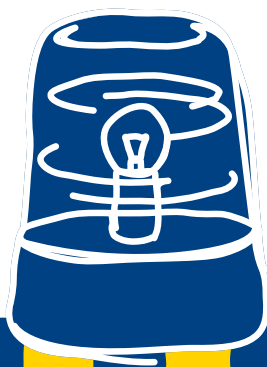




West Midlands Police



Blue Light Programme Research Summary

An evaluation of the impact
of our mental health support for
emergency services staff and
volunteers in 2015 to 16

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Partner research

We want to recognise the independent research of organisations that we work in partnership with too, which all helps to build the case for more support in the emergency services sector. This includes Police Mutual, the Police Federation of England and Wales (PFEW) and the Association of Ambulance Chief Executives (AACE) who have all released or are working on their own research into the mental health of staff and volunteers working in the different emergency services. Contact them to find out more:

policemutual.co.uk

Polfed.org

AACE.org.uk



Foreword

In March 2015, Mind launched the Blue Light Programme with the knowledge that 9 out of 10 emergency service staff and volunteers in England had experienced stress, low mood or poor mental health at some point in their career. Our research showed the need for specialist and independent support with mental health in the sector was huge.

As a pilot programme, we closely evaluated our work over the first year and the key findings are now available to share in this report. It shows that thousands of staff and volunteers across our police, search and rescue, fire and ambulance services have actively challenged mental health stigma, learnt more about mental health, and have improved their wellbeing with the support of the Blue Light Programme. We are hugely grateful to those individuals and organisations who have championed mental health as part of a powerful partnership.

But the report also shows that after just one year many people and organisations are only at the start of their journey. There are still high levels of stigma within many organisations and low levels of awareness of the mental health support and information available amongst those who are not closely involved in the programme.

Mind are committed to take 10 actions based on the evaluation findings to refine the support we provide and to raise further awareness of our work – we won't give up until there is support and respect for the mental health of everyone within the emergency services in both England and Wales. We recognise the excellent work already being done by a number of services and organisations, on both a local and national level, but there is still a long way to go.

So we call on emergency service organisations to take 10 actions themselves, based on our evaluation findings, to show their commitment to better mental health and help us to bring about sustained change together. You can find the actions at the end of this report.

One of those actions is to publically show their commitment to improving the mental health of their staff and volunteers – we're asking organisations in England that haven't yet signed the Blue Light Time to Change pledge to now do so in the next twelve months. Go to mind.org.uk/bluelightpledge to get started.

We know that real change takes time but one year on, we have come a long way together – thank you for your continued work in partnership with Mind.



A handwritten signature in dark ink that reads "Paul Farmer". The script is fluid and cursive.

Paul Farmer
Chief Executive, Mind



Introduction

Between March 2015 and March 2016, Mind delivered the first year of an ambitious programme to improve the mental health of emergency services ('blue light') staff and volunteers in England.

The programme was delivered in five strands of activity. For each of these strands, Mind selected an independent evaluation partner to conduct rigorous quantitative and qualitative research to assess the impact of the activity and identify process learning. Each evaluation partner submitted a full report detailing the findings. These reports are available at mind.org.uk/bluelightresources.

This summary report provides an overview of the initial scoping research that informed the planning of the Blue Light Programme, summarises the way each strand of activity was evaluated, and outlines the key findings. It also highlights the overall learning from all five programme strands.

More information about the programme can be found at: mind.org.uk/bluelight

Background

Mind's vision is for everyone with a mental health problem to get both support and respect. We recognise that effectively managing workplace wellbeing is critical to achieving this. Emergency services staff and volunteers operate in one of the most challenging workplace environments but can receive limited mental health support.


The Blue Light Programme was developed in collaboration with blue light staff and volunteers and supported by £4 million Libor funding, administered by the Cabinet Office. This programme focused on five areas in the first year:

- tackling stigma and discrimination
- embedding workplace wellbeing
- increasing resilience
- providing targeted advice and support
- improving pathways to services and support.

Programme strands

Within each strand of the programme, a number of key objectives and outputs were identified:

Strand one: tackling stigma and discrimination

- Run a targeted anti-stigma marketing campaign.
 - Secure 100 public pledges from blue light employers.
 - Facilitate a peer learning network for pledge signatories.
 - Support Champions to promote mental health in their workplace.
- 

Strand two: embedding workplace wellbeing

- Develop a programme of webinars available to all blue light personnel.
- Deliver a programme of face-to-face training for line managers.

Strand three: increasing resilience

- Adapt Mind's resilience approach to provide blue light-specific support.
- Pilot a targeted six-week resilience course.
- Build the evidence base to encourage sustainable commissioning of resilience projects.

