family planning, infection control, anticoagulation. We tried to engage the nurses to deliver training but due to the very long delay only two felt confident to do so. One nurse provided training (module 3) and the feedback was good on content. We have provided training on suicide prevention and are planning another training session for nurses on anxiety and depression in people who have chronic conditions – we will be seeking to involve the nurses who went through our original training programme.

The CCG remains committed to nurse education in mental health and a business case is in production for another training programme. We recognise that we were not able to maintain the momentum from our first training programme because of competing educational priorities. There is a need for practices to recognise the value of ongoing, in-depth continuous professional development, for example, releasing nurses to participate in action learning sets to refresh their learning. Although we have not been able to maintain the action learning approach or replicate in depth training for nurses, we have made other educational opportunities available for nurses in mental health. Our experiences show that in order to succeed, you do need an administrative infrastructure to make the practicalities happen, a strong clinical champion who can keep this issue on the agenda, and practices who are willing to make this a priority.



Case studies

Mental health and wellbeing ‘train the trainer’ programme delivered by the Charlie Waller Memorial Trust.

North West Boroughs Healthcare NHS Foundation Trust

The North West Boroughs Healthcare NHS Foundation Trust (NWBH) is an integrated mental health and physical health organisation. Maximising the benefits of being an integrated organisation work was undertaken around developing a set of core physical health competencies for mental health nurses and developing mental health competencies and formal training for physical health staff. A local CQUIN was developed in 2016 to deliver mental health training for teams working in physical health services within the organisation and also more widely to staff working in walk-in and urgent care centres in neighbouring organisations.

The training offered by the CWMT was chosen as the vehicle to deliver this training as it was tried and tested, there was only a charge for travel and it was felt what was on offer was more structured and comprehensive than anything else available at the time. Three of the five modules available were selected.

The CQUIN was led by a nurse consultant with support from a consultant physiotherapist both working within NWBH. Administrative support was provided for bookings, sending out invitation emails, collating evaluation etc.

Twelve trainers were trained by CWMT. A model of working across the different boroughs within the Trust footprint was utilised. Self-selecting individuals were trained as trainers in each borough. They then trained others in their own workplace. As part of the training, staff examined what mental health resources they had within their workplace and identified how this could be improved. The original model of cascade training was maintained as it was felt that diluting this would have made the training less effective. At the time of writing, a total of 177 staff members have been trained. The CQUIN ran for 12 months. Support is still in place, so work is continuing.

Mentors from within mental health teams were identified to support the cascade of the training within physical services, walk in centres and urgent care centres. Mentors and team managers participated in the delivery of the training to demonstrate commitment and to improve or establish working relationships. Mentors also met with trainers and the teams as and when they required help.

There have been huge benefits beyond the initial training such as improved relationship building, e.g. urgent care centres with mental health services, and new relationships have been developed. Project management was really important in ensuring this CQUIN was successful. We would advise organisations wishing to do something similar of the need for structure, organisation, evaluation, and an ability to challenge.

Contact: jane.neve@nwbh.nhs.uk

What do trainers need?

We talked to eight clinicians who recently trained as a trainer. They included six primary care nurses (practice nurses, advanced nurse practitioners, minor illness nurses), a mental health nurse and an emergency nurse practitioner. None of them had received in-depth training about primary care mental health during their careers and they agreed that it is important to improve mental health provision in primary care. In order of importance they listed the factors they would need to deliver the training as:

- protected time
- recognition that this is an important part of their role
- regular meetings with the other trainers
- assistance with organising sessions and preparing materials
- regular meetings with a mentor.

Case studies - Connect 5

Connect 5 train the trainer programme is the first nationally accredited programme to create a network of trainers in mental wellbeing brief advice and extended brief interventions. It is different from other mental health training programmes as it is designed to improve public mental health and prevent poor mental health. It is not a training designed to address mental illness or mental health crisis response. It has been developed and tested over 10 years by Stockport Public Health in partnership with Manchester and Bolton Public Health and the University of Manchester. The programme has been successful in training approximately 2,500 of the wider workforce and volunteers.

Health Education England has funded this particular train the trainer programme working with Public Health England and the Royal Society for Public Health and Stockport Council. Between January 2017 and July 2017 148 front line workforce have been trained as Connect 5 trainers. They are now equipped to cascade the programme to staff across England, supported by the PHE Centres. The intention is to build capacity across a range of frontline workforces; giving them the skills and confidence to have effective conversations and help individuals to improve their mental health, wellbeing and resilience through positive changes.

