Blue Light Programme Research Summary 2016-18

An evaluation of the impact of our targeted mental health support for emergency services staff and volunteers

- New recruits
- 999 call handlers
- Resilience course
- Impact on the public

mind
for better mental health

Credit: cover image, top right – West Midlands Police

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Acknowledgements

Mind's Research and Evaluation team would like to thank the staff at Mind and the local Minds for their invaluable support, and the Government for administering funding for the Blue Light Programme and evaluation. We would also like to thank all our research partners who have brought their expertise and enthusiasm to the programme. We owe the greatest thanks to the emergency services staff and volunteers who have been so generous with their time and ideas.

Suggested citation

Mind (2018) *Blue Light Programme Research Summary 2016-18*. London: Mind. Available at: *mind.org.uk/bluelightresearch*

Credit: Metropolitan Police

Foreword

The Metropolitan Police Command and Control Centre employs 1,700 members of police staff and officers handling more than six million emergency and non-emergency incidents every year, while despatching calls to officers and providing support to members of the public 24 hours a day. It is a demanding role where staff require personal resilience to enable them to support those in need of help.

Working in a stressful environment, staff raised concerns that they received little training to specifically recognise and deal with their own mental health issues. They sometimes felt overwhelmed and ill-equipped when dealing with callers and colleagues who were unwell. In order to support callers, look after their own mental health and that of their colleagues, they felt they needed additional support and this is where Mind's Blue Light Programme comes in.

Mind visited us and listened to some of the issues and demands faced when advising callers. They designed a training package for the team as part of the pilot they were running and we facilitated the staff attending. The response was phenomenal. Each course was oversubscribed and had a 100 per cent attendance rate.

The day was fascinating and reinforced the need for support, both as an individual and a manager. I attended the programme myself, and I can't think of a more positive way to explore mental health.

Virtually every team in our unit was represented, with 140 staff completing training. Feedback has been positive with several members of staff saying that it was the most valuable training in their career. Staff now have a greater understanding of mental health, and having gained this knowledge they can provide greater support to themselves and others, speeding recovery and preventing a problem from getting worse.

Importantly, with the help of Mind, I can now commit Met Command and Control to keeping mental health high on our wellbeing agenda.

This report summarises the excellent critical research that has been carried out by the Mind team in conjunction with staff from across the emergency services. The 10 actions Mind recommends we all take are empirical evidence of the need and value in providing support for blue light staff and volunteers.

It is the responsibility of all emergency services and those working in the sector, to ensure continued commitment and investment in our staff which these recommendations clearly set out.

Superintendent Tony Josephs
Metropolitan Police Command and Control

Introduction

Mind's vision is for everyone with a mental health problem to get support and respect. To achieve this, we need to make sure wellbeing in the workplace is understood and effectively managed. Emergency services staff and volunteers operate in one of the most challenging workplace environments but the mental health support they receive can be limited.

To address this challenge, we've been delivering an ambitious programme to improve the mental health of emergency services ('blue light') staff and volunteers since March 2015.

Year one: 2015-16

We developed the Blue Light Programme in collaboration with blue light staff and volunteers. It's supported by Libor funding, administered by government. In the first year, the programme focused on five themes:

- Tackling stigma and discrimination
- Embedding workplace wellbeing
- Increasing resilience
- Providing targeted advice and support
- Improving pathways to services and support.

A summary of these activities and the key learning, including extensive evidence about the mental health needs of emergency services staff and volunteers, is available at mind.org.uk/bluelightresearch

Years two and three: 2016-18

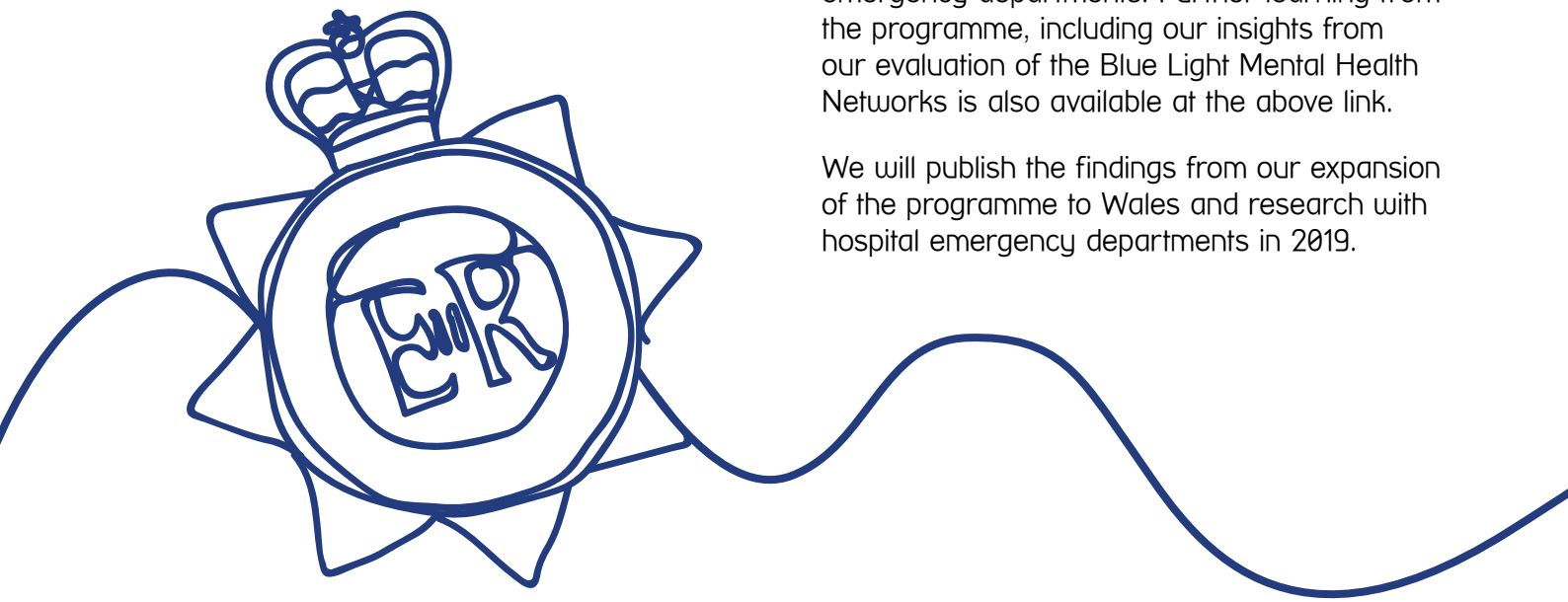
We continued to provide successful, evidence-based activities, training and information to thousands of blue light staff and volunteers. The programme has also been extended so that it effectively supports the groups who need it most. This has included:

- developing Blue Light Mental Health Networks* to sustainably deliver multiple aspects of the programme in local areas
- extending the programme to Wales
- refining the resilience course developed in the first year of the programme
- providing targeted support for new recruits
- tailoring existing support for 999 call handlers.

* Blue Light Mental Health Networks help local emergency services to work together to improve staff and volunteers' mental wellbeing. They share knowledge, resources and budgets across services and sectors.

Why we've written this report

This report summarises the evidence from the impact evaluations and additional research carried out between April 2016 and April 2018. It builds on the published report from the first year of the programme, available at: mind.org.uk/bluelightresearch. We want to share all of our learning to benefit everyone working in our emergency services.



All aspects of the Blue Light Programme have been independently evaluated by a range of research organisations. We also conducted research to explore the impact of workplace wellbeing initiatives on members of the public.

Finally, we started to explore whether it's possible to extend the programme to other audiences who face similar challenges, including staff working in hospital emergency departments. Further learning from the programme, including our insights from our evaluation of the Blue Light Mental Health Networks is also available at the above link.

We will publish the findings from our expansion of the programme to Wales and research with hospital emergency departments in 2019.

Our research partners

We've partnered with a range of independent organisations to evaluate the programme and conduct research into the needs of new audiences. This work was coordinated by Mind's Research and Evaluation team, who produced this summary report.

University of Oxford	Randomised controlled trial to test the revised resilience course
ResearchAbility	Audience research with new recruits and 999 call handlers
Institute for Employment Studies	Evaluation of the course for new recruits
New Economics Foundation	Exploratory research to understand the impact of workplace wellbeing initiatives on the public

The full reports from each area of research are also available on our website: mind.org.uk/bluelightresearch

Key findings: the headlines

Our work with specific audiences (including call handlers and new recruits) has reinforced what we learned in the first year of the Blue Light Programme. Many of the challenges we found affected the mental health of the emergency services as a whole were also raised by the specific audiences we worked with in years two and three of the programme.

- Heavy workload, lack of resources and pressure to meet targets continue to be major contributing factors to high levels of poor mental health among blue light staff.
- Demands on resources mean staff can't always be available for mental health and wellbeing training. Services need to find ways to make sure everyone who could benefit from training is able to attend.
- Supervisors have an important role to play in supporting staff wellbeing. But competing demands mean they don't always have the time. Services need to invest in making sure supporting staff wellbeing can be an integral part of a manager's day-to-day role.

However, emergency services are diverse and unique. Resources and training need to be relevant, engaging and helpful to meet the needs of staff and volunteers operating in a range of different contexts.

- New recruits and call handlers face specific pressures and need training and materials that are appropriately timed, targeted and accessible.
- Emergency services staff who took part in our revised resilience course showed significant improvements in mental health awareness and confidence to manage their mental health.
- Trainers of new recruits benefitted from opportunities to increase their knowledge around mental health and share ideas and learning about how to better support and advise new recruits.

Emergency services staff felt that, with the right support, they could use their lived experience to provide support and empathy to members of the public in distress.

- They felt the most important effect their improved mental health would have on the public would be taking less time off work, which would mean more staff available when they were needed most.
- More research is needed to understand the impact on the public of initiatives aimed at improving staff mental health.

Overall:

- Our targeted support for emergency services staff and volunteers has successfully helped to improve their mental health, resilience and confidence to seek support.
- We have given line managers and trainers more confidence in supporting staff and helped blue light staff feel better able to respond to difficult situations.
- Our research has shown that a degree of stigma and lack of awareness of available mental health support still exists – but this is improving.
- To sustain change, there needs to be practical investment, as well as commitment, passion and enthusiasm, at all levels of emergency services.

Key insights and learning

As the Blue Light Programme has developed, we've gathered insights and learning from the programme activities and the people we work with. We've used this to adapt and tailor what we offer to the needs of a range of staff and volunteers within the emergency services and to broaden our reach. Our findings show that while there are similarities between them, there are also many unique insights and challenges faced by specific groups. We continue to learn from these findings, making sure that the Blue Light Programme remains relevant and reaches the people who need it most.

These are the key findings from our initial research and impact evaluations grouped together. You can find more detailed findings from each evaluation and piece of research later in the report.

Creating change

In year one of the programme, our face-to-face training sessions and Blue Light Champions helped to boost staff and volunteers' knowledge and confidence around mental health. It gave them tools to manage their own mental health better, and helped line managers to support staff experiencing mental health problems.

Since then, as well as continuing with these activities, we've designed and delivered training to new recruits and call handlers and redesigned and piloted a successful resilience course. We've also piloted four Blue Light Mental Health Networks and extended the programme to Wales.

Resilience is a critical part of promoting positive mental health among emergency services staff and volunteers. In the first year of the programme, we piloted and evaluated a group-based resilience course for emergency services staff. It was well received, but showed no reliable change on any of the resilience and wellbeing outcomes we measured.