Strand four: providing targeted advice and support

- Produce and distribute a wide range of literature through print and digital channels.
- Establish our dedicated Blue Light Infoline service.
- Develop a referral framework for blue light personnel who require more intensive support.

Strand five: improving pathways to services and support

- Train personnel to act as Blue Light Peer Supporters, providing peer support and signposting colleagues to further support.
- Commission local Blue Light Mental Health Networks – sharing learning and increasing coordination between employers and mental health service providers.

Research partners

Mind appointed a range of expert organisations to carry out initial scoping research and evaluate the impact of the Blue Light Programme. They were coordinated by Mind's Research and Evaluation team, who have produced this summary report.

Future Thinking	Strand one
Institute for Employment Studies	Strand two
University of Oxford	Strand three
BMG Research	Strand four
Leeds Beckett University	Strand five

In addition to the evaluation partners, we also worked with a range of research organisations to explore particular issues to inform programme design.

Centre for Mental Health	Clinical support pathways
ESRO	The needs of BME personnel
Fiveways	The information needs of blue light personnel
ResearchAbility	The mental health needs of blue light personnel

Key findings

Several key findings came out of our initial scoping research, carried out to develop the programme before it started, and our impact evaluations, carried out after the programme had been delivered for one year. We've grouped all of these findings together in this section in themes – mental health in the workplace, stigma, sources of support, resilience and information needs. We outline the scoping research and impact findings in more detail later in the report.

Mental health in the workplace

Poor mental health is common within the emergency services, with workload and management pressure a major contributing factor

The need for the Blue Light Programme was clearly shown by Mind's scoping research. This highlighted that blue light personnel are disproportionately affected by mental health problems, and that this is strongly linked to the work they do. Nearly nine in ten blue light staff report having experienced stress and poor

mental health at work, and they are around twice as likely to identify problems at work as the main cause of those mental health problems as the general workforce.

The role of many emergency services personnel involves repeated exposure to trauma. However, workload and management pressure emerge as bigger triggers for poor mental health than exposure to trauma in itself. Many staff report that reduced budgets and more challenging targets are reducing the opportunities for informal support that they have counted on in the past, while increasing the pressures that they are under.



BME staff face specific needs but resist being treated differently

The scoping research highlighted some specific issues faced by particular groups within the blue light community. Black and minority ethnic (BME) personnel are subject to the same pressures and experience similar mental health issues to other blue light staff. However, they also report experiencing specific issues – including pressure to work harder than white colleagues to prove their competence, and the mental health impact of racial discrimination. Stigmatising attitudes to mental health have also been shown to be more prevalent in some BME communities, further discouraging disclosure and help-seeking behaviour.

However, the scoping research found that these personnel were generally anxious not to be marked out as different in any way. BME personnel resisted the option of a targeted intervention and strongly favoured mainstream support.

Members of Search and Rescue are less affected by mental health issues despite potential for isolation

Search and Rescue (SAR) staff and volunteers report better levels of mental health and support than other blue light services. As a volunteer-led service, many of the workplace pressures experienced by the other emergency services do not apply. Indeed, many SAR personnel reported that their volunteer role has a positive impact on their mental health because it provided purpose and community.

However, time pressures and the potential for isolation are both concerns that affect SAR staff disproportionately. There were also concerns that volunteers who are experiencing poor mental health could be more vulnerable because it is easier for them to ‘drop off the radar’ and less wrap-around support is available.

Stigma

Mental health stigma is common within blue light workplaces

The scoping research revealed that, despite disproportionately affecting blue light personnel, mental health problems are stigmatised within the blue light community. Personnel say that discussion of mental health is not encouraged within their organisations, and there is a widely-held suspicion that colleagues would be treated differently by their peers if they disclosed a mental health problem. At the root of this is an often unstated assumption that the people who ‘fix problems’ cannot be seen to have problems themselves. The disproportionate exposure of the emergency services to people experiencing mental health crisis has also shaped understanding of mental health and can make it harder for personnel to acknowledge their own mental health experiences.

There are positive indications about the impact of anti-stigma initiatives but progress is slow

Strand one of the Blue Light Programme aimed to tackle stigma and discrimination through the implementation of the Blue Light Time to Change Pledge and recruiting Champions within emergency services. One year in, initial indications are positive. Employers reported that the anti-stigma activities had met or exceeded their expectations, two-thirds would recommend the programme to other emergency service organisations, and all were complimentary about both the support provided by Mind and the resources available.

Blue Light Champions – as well as their friends and family – also felt positive about the programme and the impact it had had on their own mental health. However, they were less positive about the support provided by their organisation. Despite evidence of this initial success, the process of translating employer commitments to improved experiences for staff is slow. Only a little over a quarter of Champions reported that they had seen positive changes from

their employer. While senior buy-in appeared to be driving some good practice, mistrust of management motives remained widespread.