Connect 5:

- delivers Making Every Contact Count for mental wellbeing which encourages all those who have contact with the public to use opportunities to talk about how to make positive improvements to their health and wellbeing
- aligns with the skills and competencies outlined in the Core Skills for Mental Health Education and Training Framework for tier 1 and tier 2 section of the workforce
- promotes a self-help philosophy of helping people to better understand, manage and improve their mental health through an integrated bio-psychosocial understanding of mental health and wellbeing
- enhances the prevention offer of the stepped care model of mental health intervention used within community, primary care and in-hospital settings
- has synergy with the Improving Access to Psychological Therapies (IAPT) Programme through the evidence-based approach.

What skills and attributes does a connect 5 trainer need?

- ability to deliver training objectives through a set programme
- a basic knowledge and understanding of mental health and wellbeing issues
- knowledge of the principles of behaviour change, brief advice and brief interventions
- skills to create an effective learning space, manage group dynamics and manage difference e.g. learning styles, personalities, professional approaches
- ability to manage the resistance which may arise when challenging existing practice or personal constructs
- ability think on feet in order to engage with the individual learning journeys
- be committed to personal ongoing learning to support delivery.

Progress to date

The national Connect 5 Train the Trainer programme has trained 148 people in the first year, ranging between 11 and 22 trainers in each of the nine Public Health England (PHE) centre areas across the country. There has been a range of participants from across health, education, housing, care and welfare sectors from public sector and voluntary organisations. Roles include occupational therapists, drugs workers, family workers, wellbeing practitioners, housing advisers, student learning mentors, health and safety trainers, counsellors and coaches, link workers, domestic abuse practitioners, health improvement and behaviour change specialists, youth workers, volunteer trainers, carers support, employment advisers and fire and safety officers.

PHE centres have supported delivery and evaluation, including follow-up support to all the trainers in their next stage of rolling out the training to their workforce. Having an infrastructure in place supports the cohort of trainers, maintains momentum, encourages training delivery and makes the difference to overall impact. The Royal Society for Public Health (RSPH) is undertaking the evaluation which includes pre and post-training measures of change in participants' knowledge and confidence, as well as capturing change in practice over the first three months. All participants were asked to deliver a Connect 5 course within three months of completing their training.

RSPH will also collect feedback from centres on the programme implementation and how it is being used to meet local system priorities around prevention and self-management. The evaluation will influence direction and further support to the programme.

HEE North West has committed a further £100k to support sustainability of Connect 5 within the health care workforce. Connect 5 is seen as the right programme for the NHS to meet the mental health and wellbeing needs of all patients, creating a mental health literate and psychologically-minded workforce active in achieving parity of esteem and the shift to prevention. As Connect 5 aligns to IAPT, this will help build a coordinated offer.

Other areas are also considering how Connect 5 can be used at-scale as part of new ways of working to prevent mental AND physical ill-health.

Contact: jude.stansfield@phe.gov.uk

Checklist for providers

To assist providers to deliver TTT mental health training locally, we have written a checklist of key points to consider. We have deliberately kept it brief for ease of reading and to allow for flexibility.

10 steps to organise a TTT programme

1. Organise funding for the programme.
2. Identify which organisation will run the programme. Options include:
   - federations (e.g. practice nurses teaching other practice nurses)
   - working collaboratively with another organisation (e.g. different healthcare professionals train as trainers together)
   - commissioning another organisation (e.g. mental health nurses from a trust to teach practice nurses).
3. The hosting organisation should provide a commitment to releasing trainers to receive their training, deliver the training, and attend any support networks provided. The trainers should have formal recognition that teaching is part of their role.
4. Assign:
   - someone to manage the TTT programme. This could be a commissioner or clinician with a keen interest in the subject
   - administrative support.
5. Governance. To keep the project on target, you could consider having a steering group.
6. Organise support networks for trainers. This could be in the form of action learning sets or supervision from a mentor.
7. Select your training – see page 7.
8. Identify your trainers. Trainers should be willing to undertake this role and be advised they will be given appropriate support. Consider the skills and qualifications you require from your trainers. You may have established educators in post who could take this on.
9. Organise the trainers' sessions with your selected training supplier. Responsibility for booking venues, arranging refreshments and printing materials will generally lie with the hosting organisation.
10. Anticipate how you will evaluate the programme. The training supplier will usually provide evaluation forms for the training sessions. You may also want to measure the impact of the training. Assign someone in the organisation to undertake the evaluation.

Rolling out the training

Work out how your trainers will deliver the training. This will be dependent on the number of trainers trained and their geographical spread. Some options:

Arrange classroom sessions

Advantages
Large numbers can be trained at one time; training sessions are delivered quickly; staff meet people from other areas.

Disadvantages
More costly; trainers may require more support or training if they are not used to teaching large groups; requires planning and organisation; training is less effective in large groups.

Short sessions in practice (own practice or groups of practices)

Advantages
Can be fitted into lunch breaks and PLT sessions; small group enhances learning and team support; trainers more confident to deliver this way; minimum organisation required.

Disadvantages
Takes more time to get through programme; other responsibilities may take precedence.

Arrange certificates for attendees.

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