Working with our partners at the University of Oxford, the course was redesigned looking at known causes of mental health problems in the emergency services and effective ways to target them. The course was evaluated in a new randomised controlled trial.* Emergency services staff who took part in our revised resilience course showed significant improvements in measures of wellbeing, social capital, psychological distress, mental health awareness and confidence to manage their mental health.

Our pilot training course for new recruits successfully increased understanding and knowledge around how to build resilience and seek help. Our evaluation highlighted the benefits of a two-stage approach to help embed learning and demonstrated the value for new recruits of having a space to reflect on their experiences.

Call handlers benefitted from our short introductory briefings which increased their confidence to support callers experiencing mental health problems and equipped them with tools and techniques to look after their own wellbeing.

These results are key successes of the Blue Light Programme. They demonstrate how effective our evidence-based approach to developing targeted training activities is, as well as our ability to bring about lasting change within the emergency services despite organisational challenges, such as understaffing and pressure from targets, which often make it difficult to implement a new programme.

* A study in which a number of similar people are randomly assigned to two or more groups to test a specific intervention.

Culture change

Since it began in 2015, the Blue Light Programme has helped improve the way the emergency services think and act about mental health. We have recruited over 2,500 Blue Light Champions who have helped to increase awareness and understanding of mental health problems and encouraged staff to talk more openly about their mental health.

However, our initial research with new recruits and control room staff showed, despite some organisational efforts to promote a positive culture around mental health, a degree of stigma and lack of awareness of available mental health support still exists. This is especially true where awareness of and engagement with the Blue Light Programme has been lower.

Call handlers working in emergency control rooms talked about a culture where they were expected to "just get on with it" and not allow themselves to be affected by the calls they receive. Similarly, new recruits feared disclosing a mental health problem would impact on their career progression. They worried that more experienced colleagues would see them as "weak".

But attitudes are shifting. Our evaluations have highlighted positive cultural changes within emergency services teams that have taken part in our training and activities. The Blue Light Programme is just one factor in tackling stigma, however. Our research has shown that to sustain change there has needed to be investment from services and endorsement from senior managers. Embedding awareness of mental health and demonstrating a commitment to staff wellbeing from the start of their careers can help to normalise discussions around mental health. It gives employees the tools and confidence to get help for a mental health problem if they need to.

Organisational pressures

Our initial research in 2015 clearly demonstrated that heavy workload, lack of resources and pressure to meet targets were major contributing factors to high levels of poor mental health among blue light staff. These challenges make the inherent stress of responding to an emergency much worse. And it's more difficult for employees to access the support they need.

Issues have been felt widely across the emergency services. Our research with call handlers and new recruits showed that both groups have had to take on extra responsibilities because of internal and external pressures, such as resource shortages and budget cuts. This additional work has been detrimental to their mental health.

New recruits may have had less exposure to these organisational issues. However, they often report feeling unprepared for the practical realities of their roles and the huge increase in responsibility. They also feel pressure to perform at the same level as their longer serving colleagues.

Attending training

There is a high demand for mental health training and feedback on face-to-face courses delivered by the Blue Light Programme has been extremely positive. However, demands on resources mean that staff can't always be released for training. This can limit the number of staff who engage and those who can't attend can feel isolated. Many staff and managers chose to attend training in their own time. To make sure training reaches everyone who could benefit from it, services should find ways to make sure as many staff as possible can attend.

Informal emotional support

Our research with new recruits highlighted the importance of emotional support from trainers and their ability to influence attitudes towards mental health. Trainers would welcome more knowledge about mental health and ways to support participants, and they appreciated opportunities to come together to share learning and best practice. They praised local Mind staff for their skills, expertise and pragmatic approach to delivering training and engaging staff.

Supervisors also have an important role to play in supporting staff wellbeing. But demands on time and resources mean they don't always have the capacity to invest in the wellbeing of their staff as much as they would like. Opportunities for informal support become more limited as resources are stretched. As the culture around mental health begins to change, it's important that services invest in giving managers the appropriate skills to make supporting staff wellbeing an integral part of their day-to-day roles.

Targeted and tailored support

Emergency services are diverse and unique. We've made every effort to ensure the Blue Light Programme's resources and training are relevant, engaging and helpful to a wide range of emergency services staff and volunteers. We recognise the need to listen carefully to the groups we have spoken to and adapt the programme based on their specific needs.

We've made progress with many large organisations. But we know it's important that we continue to consider the context of each organisation and adapt to their cultures and ways of working.

Our research with new recruits and call handlers taught us about the specific pressures that these audiences face and highlighted how important it is to have training and materials that are appropriately timed, targeted and accessible.

New recruits told us that they couldn't always see the relevance of mental health training when it was delivered before they had gained operational experience to relate it to. We responded by designing a two-stage approach to training which allowed them to revisit and reflect on what they had learned after they had spent more time in their roles.

Call handlers described feeling overlooked within the wider structure of the emergency services. So we adapted our information materials to be more relevant to the call handler role, updated our imagery to make it more inclusive, and included specific content relating to supporting callers with mental health problems in our training briefings.

Alternative approaches

The focus of the Blue Light Programme has always been to improve the mental health of emergency services staff and volunteers. However, we were also interested to explore the effect this improvement might have on how blue light staff and volunteers interact with the public, and how we might demonstrate this through further research.

Initially, we asked emergency services staff how they felt improving their own mental health might affect their interactions with members of the public. Many of those who took part felt that, with adequate support, staff with a greater level of awareness around mental health would be able to use their own and others' lived experience to provide support and empathy to members of the public in distress. However, staff felt the most important effect their improved mental health would have on the public would be taking less time off work, which would mean more staff available when they were needed most.

More research is needed to understand the impact on the public of initiatives aimed at improving staff mental health. This will provide the evidence needed to support future decisions about investing in wellbeing resources for staff and volunteers. However, any future research in this area can't exist in isolation. It needs to take into account the wider organisational context in which it sits.

You cannot underestimate just how positive this whole programme has been for our staff. If I could do it every six months, I know I would have the same response. It's just been amazing.

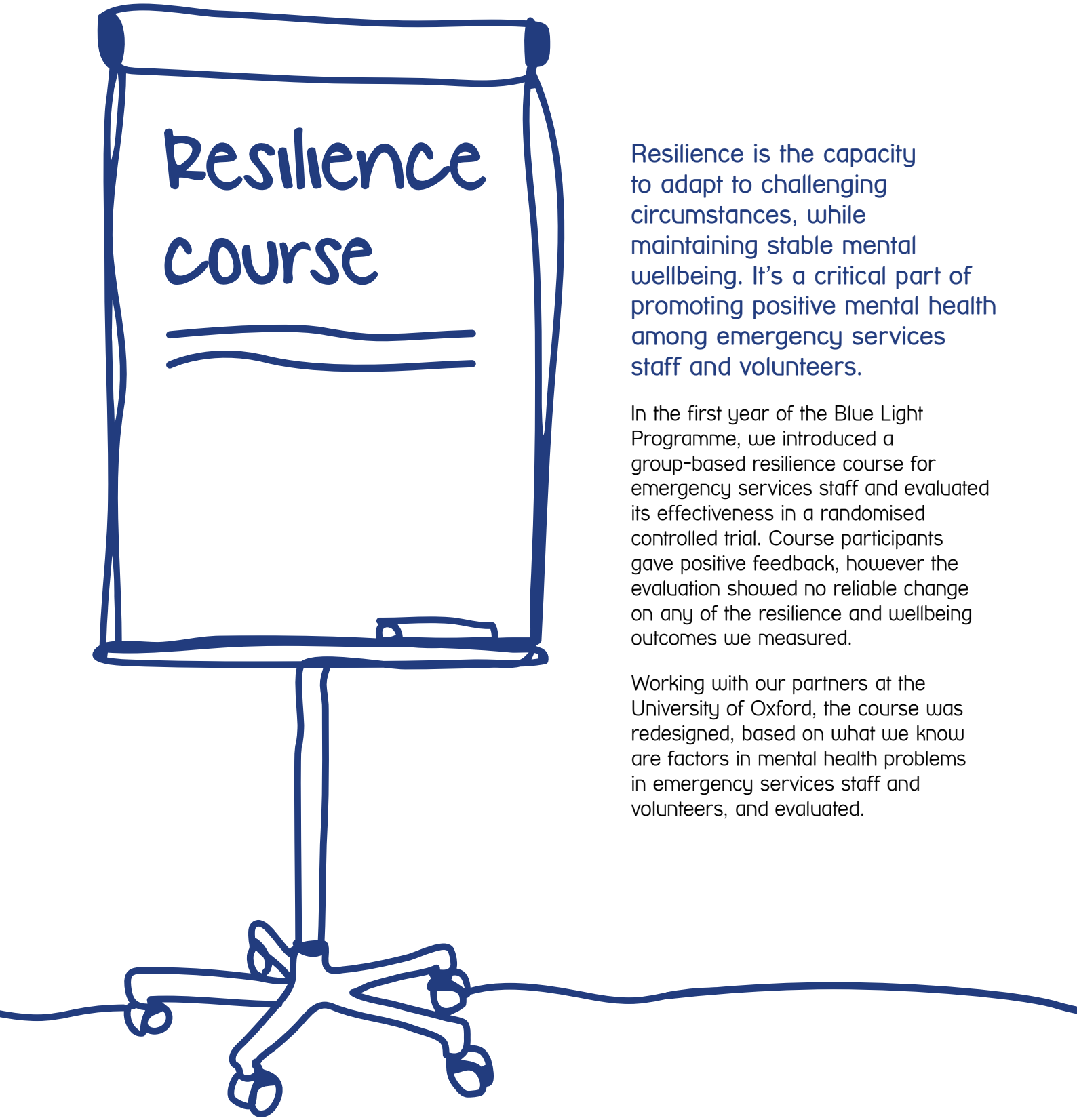
Manager, Police service

Conclusion

We're proud of our evidence-based approach to providing support for emergency services staff and volunteers that is tailored, targeted and effective. Our research in a range of contexts has taught us more about the challenges faced by emergency services staff and volunteers and reinforced much of what we already knew about the factors that contribute to poor mental health. We've used these insights to design training and support that responds to these challenges and takes into account the unique environment in which emergency services staff and volunteers work. This has enabled us to make a real difference to their wellbeing and confidence to support their own and others' mental health.

We're confident that change is happening. But we can't do it alone. It requires emergency services to demonstrate their commitment to the mental health of staff and volunteers from the very beginning of their careers and sustain this with passion and enthusiasm at all levels.

With your help, the knowledge gained can be used to ensure better mental health for all emergency services staff and volunteers and create a positive culture where mental health is championed.



Resilience is the capacity to adapt to challenging circumstances, while maintaining stable mental wellbeing. It's a critical part of promoting positive mental health among emergency services staff and volunteers.

In the first year of the Blue Light Programme, we introduced a group-based resilience course for emergency services staff and evaluated its effectiveness in a randomised controlled trial. Course participants gave positive feedback, however the evaluation showed no reliable change on any of the resilience and wellbeing outcomes we measured.

Working with our partners at the University of Oxford, the course was redesigned, based on what we know are factors in mental health problems in emergency services staff and volunteers, and evaluated.

The revised resilience course

180 emergency service staff were randomly allocated to receive the new 'mixed format resilience course', a 'placebo online course', or a 'wait period'.

Mixed format resilience course

The resilience course activities involved four online modules and four group sessions (two hours each, delivered once a week for four weeks).

Online modules were released one week before each group session and took around 15 minutes to complete.

Module 1: It matters what you focus on: helpful and unhelpful attention

Module 2: Habits and dwelling: how to change them

Module 3: Dealing with difficult emotions

Module 4: Transforming worry and improving performance

The group sessions reviewed and built on the material covered in the modules, with further experiential exercises and opportunities to ask questions and meet other emergency services staff.

The course aimed to improve resilience to stress by targeting factors that contribute to long-term stress in emergency services staff.

For more information on the methodology, see page 44

Placebo online course

In the placebo course, participants could access Mind's mental health information already available online. Where possible, this information would be tailored for emergency service workers. The online course was delivered over four weeks and included four topics:

Module 1: Stress

Module 2: Sleep

Module 3: Anger, PTSD and depression

Module 4: Mindfulness

A link for each topic was emailed to participants once a week and participants completed them remotely.

Wait period

Participants allocated the wait period were asked to complete a set of questionnaires at three different time points (before the course began, at four weeks and again at three months). Once they had completed the final questionnaires they were offered the online modules of the mixed format resilience course.

What did we measure?

Participants completed several measures assessing resilience, wellbeing, coping and social capital at three assessment points: before the course, after the course and after three months. For definitions of each outcome, see the full research report, available at mind.org.uk/bluelightresearch

Evaluation of the mixed format resilience course

Our evaluation aimed to:

- establish the effectiveness of the revised resilience course
- link changes in key outcomes to specific course material – this would help us identify the most effective parts of the course so we could develop them further
- find ways to predict how successful the course would be for specific groups of participants
- give us information we needed to develop evaluation tools for continued use by local Minds.

Key findings

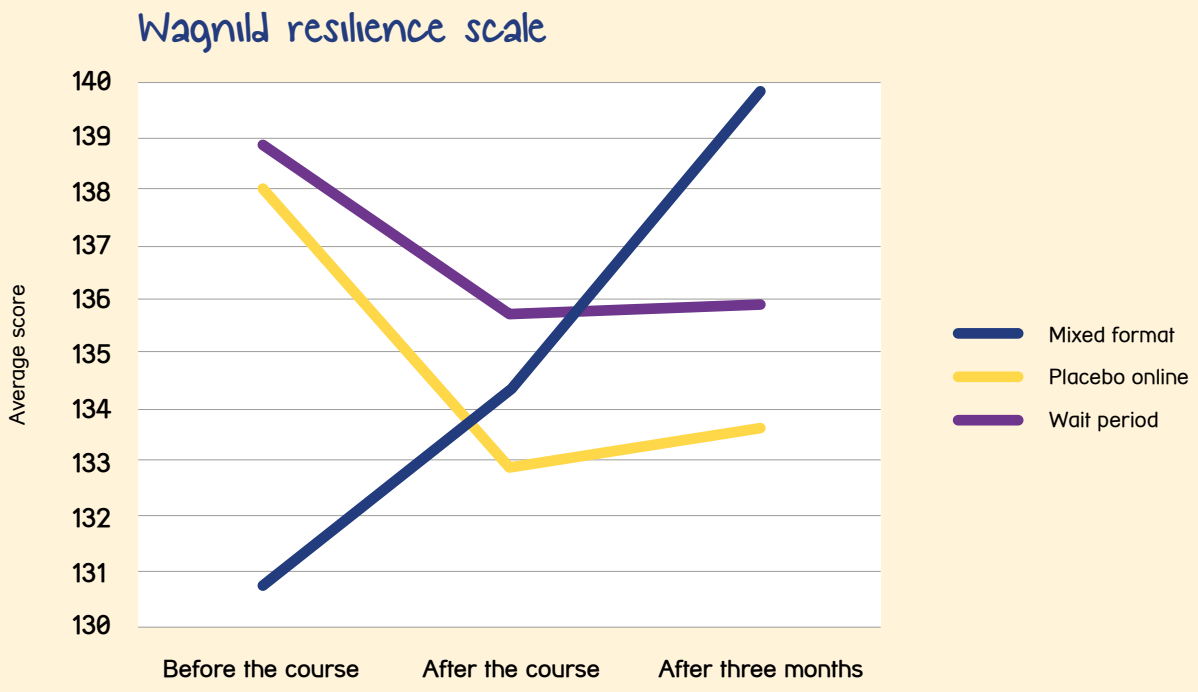
There were significant improvements across the board.

Participants who took part in the mixed format resilience course showed significant improvements over time in resilience, wellbeing, social capital, psychological distress, mental health awareness, and confidence to manage mental health. Improvements weren't seen in the placebo or wait conditions.

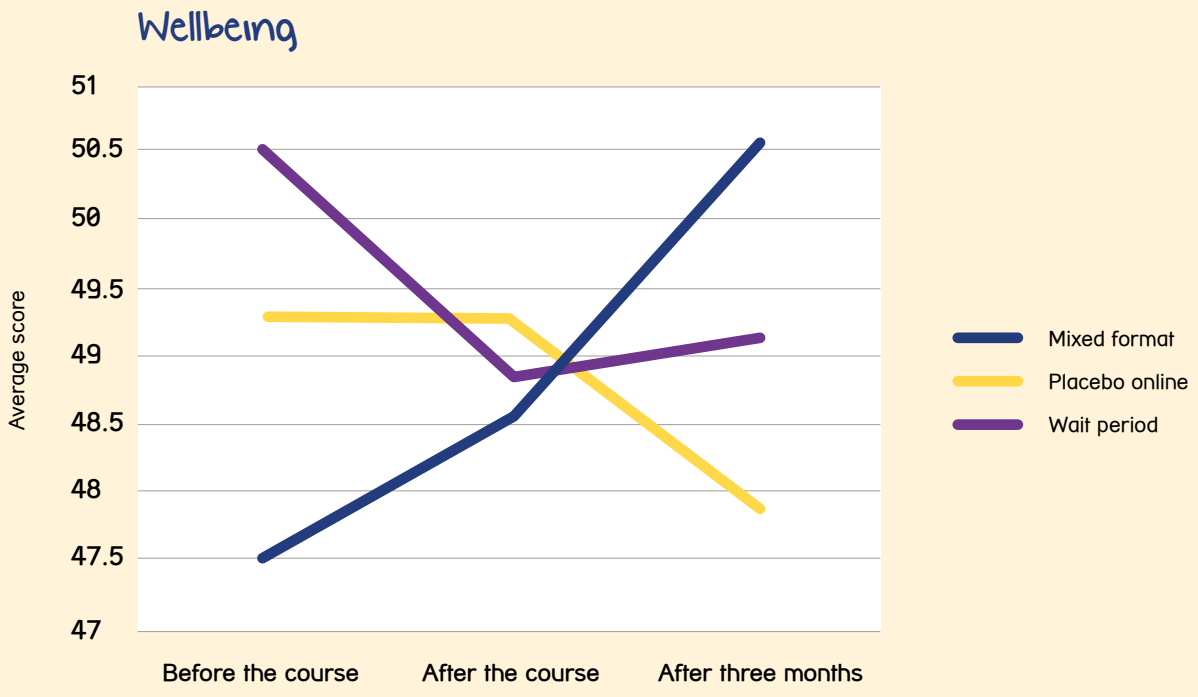
Mixed format resilience course participants also demonstrated a trend to ruminate less often when responding to unwanted memories after completing the course, compared to participants receiving the placebo and wait conditions. This change lasted over three months.

The strongest effect was linked to improvements in mental health awareness, which assessed participants' awareness of and use of coping strategies to manage mental health.

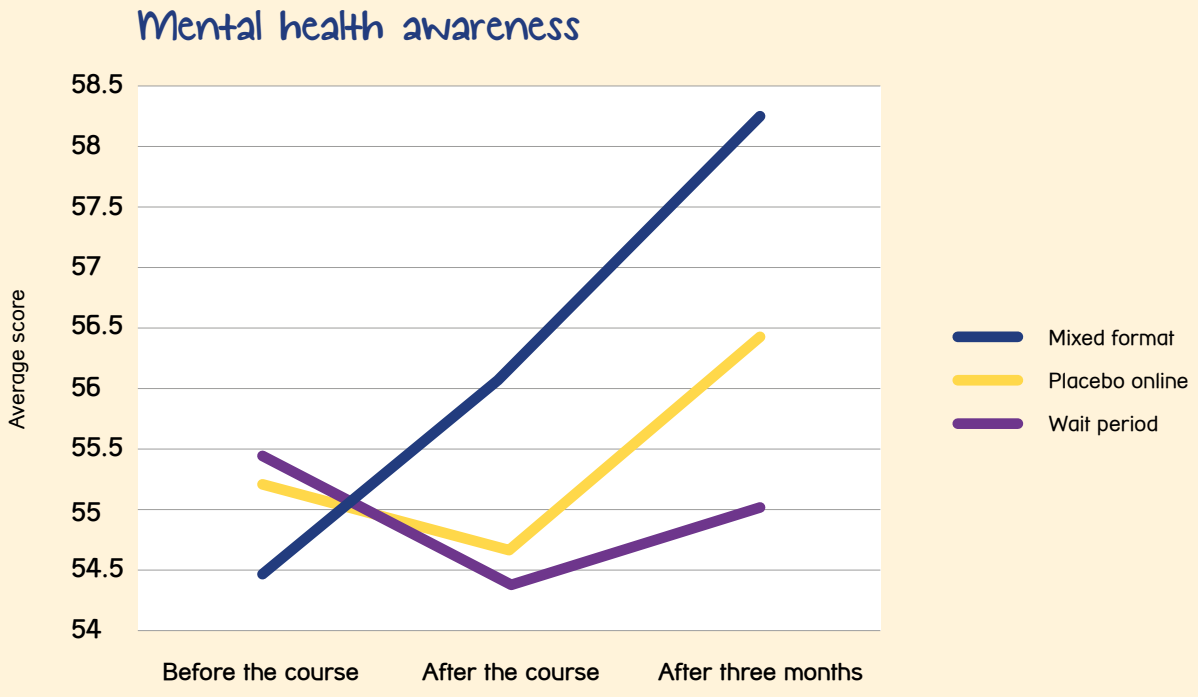
Changes in resilience by condition over time



Changes in wellbeing by condition over time



Changes in mental health awareness by condition over time



Over-thinking support was most valuable.

The most successful modules in terms of helping to improve wellbeing and resilience were on 'Habits and dwelling' and 'Transforming worry', which both target over-thinking. Generally, these were also the areas of the training that participants said they found most useful.

People who scored higher on mental health measures saw greater benefits.

Generally, participants with higher scores on measures of depression, anxiety, PTSD, depressive attributions, rumination and wishful thinking before the course saw greater improvements. This suggests that participants most likely to benefit from the training may be those at greater risk of experiencing mental health problems. It is important to keep in mind that scores on mental health measures typically fell in the non-clinical range, meaning they didn't reach the threshold for being diagnosed with a mental health problem.

Participants were generally very positive about the course.

The content and the way it was facilitated was well received. Most participants said that they enjoyed the training and learned from the course.

Most participants said that they preferred the face-to-face training. They felt the peer support helped motivate them.

> **I probably wouldn't have been as inclined to do the practices as regularly as we did if we hadn't gone and reported back on it every week. You'd have to be quite honest and say whether you'd done it that week or not.**
>
> Course participant

Credit: West Midlands Police

The online modules were felt to be user-friendly. Those who took part in the mixed format course said the online modules complemented the face-to-face training.

All modules were found to be useful. Participants found the modules on 'Dwelling' on the mixed format and 'Anger, PTSD and depression' on the online format most valuable.

The course may not be reaching its intended audience.

Participants interviewed in our evaluation raised questions around whether the course is reaching the right audience. The majority worked in support roles, and some felt that the course would have been more useful for them if they were in a frontline role.

But there were barriers to frontline staff taking part: the lack of time available (due to under resourcing) and the varied working hours. Some participants felt that they would have benefitted from having more notice ahead of the training. A lack of time to make the necessary arrangements to attend training may have prevented more frontline staff taking part.

Conclusion and recommendations

- The course's success is promising. It appears to be targeting and making an impact on the factors that contribute to poor mental health in this group.
- Participants enjoyed the course and found it valuable. Emergency services want to see it rolled out more widely. We now need to design and test a way to deliver the course so it can reach greater numbers of emergency services staff and volunteers.
- If the course is to be delivered more widely, it is important to take into account logistical challenges for emergency services staff, such as shift patterns and varied working hours. More notice about training will ensure more staff are able to arrange the time to take part. Organisations also need to start or continue to put an emphasis on staff mental health and wellbeing to make sure people can participate.

New recruits

In November 2016, the Government provided an additional £1.5 million for Mind's Blue Light Programme. This allowed us to continue to deliver the programme in England, extend it to Wales, and begin working with additional 'at risk' groups, including 999 call handlers, new recruits and emergency department staff.

To help us plan and develop a pilot service tailored specifically towards supporting new recruits, we carried out a focused research project. The aim was to find out what issues new recruits face when it comes to their mental health needs, as well as their awareness and perceptions of existing support.

The research included: service specific focus groups and interviews with staff who had been employed in the emergency services for less than three years, plus interviews with managers, trainers and senior lecturers.

For more information on the methodology, see page 44

Specific challenges

Adjusting to the emergency services can be tougher than anticipated.

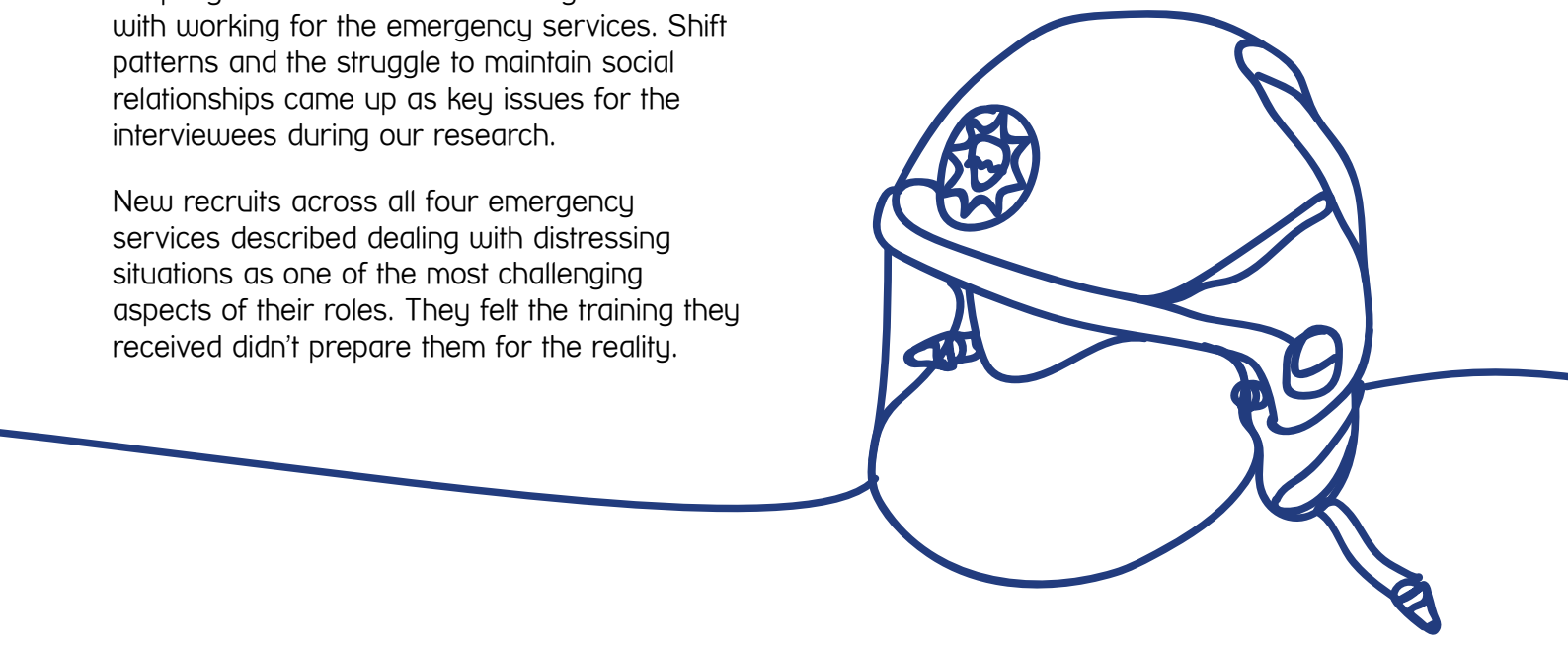
One of the key challenges for new recruits is adapting to the differences in lifestyle associated with working for the emergency services. Shift patterns and the struggle to maintain social relationships came up as key issues for the interviewees during our research.

New recruits across all four emergency services described dealing with distressing situations as one of the most challenging aspects of their roles. They felt the training they received didn't prepare them for the reality.

> **You can get taught all of the legislation and all of the techniques in the world to get on scene and to deal with it in a professional and legal and effective way, but the reality is nothing can prepare you for how your body and your mind are going to respond in that situation.**
>
> New recruit, Police service

Resource constraints are affecting new recruits more than ever before.

The impact of trying to 'do more with less' was felt amongst new recruits. One representative from the police service described the increasing pressure on officers in their probationary period (within the first two years of service) to perform at a level beyond their experience. In the past, these officers were consistently supported and mentored, but they are now frequently used as an additional resource and often attend incidents alone.



Organisational culture and stigma

There's a tendency for staff to 'self-stigmatise'.

Those new to the emergency services were generally able to see the positive effects of efforts made to improve attitudes towards mental health. Nevertheless, it was felt that a sense of stigma does still exist across the emergency services. This comes from a tendency for staff to 'self-stigmatise'. Despite efforts to encourage conversations around mental health and increase awareness of support, many staff would not feel comfortable disclosing or seeking help for a mental health problem, especially those new to the service. This sense of stigma was felt to be reinforced by what was described as a 'masculine culture', particularly within the police and fire services.

There are fears around seeking help.

Participants, especially those in the police and fire services, reported a general reluctance to seek help for, or divulge, mental health problems. They feared it would put their job at risk, or have a detrimental effect on their opportunities to progress their career.

What I think may be one of their fears is that they couldn't disclose something like that because they might get removed from their post. That wouldn't happen, but what I mean is they might have the fear that, 'I'm only new to the organisation. If I start saying I'm suffering with really bad mental health problems then they might, you know, get rid of me before the end of training.'

Trainer, Police service

Mental health training isn't always relatable and can add to a feeling of information overload.

New recruits, trainers and more senior staff all highlighted how intense training was. New recruits were expected to absorb large volumes of information in a relatively short period of time during initial training. They felt this 'information overload' contributed to them not being able to remember the information relating to mental health. Another factor here was a lack of relatable experience – as new recruits, they felt the information on resilience, coping skills and supporting wellbeing was not useful or relevant to them. New recruits initially felt a sense of immunity to the job. They didn't expect that the stressful and distressing aspects of their job would have such an impact on their mental health.

Most interviewees were aware of the Blue Light Programme since it was highlighted in training, but the consensus was that it was not relevant for them yet.

Existing support and training

Support offered differed significantly between organisations.

For the majority, training on mental health was focused on supporting the public's mental health needs and identifying common mental health problems they might come across in the role, rather than building personal coping mechanisms.

New recruits, trainers and senior managers all emphasised the importance of trainers in supporting new recruits in the early stages of their career. They are often the first recourse for new recruits who are struggling, even when they have finished training and can be highly influential in shaping new recruits' attitudes towards mental health. However, trainers felt that the guidance they were given on how to support new recruits and their awareness of available resources was limited and would value more input in this area.

Training preferences

New recruits felt a two-stage approach to training was generally most useful.

An introduction in initial training to show the organisation's commitment to mental health support was seen as important. But further training after they had gained practical experience is also vital to refresh and embed what they had learned.

New recruits felt content tailored to the demands placed on them was important, including a focus on identifying signs and symptoms, preventative strategies and building resilience. Interviewees had also found tips on relevant coping strategies, with relatable examples or case studies, useful in previous trainings.

Pilot course for new recruits

Using findings and recommendations from our research with new recruits, we designed a two-part training course and piloted it with 223 new recruits between January and July 2018.

The first part of the course was designed to be delivered during initial induction training to help prepare new recruits for the challenges ahead. It focused on the following areas:

- increasing awareness of mental health
- understanding tools and techniques to help build resilience
- seeking support.

Part two was designed to be delivered 8 to 12 weeks after part one, once new recruits had gained some valuable experience in their roles. As well as consolidating what they learned from the first session, the course aims to provide new recruits with an opportunity to reflect on their early experiences in the emergency services, whether they have been able to put into practice anything they learned in the first session, and how they will support themselves and others in future.

As well as training for new recruits, we delivered one-day workshops to support trainers to embed awareness of mental health into existing training practices for new recruits and to increase awareness of the Blue Light Programme. The training covered:

- general mental health awareness
- resilience building tools and techniques you can use when training new recruits
- embedding mental health awareness into induction training – tips and tricks
- The Blue Light Programme – how it can support new recruits
- looking after your own mental health.

These workshops were not included as part of the evaluation of the pilot programme, but feedback from trainers has been reflected in this report.

Evaluation of the pilot course

Our evaluation of the two-part pilot course for new recruits aimed to:

- determine the extent to which the training course could be made most relevant and engaging to new recruits and their employers
- understand whether the course had led to any change in new recruits' mental health knowledge, help-seeking behaviour and coping skills
- where changes had occurred, identify how long these lasted for.

For more information on the methodology, see page 45

Key findings

Approval ratings for the training were high.

Of the new recruits attending part one of the course, 94 per cent agreed it was useful. The training materials were felt to be relevant and high quality. Mind's experienced trainers successfully engaged participants and facilitated open group discussion, and they were able to respond flexibly to the interests and needs of the different blue light services.

Fewer participants attended part two than part one.

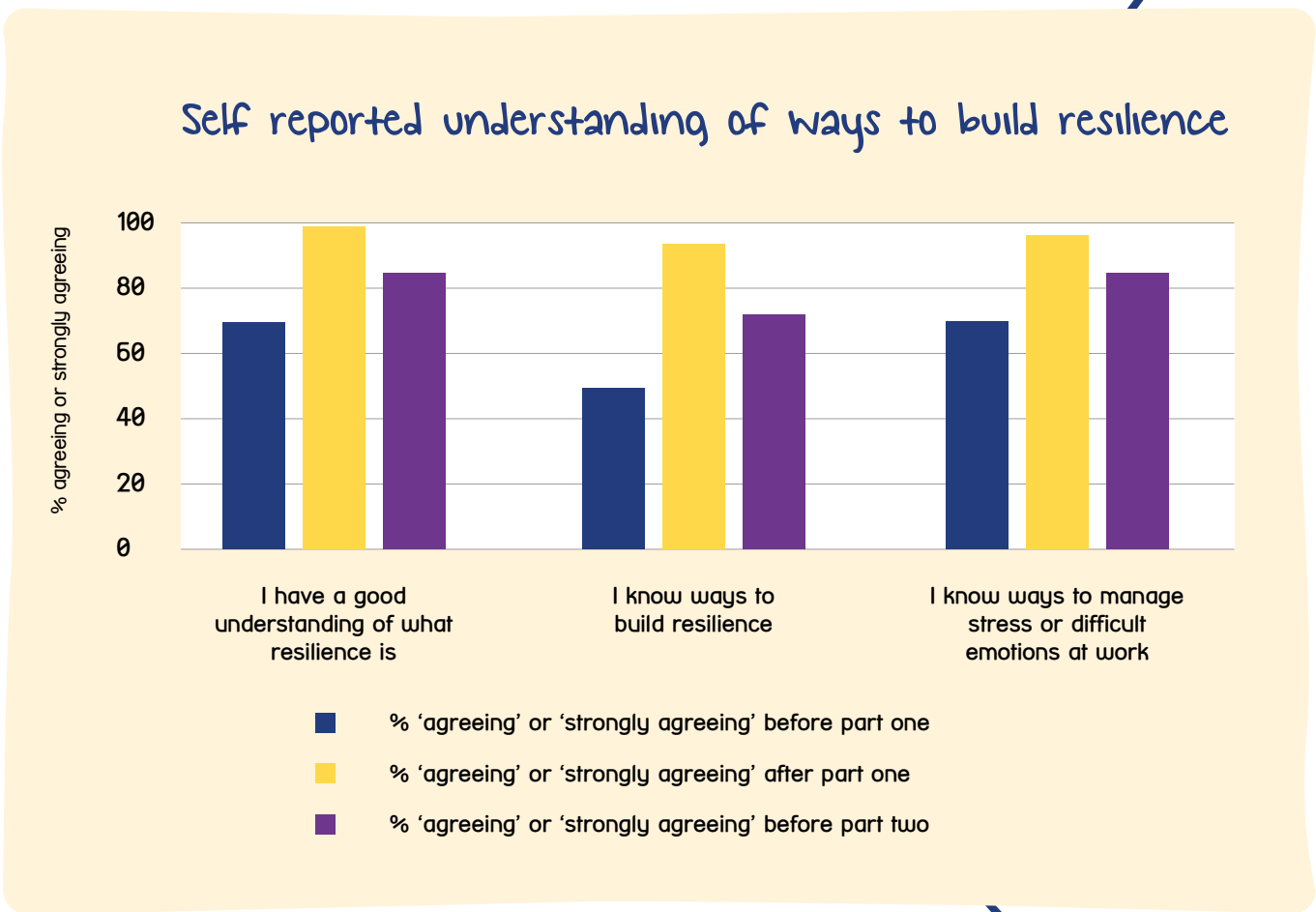
However, there was no evidence to show that people failed to attend part two because they weren't satisfied with part one of the course. it seems likely that many participants simply had competing priorities and/or services found it more difficult to make part two of the course mandatory (among recruits who came to the first part of the training, 71 per cent said that attending had been mandatory). Recruits who attended the second part said that it had helped cement what they had learned and made them more likely to make useful changes in the longer term.

Knowledge and understanding was high before the course.

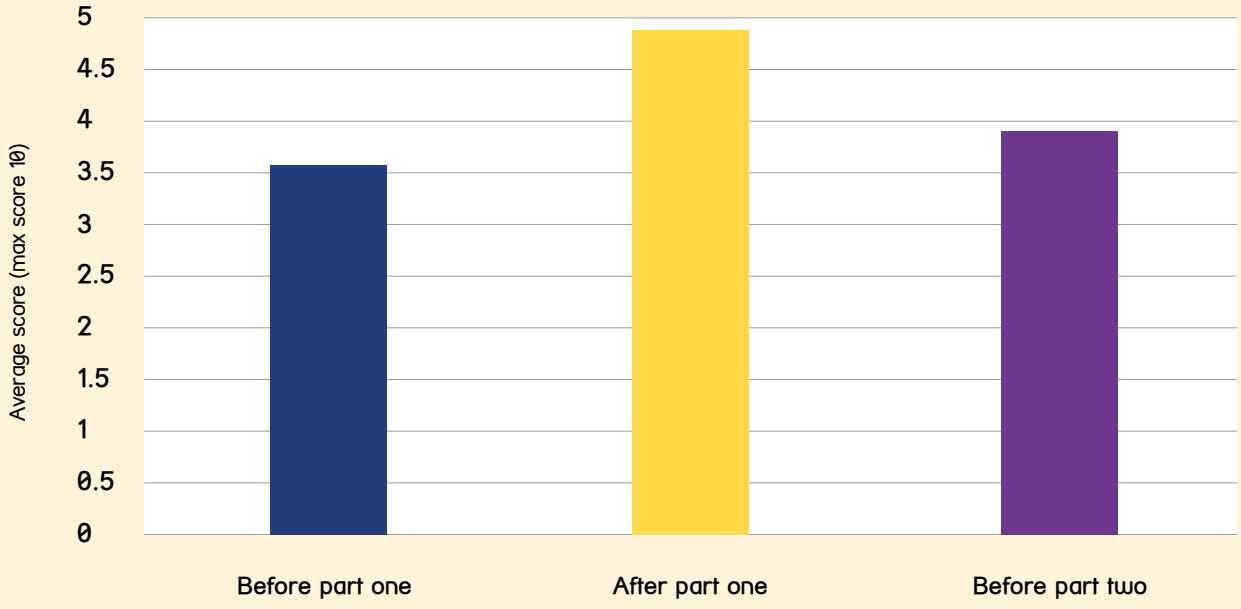
Recruits demonstrated relatively good levels of knowledge and understanding of mental health before part one of the training. Where levels of knowledge were high already, there was limited room for improvement.

Understanding of resilience improved.

The biggest impact of the training was found to be on self-reported understanding of ways to build resilience. The percentage of participants saying they understood this rose from 48 per cent before part one of the training to 93 per cent afterwards. This decreased to 71 per cent after the follow up period (just before part two), demonstrating how difficult it can be to retain new knowledge after several weeks, and the potential benefits of having the training in two stages.



Participants knowledge recall around tools and techniques that can be helpful for building resilience



Participants used the coping techniques they had learned.

At the follow up stage, 32 per cent had applied a coping technique that they had learned in part one and a further 20 per cent intended to try. The most popular techniques were mindfulness, meditation and sharing experiences with colleagues. There was increased understanding of the support needs of people with mental health problems but also a recognition of the boundaries of the first responder role.

Participants found it useful to reflect on when they should intervene.

The most powerful changes appeared to be about prompting people to reflect on their 'domain of control': what problems they can realistically intervene to solve and what is best left to other professionals. These changes were particularly impactful when working with the public – 41 per cent of participants felt the training had made a difference in this respect.

Training improved awareness of the Blue Light Programme resources.

The training was also successful in raising awareness of and getting people to use Blue Light Programme resources. Awareness of the Blue Light Infoline doubled from 43 per cent before part one training to 90 per cent at the end of the follow up period. The proportion of new recruits who had accessed blue light booklets also doubled, increasing from 9 per cent at part one to 20 per cent by the end of the evaluation.

Conclusion and recommendations

- The two-part training for new recruits increases understanding and knowledge around building resilience and seeking help. It's considered useful and engaging. The evaluation demonstrates potential for the training to make a positive impact on blue light new recruits' wellbeing and would benefit from being rolled out more widely.
- Achieving long-term impact is a challenge for any training provider but the two-stage approach appears to make meaningful change more likely. Our findings show that the two-session training package is an effective one. However, in future new recruits should be required to attend both sessions. Ideally senior managers should back this, for example by building time in schedules to allow staff to attend training.
- Knowledge around mental health among new recruits appeared to be relatively high before the sessions and there may be some value in shifting the emphasis of training to where there is most potential for new learning. Highlighting the content around coping skills and showing how the training is relevant to future work scenarios could help to overcome resistance from those who feel they already know about mental health.
- Providing space for reflection and open discussion was particularly valuable to new recruits who took part in the course, particularly as some noted that they had little opportunity to talk with colleagues during shifts. Any future courses should make sure there's enough time built in to make the most of group discussions.
- Trainers of new recruits welcomed the opportunity to share learning and best practice. They wanted to gain further knowledge about how to support new recruits' mental health and embed an awareness of mental health into their existing training practices. It's important to continue to work with training departments and senior leaders in the emergency services to ensure that mental health is placed at the top of the agenda from day one.

999 call handlers

Call handlers are increasingly expected to take on higher volumes of calls – against a backdrop of reduced staffing levels and strictly enforced targets. These issues are overwhelmingly felt to be the main cause of poor mental health and wellbeing among call handlers, and a key contributor towards high levels of staff sickness and poor staff retention.

To help us plan and develop a pilot service tailored specifically towards call handlers, we carried out a focused research project. The aim was to find out what issues call handlers face when it comes to their mental health needs, as well as their awareness and perceptions of existing support.

The research included: focus groups and interviews with call handlers; interviews with managers, federation representatives and trainers; and observations in ambulance, fire and police control rooms in central London, including listening to live 999 and/or non-emergency calls.

For more information on the methodology, see page 45

Key findings

999 call handlers face unique challenges.

Research participants from all four services described the mental agility and energy required to deal with the range of calls received. They felt that not having the time to process their thoughts between calls exacerbated the 'emotional turbulence' associated with the role.

> **So, one minute you might get just an everyday run-of-the-mill someone has fallen over in the street. Then your next call could be someone who has taken their own life, and then your next call could be a cardiac arrest. I mean, that's part and parcel of the job, but because there's no break between the calls, you're going from one thing to the other. So, emotions are all over the place.**
>
> Supervisor, Ambulance service

Another issue that came up frequently, particularly from ambulance call handlers but also within the fire service, was the lack of closure associated with the role. They rarely find out the outcome of the calls they handle, which can be difficult and often leads to them imagining the worst. Linked to this was what was described as the effect of 'sense loss' – imagining the scene without being able to see what was happening. This was particularly distressing to many staff.

Staff from all services said they didn't feel confident in dealing with callers experiencing mental health problems, and described this as one of the main challenges of the role which had an impact on their own wellbeing.

Call handlers often have to stay on the line with callers experiencing suicidal thoughts or feelings for long periods of time, while waiting for frontline response to arrive. Participants described worrying about the risk of exacerbating the situation by saying the wrong thing.

If you end up with someone on the phone who's saying, 'that's it, I'm going to end my life. There's nothing you can say,' we don't have any of the tools to speak appropriately to that person, and we've got to just work out what we think is best. Because we don't have the training and we don't have the knowledge, we run the risk of saying something completely wrong and making the situation worse.

Call handler, Coastguard

Most call handlers described feeling anxious and unprepared to deal with these callers. They reported receiving no training or guidance around mental health. This meant that they had a limited awareness of the range of mental health problems that callers may be experiencing and, crucially, any implications for how to handle callers experiencing a mental health crisis.

Call handlers can feel like the 'hidden' emergency service.

Call handlers described feeling quite separate from other frontline staff. They were usually working separately from both response staff and wider organisational support services (for example, HR) and this increased their sense of themselves as the 'hidden' emergency service. In general, they felt that their roles received little acknowledgment or thanks.

You're still dealing with a lot of life and death. I think there's a sense, sometimes, that they're minimised in the role, that they're 'control', they just pick the phone up. Well, they don't. They're still very much part of it but without the same sense of being given support.

Senior manager, Fire service

Organisational pressures

Limited resources and pressure to meet targets are increasing stress.

Staff from all four emergency services said understaffing and poor staff retention were an issue. During busy periods this made it difficult for call handlers to take breaks.

It's been so busy and the calls are queuing relentlessly and they don't have a second, or 10 seconds or a minute in between each call. They put the phone down and then the next one's in their ear already.

Senior manager, Police service

Lack of resources makes stress worse. Call handlers are responsible for allocating resources and often face agonising choices about where to dispatch frontline response. There might be two equally urgent cases but only one vehicle available.

Ambulance staff highlighted how those waiting for an ambulance often direct their frustration and anger towards the call handler.

So, they're getting the next call and it's someone saying 'where the hell is my ambulance?' and, for them, they're frustrated because it's almost like 'well, that's not my job'.

Trainer, Ambulance service

The need to 'do more with less', means call handlers are under increasing pressure to meet difficult targets.

While participants understood the purpose of audits, there were concerns, especially from ambulance staff, about the scrutiny they felt they were under and the lack of flexibility and timely feedback in the audit process.

Time-driven targets also exacerbated stress levels among call handlers. Some participants described situations where supervisors intervened to find out why a call was taking longer. In some cases this was intended to be supportive, but it was generally regarded as unhelpful and increased the pressure felt by call handlers trying to deal with difficult situations.

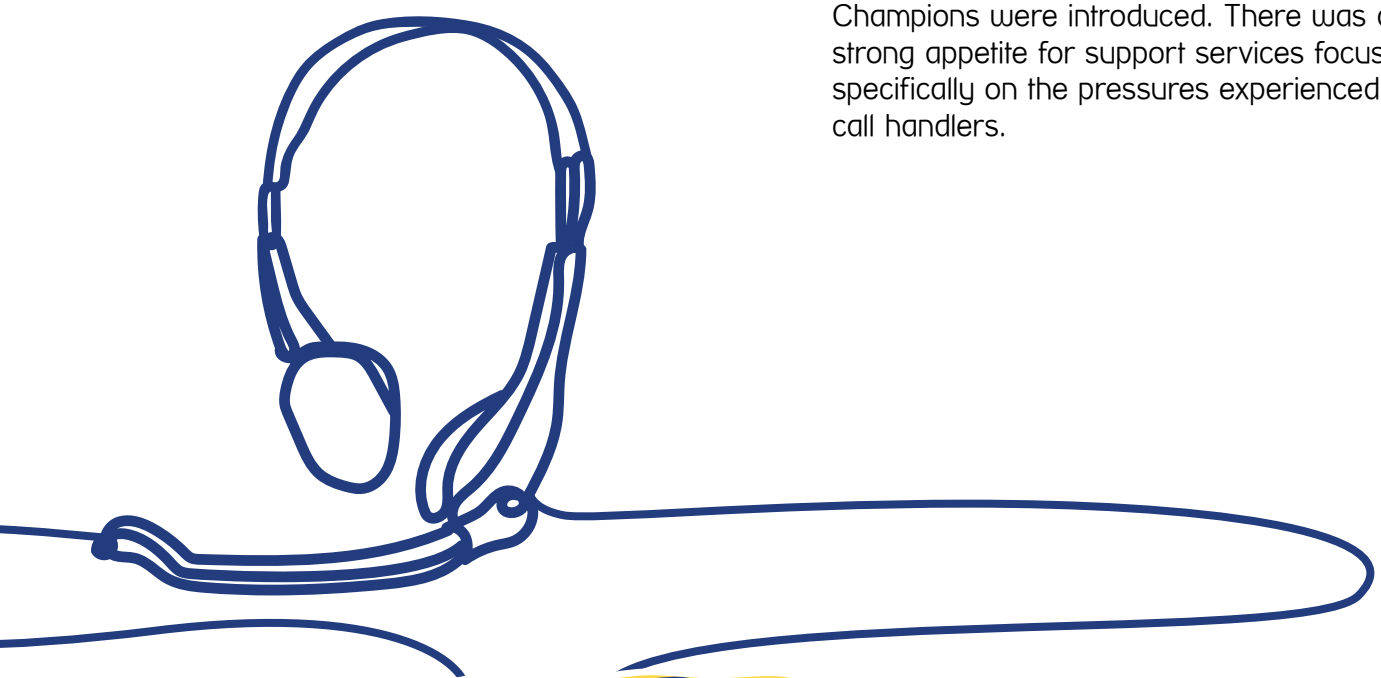
Stigma and discrimination

The culture is changing, but there is still a long way to go.

While there appears to have been some reduction in stigma and discrimination around mental health generally, a 'just get on with it' organisational culture continues to exist in the emergency services.

Staff from all four services talked of an organisational culture where dealing with distressing incidents and stressful situations is intrinsic to the call handler role. They are expected be able to handle them with little support. One call handler said that she would appear 'needy' if she asked for a debrief.

Several participants felt that, due to the nature of their job, admitting to struggling with their mental health would be perceived as a sign that they are unfit to be in the role. Call handlers expressed fears around the confidentiality of support services and general levels of mistrust within the services.



Organisational support and barriers to seeking help

Staff find it difficult to access the support they need.

Many participants simply did not know where or who to go to, to get support. When they did, most found that getting time to access any support available was very difficult.

Call handlers felt that they are getting less support from their managers, as targets have become the priority for managers.

Feedback on organisational support is mixed.

Attitudes towards occupational health varied. Some participants reported positive experiences of being referred for counselling, while others referred to occupational health as 'unapproachable' and reported long waits for appointments.

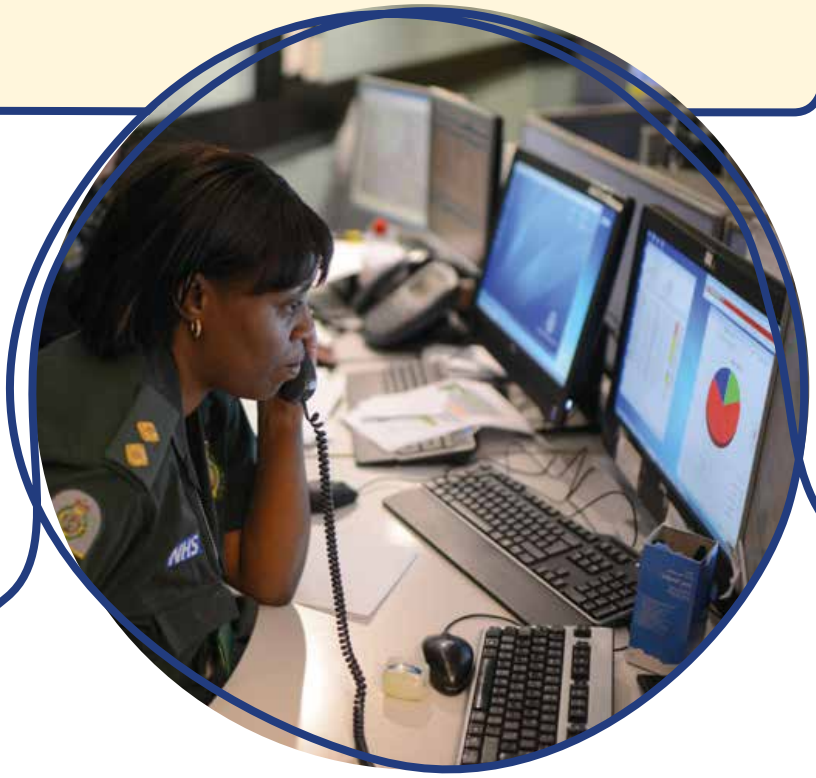
But organisational change means more support is slowly filtering through.

The general feeling was that the Blue Light Programme had taken a little longer to be introduced in control rooms and perhaps was more difficult for them to access than their frontline response colleagues. This was linked to seeing themselves as the 'hidden service'. However, some participants felt that this was starting to change, as more Blue Light Champions were introduced. There was a strong appetite for support services focused specifically on the pressures experienced by call handlers.

Targeted support for call handlers

The findings and recommendations from our research with call handlers were used to develop a programme of support specifically tailored towards control room staff's needs. This was piloted in our four Blue Light Mental Health Network areas between January and July 2018 and included:

- **Control room pledge** – Blue Light Time to Change Pledges with targeted action plans that recognise the specific context of call handlers, while connecting the control room to the overarching organisational commitment to mental health.
- **Champions and peer support hints and tips** – Online and offline resource with hints, tips and examples of how to apply the existing Blue Light Champions toolkit in the control room.
- **Call handler briefings** – Short introductions to three subjects: Mental health awareness, Building resilience, and Supporting callers with their mental health. These were delivered either as a one-day (5.5 hour) course or as 3 separate components lasting between 1.5 hours and 2 hours each. The briefings were designed in this way to reflect feedback by staff and managers that it would be difficult to release staff for a full day of training.
- **Managing mental health in the emergency services (MMHES) training** – Reviewing and adapting activities and case studies to reflect the roles of control room managers and supervisors.
- **Workplace wellbeing webinars** – Subtitles to be added to existing webinars to enable them to be played in the control room.
- **Adapting existing materials** – Reviewing and where necessary adapting existing materials to ensure they are relevant to and include call handlers.



Evaluation of targeted support for call handlers

We evaluated how these activities were perceived and the extent to which they have had an impact on staff working in the control room. Some of the key areas we considered are:

- participants' experiences of the courses, briefings and Blue Light Programme materials, including format, content, relevance and quality of delivery
- the extent to which call handlers were aware of and engaged with Mind's Blue Light Programme
- the visibility of tailored Blue Light Programme resources within the control room and the extent to which these were considered useful and relevant
- the degree to which support for the mental health and wellbeing of call handlers and attitudes towards mental health is perceived to have improved at an organisational level
- call handlers' confidence in managing their own mental health and supporting callers, colleagues, and friends and family members experiencing a mental health problem after they have engaged with the Blue Light Programme.

The introductory briefings and MMHES training were tailored from existing Mind content that has already been evaluated. As a result, the primary focus of the evaluation was on measuring participants' attitudes towards the tailored resources and the extent to which they are considered relevant and useful to staff, rather than measuring specific outcomes.

For more information on the methodology, see page 46

Key findings

Demand for training was high.

During the pilot period, 316 call handlers attended the briefing sessions, with the majority doing so in their own time.

> **They all came in on their days off to do it. It wasn't in work time. The buy-in was such that they were just craving to actually unravel the issues that they had.**
>
> Manager, Police service

Many staff attended the briefings because they felt that mental health was relevant to their work. However, they also welcomed the opportunity to reflect on their own mental health outside of a work setting. Managers and call handlers also thought that one of the main reasons for attending the briefings was an existing interest in, or personal experience of mental health problems.

Some staff said that they had signed up for the briefings after recommendations from colleagues who had positive experiences of the training. Of the staff who took part in the evaluation, 97 per cent said they would recommend the briefings to a colleague.

Demand for training among managers was equally high. Some services were able to ensure that all line managers working in the control room could attend the MMHES training.

But making training voluntary meant that some staff were not able to attend.

Despite the relatively high numbers of staff attending, course participants and managers highlighted several things that may have prevented staff from going to the briefings. These were mainly around staff needing to attend training in their own time. Barriers included caring responsibilities, travelling distance and unwillingness to give up their days off.

Managers highlighted that staff were either paid or given time off in lieu for attending training. But for many staff this is still impractical or something they don't want to do on their day off. Therefore, there is a risk that the training does not reach many staff who might benefit from it.

The culture around mental health is changing.

Some managers were surprised by the diverse range of staff that had asked to attend the briefings. They felt this was because of positive feedback and encouragement from colleagues, but also indicates a change of culture surrounding mental health in the emergency services generally that has also been felt in the control room.

There was such a variety of people. Some roughty-toughty blokes, who you just wouldn't expect, and they all had a tale to tell.

Manager, Police service

Some staff felt that this was a generational shift, others that it was a result of a greater organisational commitment to staff mental health, and some felt it to be a direct result of the influence of the Blue Light Programme.

People are a lot more open to talking about stuff, and people aren't afraid, now, to say, 'I've been upset by that'. In the past, people didn't used to, whereas now, they're like, 'I need five minutes. I need time out'. That's come from the Blue Light Programme, because of all of the input we've had.

Trainer, Fire service

Training increased the confidence of staff to support their own and others' mental health.

Of the call handlers who attended the briefings:

- 87 per cent said they knew more about different mental health problems after the training.
- 94 per cent said their knowledge of personal resilience had increased.
- 90 per cent said they knew more about how to look after their wellbeing.

Participants valued having space to reflect on their own mental health with their colleagues, and took away some key messages about the importance of their own wellbeing.

To hear people having the same feelings and know that there is support out there, it's quite reassuring. Also, it's like the analogy about the plane, you've got to put on your own mask before you help others. That is quite brave and feels like a good thing to hear.

Call handler, Police service

Of the call handlers who attended the briefing, 90 per cent agreed or strongly agreed that the briefings had made them feel more confident in supporting callers with mental health issues. They felt that the training had validated some of their existing practice. And it had given them the confidence to be more direct and less worried about talking to callers about their mental health, particularly those who are feeling suicidal.

Following the MMHES training, 98 per cent of managers said that they felt confident that they could support a colleague experiencing a mental health problem at work, and 100 per cent agreed or strongly agreed that they understand the tools and techniques available to promote mental health and wellbeing at their workplace.

I felt really empowered to be able to make more of a difference and positive change within my areas of responsibility.

Manager, Police service

Awareness of the tailored resources was lower, but there is evidence they are being used.

Feedback from call handlers about the hints and tips cards and tailored booklets was limited, but Blue Light Programme materials were visible in all the control rooms visited as part of the evaluation, and managers told us that staff were taking them away.

Some staff were vaguely aware the booklets existed, but hadn't read them in detail. Some suggested that they would refer to them if they felt they needed to, but it was generally agreed that face-to-face training was more helpful.

There were difficulties accessing the subtitled webinars in the control rooms, which meant not many people knew about this or used it.

Some services struggled to generate the momentum needed to refresh the Blue Light Time to Change pledge.

Some managers said it had been difficult to get senior buy-in to refresh the pledge and that attempts to move this forward felt 'half-hearted'. Awareness of and interest in the pledge from call handlers was low. While managers understood the purpose of the pledge, some felt that it was more important to demonstrate a commitment to staff mental health through investing in training and a drive from senior leadership, rather than focusing on the paperwork associated with the pledge.

I think the main issue was getting the message over to staff in the first place, by the managers. No-one's ever referred to the pledge. None of our staff. You know, they're aware of its existence, but no-one has ever turned around and said to me, 'What's happening with the pledge? Where is it?'

Manager, Police service

Conclusion and recommendations

- The briefing sessions increased understanding around resilience and help seeking and gave call handlers confidence to support callers experiencing a mental health problem. Managers who attended the 'Managing mental health in the emergency services' (MMHES) training said that the course gave them more confidence to support their own and their colleagues' mental health.
- Many staff and managers felt strongly that both the briefings and MMHES training should be made mandatory for call handlers and line managers. Demand for the training was high and many staff attended in their own time. Some felt that the briefings should be included as part of the initial induction package for call handlers, as this would reduce some of the barriers preventing staff being released for training.
- Senior level buy-in is needed to ensure call handlers' wellbeing is prioritised and they are given enough time for training and wellbeing activities.
- Call handlers found the briefings relevant and engaging, but some areas were considered more useful than others. Any wider roll out of the training should take into consideration feedback from call handlers to refine and adapt specific content.
- There is little evidence for the success of the control room pledge and some managers felt it was more important to demonstrate their commitment to the mental health of staff in other ways. If staff are unaware of the pledge and maintaining enthusiasm for it is challenging then further investment in continuing the pledge in this context is not recommended.
- Call handlers need clear signposting and communication, from existing channels such as their intranets, line managers and staff noticeboards. This will increase awareness of support available and allow call handlers to make informed choices about the support they choose.

Credit: South Wales Police Visual Media Unit

Impact of workplace wellbeing initiatives on the public

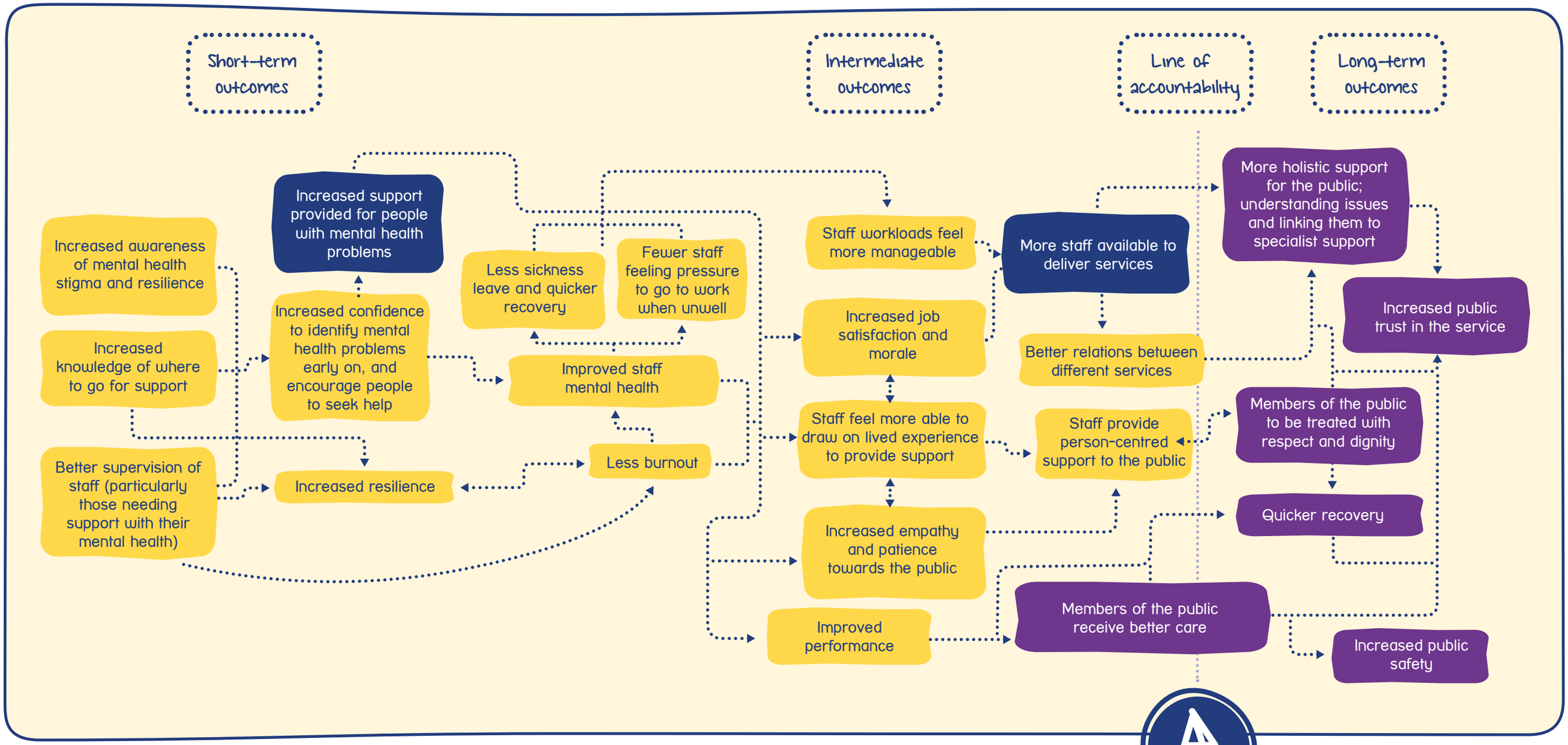
Mind's Blue Light Programme focuses on the mental health and wellbeing of emergency services ('blue light') staff and volunteers. However, it doesn't operate in isolation. Workplace wellbeing initiatives like this can potentially affect the wider public.

We wanted to explore the link between emergency services staff and volunteers' mental health and wellbeing and their ability to support members of the public, particularly those experiencing mental health problems. We carried out a research project, which began with a literature review. As there is very limited research on the emergency services specifically, most of the evidence we have found has come from research on medical professionals, which we can assume has some relevance to the emergency services. Our research also included a series of qualitative discussions, interviews and survey questions with emergency services staff.

For more information on the methodology, see page 46

Some key findings from the literature review:

- Increased staff wellbeing results in less sickness absence, which means that there are more staff available to support the public.
- Some research suggests that by supporting staff wellbeing employers may also see positive changes in their employees' performance.
- Compassion fatigue, which can mean that staff are unable to see 'the person' in members of the public, is common among emergency services staff. In interviews conducted by Mind in 2015, 60 per cent of ambulance workers and 40 per cent of police agreed that they were less patient with members of the public because of their own poor mental health.
- Studies have shown that feeling like staff are more 'than just doing their job' can improve the public's perception of the care they have received.
- Good communication with members of the public has been found to contribute positively to their wellbeing. In the case of medical patients, it has helped to speed up their recovery.
- Recent research has shown that NHS Trusts using good people management practices were over twice as likely to have staff with the highest levels of job satisfaction, compared to NHS Trusts that used these practices the least. They were also over four times more likely to have the most satisfied patients.



What do emergency services staff think?

Many interviewees from the emergency services felt that experience of poor mental health should not necessarily affect the way they treat the public. They felt that, with adequate support, staff who were able to understand their own response to mental health problems could draw on their own and others' lived experience to provide support and empathy to the public.

Theory of change: a way to move forward

This theory of change diagram, informed by our research, considers the long-term outcomes we want to see for the public. It shows how short-term and immediate outcomes can build towards these. We have used the example of the Blue Light Programme to illustrate outcomes that a workplace wellbeing initiative would be expected to generate.

In this example, the short-term and intermediate outcomes come under the remit of the Blue Light Programme, and the long-term outcomes should follow from these. The line of accountability is the point where the Blue Light Programme is no longer responsible for achieving these outcomes – their contribution to previous outcomes acts as an enabler or catalyst for later change.

There are many independent organisational factors that come into play alongside any workplace wellbeing initiative. Ways that employers can contribute towards these long-term outcomes include: adopting an organisational anti-stigma culture, more support for staff, and allowing staff some flexibility to manage their own workloads.

Measuring the impact

Innovative approaches could allow us to understand more about the public experience.

The information we currently have is still speculative. We need to consider the best ways to accurately measure the impact of increased staff wellbeing on the public.

Existing research has adopted a variety of methods to explore public experiences and understand situations from their perspectives. This research has primarily been in healthcare, but the examples below are approaches which can be adapted to the emergency services.

- **A patient-centred narrative approach** can be used to get a deeper understanding of how users feel about their treatment. This could involve online forums, social media or 'Photovoice', which allows users to document their journey using pictures and captions. This has been shown to work with people who didn't feel they could tell their story in a more conventional way.
- **The 'Most Significant Change' technique** can help capture a range of voices by asking people to document what has significantly changed for them and their reasons for thinking this. Strategy teams would be asked to prioritise the accounts they feel are most significant, and explain their reasons to senior executives. Although resource heavy, this can allow us to see the similarities and differences between participants, and the effect of context.
- **Observational studies** can be used where the interviewee experiences the patient's journey. This could mean taking a tour of the facility (for example, a hospital or clinic) through the patient's eyes, or shadowing a patient receiving a cycle of care. In an emergency services context, this could mean a researcher shadowing emergency services staff as they interact with members of the public.
- **New technology**, such as police body cameras, have been effective in showing the attitudes and experiences of frontline staff in different contexts. The language they use can then be coded and analysed. This is most appropriate for police staff, but would not necessarily be feasible for ambulance, fire or search and rescue staff.

More principles to consider

For a workplace wellbeing initiative to have a positive impact on the public, employee training should focus on the implications of their behaviour. A similar principle can be used in data collection, creating shared knowledge to inform how services are delivered, as well as encouraging the public or staff member to make sense of their own experience.

Principles of action research could be employed to develop and test data collection methods and help staff understand how to make use of their own lived experience to support members of the public.

It would be helpful to look at how staff behave within the structure of their organisation. **'Actor Network theory'** can be used to focus on the relationship between how services are delivered and the context they operate in.

A multi-stage approach

As most interactions with the public are short term, often in a time of crisis, the evaluation process would need to work over several stages to capture the most insightful data. This could involve:

- gathering insight from staff about the changes they have experienced as a result of efforts to improve their wellbeing
- identifying an appropriate sample of the public who are in contact with the emergency services, keeping the context of their interactions in mind during the research
- gathering appropriate data from the staff and the public on their perceptions of treatment, and looking at observational data
- bringing together the information from these different sources and using it to redefine our understanding of the impact of workplace wellbeing initiatives for emergency services staff on the public.

Preparation stage: Selecting cases

- Select sites from across the four emergency services.
- Select sites that have not taken part in research and evaluation activities before.

Stage one: Understanding change experienced by staff

- Recruit emergency services staff and volunteers
- Gather insight into their perceived changes to attitudes and behaviour (short and intermediate outcomes).

Stage two: Identifying a sample of members of the public

- Select people who come into contact with emergency services staff and volunteers.
- Define the interactions.

Stage three: Gathering data from staff and the public

- Data from staff: perceived changes.
- Data from members of the public: perceived changes.
- Observational data from interactions with the public.

Stage four: Combining information

- Analyse data from different sources.
- Use analysis to understand theoretical public impact.
- Inform future data collection on a wider scale.

Conclusion and recommendations

Using a multi-stage approach is one way to broaden our understanding of the potential public impact of workplace wellbeing initiatives such as the Blue Light Programme, while keeping in mind local conditions and other external and internal factors, such as resource shortages and budget cuts, that could affect staff wellbeing.

- The proposed approach combines several ways of collecting data that were well received by frontline staff. It's also a process that centralises learning. It focuses on developing deeper knowledge about what is happening in a small number of cases. This in-depth analysis will help to overcome some of the practical limitations we've mentioned and could inform future work on a wider scale.
- Many emergency services staff believe that the most important outcome for the public is that more staff are well, so they are available to support the public when they're needed. This should be taken into account in any future research. However, workplace wellbeing initiatives should encourage emergency services teams to reflect on the broader impacts of improving the mental health of their staff and volunteers to help them understand all the benefits to the public.

Credit: Gwasanaeth Tân ac Achub De Cymru / South Wales Fire and Rescue Service

10 actions we can all take

The following 10 actions are drawn from our targeted research and evaluation findings. Whether you're working in the emergency services or supporting those who do, these are things we can all do to help ensure better mental health for blue light staff and volunteers.

1. Consider the unique and diverse environments that emergency services staff and volunteers operate in when designing and delivering training and support services.
2. Promote an organisational culture that emphasises the mental health and wellbeing of blue light staff and volunteers.
3. Use the learning from our research and evaluation to make sure that training and support is accessible to all staff and volunteers.
4. Demonstrate a commitment to staff wellbeing from day one by making mental health training mandatory for new recruits and providing space for them to reflect with their colleagues.
5. Invest in line manager training to help supervisors feel more confident and better support their staff.
6. Maintain and support a strong network of Blue Light Champions who can raise awareness of mental health and help to reduce stigma.
7. Invest in building the resilience of emergency services staff and volunteers so they can keep themselves well in a challenging environment.
8. Consider the wider benefits to the public of initiatives to improve the mental health and wellbeing of emergency services staff and volunteers.
9. Help staff and volunteers to understand how important it is to look after their own wellbeing by providing support that is targeted and relevant.
10. Download our Blueprint Pack to learn more about how to embed staff wellbeing support into core business practice.

mind.org.uk/bluelightBP

About Mind

We're Mind, the mental health charity. We're here to make sure anyone with a mental health problem has somewhere to turn for advice and support.

Our vision:

We won't give up until everyone experiencing a mental health problem gets both support and respect.

Our mission:

We provide advice and support to empower anyone experiencing a mental health problem. We campaign to improve services, raise awareness, and promote understanding.

Our values:

- **Open**
  We reach out to anyone who needs us.
- **Together**
  We're stronger in partnership.
- **Responsive**
  We listen, we act.
- **Independent**
  We speak out fearlessly.
- **Unstoppable**
  We never give up.

Local Minds:

Our unique and successful network of around 135 local Minds is fundamental to everything we do.

We work together in partnership to deliver excellent mental health services to anyone who needs them.

Local Minds directly support around 380,000 people every year.

We also coordinate and test innovative new services across our network.

Methodology

Resilience course

Partner: University of Oxford

This evaluation tested the effectiveness of the group-based resilience course.

The evaluation was based on:

- **a randomised controlled trial.** 180 emergency service workers were randomly allocated on a 1:1:1 basis to receive either the new resilience intervention, a placebo intervention or a wait period of four months. Participants completed several measures to assess their resilience, wellbeing, coping and social capital at three assessment points: pre-intervention, post-intervention and three-month follow-up
- **qualitative interviews.** Purposive quota sampling was used to select the participants for in-depth qualitative interviews, to ensure the interviewees covered a wide range of characteristics. Interviews were conducted with 12 resilience intervention participants, four control intervention participants and eight course facilitators.

New recruits: scoping research

Partner: ResearchAbility and Mind

This scoping research explored the issues facing new recruits in the emergency services.

Methods used were:

- four service specific **focus groups** within the existing Blue Light Mental Health Network areas (three police and one fire). Staff who took part had been employed in the emergency services for less than three years
- two service specific **interactive workshops** – one for new recruits to Merseyside Fire and Rescue Service and the other for new recruits across several search and rescue services around England
- two service specific **group interviews** with staff from the ambulance and police service
- four in-depth **telephone interviews** with staff with less than three years of employment in the fire and police services
- eleven **in-depth interviews** (telephone and face-to-face) with 'expert' stakeholders, including senior management, trainers and senior lecturers
- a **teleconference** attended by representatives from training departments from five emergency services (three police, one fire and one search and rescue).

The research was carried out in partnership with ResearchAbility, who Mind commissioned to facilitate the four focus groups. All other aspects of the research, including planning, designing topic guides, fieldwork and analysis were conducted in-house by Mind's Research and Evaluation team.

New recruits: pilot course evaluation

Partner: Institute for Employment Studies

The broad aim of the evaluation was to capture actual and potential impacts of the training for recruits across the blue light services and gain an understanding of issues that need to be considered in any potential wider rollout.

The Institute for Employment Studies used a mixed-methods approach:

- three waves of survey
- in-depth qualitative interviews
- training observations
- post-training focus groups.

Surveys were carried out over the course of the evaluation to explore immediate as well as longer lasting outcomes:

- a baseline survey: participants completed this prior to receiving part one of the training
- post-training survey: participants completed this immediately after attending part one
- 'follow-up' survey: participants completed this prior to receiving part two of the training; this was normally 8 to 12 weeks after attending part one.

Different qualitative approaches were applied strategically to:

- understand the training objectives, content and delivery
- evaluate how recruits engaged with the training
- identify learning outcomes and any changes in behaviour.

999 call handlers: scoping research

Partner: ResearchAbility and Mind

This scoping research explored the issues facing 999 call handlers.

Methods used were:

- four **focus groups** in the existing Blue Light Mental Health Network areas, attended by call handlers from the ambulance, fire and police services
- six **in-depth telephone interviews** with call handlers in the ambulance, fire, police and search and rescue services
- nine **in-depth interviews (telephone and face-to-face)** with 'expert' stakeholders; including line managers, senior management, federation representatives and trainers
- **observations within ambulance, fire and police control rooms** in central London, including listening to live live 999 and/or non-emergency calls, plus a site visit to the Coastguard Operations Centre.

The research was carried out in partnership with ResearchAbility, who Mind commissioned to facilitate the four focus groups. All other aspects of the research, included planning, designing topic guides, fieldwork and analysis were conducted in-house by Mind's Research and Evaluation team.

999 call handlers: briefings and tailored resources evaluation

Partner: Mind

The evaluation of the call handler briefings and tailored resources was carried out by Mind's Research and Evaluation team.

Its aim was to evaluate the targeted rollout and delivery of the various activities and resources to assess how they were perceived and the impact they had on staff working in control rooms.

Mixed methods used were:

- post-training evaluation forms, given out face-to-face after the MMHES training and call handler briefings, inviting participants to share their views on aspects of the training and self-report on key learning outcomes
- observation of two full-day training sessions (incorporating all three briefings) for call handlers from the police service
- two focus groups with call handlers from the police service who took part in the briefing sessions that were observed
- five in-depth face-to-face interviews with line managers, trainers and employee engagement representatives
- site visits and observations at three control rooms.

Impact of workplace wellbeing initiatives on the public

Partner: New Economics Foundation

This exploratory research looked at the connection between the mental health and wellbeing of emergency services staff and their support for the wider public.

Methods used were:

- **rapid literature review.** Before data was collected, a review of relevant literature was carried out, based on research questions codesigned with Mind and using Google Scholar, Deepdyve and library search functions. Desk research was also done into methods for gathering data on the impact of the wellbeing of staff on members of the public
- **qualitative research.** A series of qualitative discussions were held with police and fire and rescue service staff. Two workshop discussions (involving 20 people) were held with staff from the fire and rescue services who had attended a conference on trauma support in the emergency services (that included input from Mind's Blue Light Programme). A question was inserted into the Work2health and Work Research Centre survey of Blue Light Champions in Wales, which was undertaken as part of the independent evaluation of the Blue Light Programme in Wales. A further seven telephone interviews were held with participants from across the emergency services who were already engaged with the Blue Light Programme.

The research findings and theory of change developed from the literature review and qualitative research were also reviewed by a small sample of staff working within the fire and police services.

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