Sources of support

Low awareness of mental health support

The scoping research revealed that most blue light staff are unaware of the mental health support their organisation offers. Personnel were generally positive about the support that is available immediately following a highly traumatic incident, but reported poor or non-existent support to help with the 'drip drip' effect of role pressures.

The stigma surrounding mental health within the blue light community means that personnel are often reluctant to seek support from Human Resources or their manager. Many seek support from friends or family with the stress, but a significant minority turn to drink, drugs, or isolation in order to cope.

Strand two and strand five of the Blue Light Programme both aimed to improve support pathways within organisations. Strand two focused on the provision of training to embed workplace wellbeing within blue light organisations, including a particular focus on management behaviours. Strand five looked at ways to improve pathways to mental health services, through the introduction of Peer Support Champions in the workplace. Both of these strands had a positive impact in their pilot sites.

There was high demand and positive impact of face-to-face training sessions. However, engagement with webinars was disappointing due to technical and scheduling issues

The results of the strand two evaluation indicated that there was high demand for face-to-face training sessions. The training provided to line managers boosted their understanding of mental health problems, of the prevalence of these problems in the blue light workplace, and

their ability to recognise the signs and symptoms of common mental health conditions. The evaluation also revealed that this improvement in line managers' own assessment of their skills in this area was sustained over subsequent months – although at the time of follow-up, they had not always had the chance to apply what they had learnt.

Engagement with the webinars was disappointing. Participation was hampered both by IT difficulties (including strict security controls) and the challenge in finding space and time to participate. Nevertheless, the sessions were seen as useful refreshers by those who already had existing knowledge.

Peer Support Champions training boosts knowledge, understanding and self-confidence to help others – though there is some evidence that effects tail off

The strand five evaluation assessed the impact of training on Peer Support Champions – including whether the training was relevant to their work situation, the degree to which it empowered them to support their colleagues, and the extent to which it boosted their own wellbeing.

Here, too, results were positive. Participants felt the training met their expectations fully and would recommend the Champion role to other colleagues. They gave positive feedback on the training – they valued it highly for its content, for the trainer's skills, and for the mixture of methods used. In particular, they appreciated the way the trainer incorporated practice-focused problems and scenarios into the sessions, and allowed participants to share perspectives.

The practical focus was seen to be a particular strength of the multi-service training, with its focus on implementation issues and ways of working across organisations – even if some participants were sometimes uncertain how the learning would be implemented in their workplaces.

Critically, the evaluation also revealed significant impacts on the main outcome measures –



training participants showed large increases in peer support knowledge, understanding, and self-confidence between the beginning and the end of the course, and between baseline and follow up. Despite this success, there was some evidence that knowledge, understanding, and confidence to undertake peer support in the workplace reduced slightly between post-training and follow-up.

Resilience

No reliable impact of resilience intervention on key outcomes, despite good feedback from participants

Resilience is the capacity to adapt in the face of challenging circumstances whilst maintaining a stable mental wellbeing. With poor mental health common among emergency services personnel, the capacity for blue light services to build resilience among their staff is a critical part of promoting positive mental health. One strand of the Blue Light Programme was the introduction of a group-based resilience intervention for blue light staff, developed by Mind. The evaluation of strand three sought to establish how effective

the intervention was, to identify the elements of the course that were more and less effective, and to isolate the course's effects from other elements of the programme available to blue light personnel.

The course was evaluated using a randomised controlled trial, where the group-based resilience intervention was compared to a control group receiving online mental health information. Despite positive feedback indicating that the intervention was well-received by participants, the outcomes data was disappointing. Most participants in the group-based intervention showed no reliable change on any of the outcome measures – resilience, wellbeing, self-efficacy, social participation, or the ability to problem-solve. The group-based course emerged as no more effective in boosting these outcomes than reading online mental health topics. Neither intervention (course or online information) showed a reliable change from the beginning to the end of the course or three month follow-up. This was particularly surprising because a similar course has been shown to have positive effects with other groups. In addition to evaluating the overall effectiveness of the intervention, the research partner sought

to identify predictors of poor mental health and resilience (e.g. rumination). It is apparent that those participants who were more vulnerable at the outset – those with significantly lower resilience, wellbeing, self-efficacy, and problem solving scores – were more likely to improve following the intervention than those who started with better mental health. Those participants who had been initially excluded from the study because they were above clinical cut-off on measures of post-traumatic stress disorder (PTSD), anxiety, or depression were also more likely to make significant improvements on the outcome measures.

While the results of the resilience pilot were disappointing, they are consistent with results of other evaluations of interventions aimed at improving emergency workers' mental wellbeing – for instance, trauma risk management and critical incident stress debriefing. It is possible that these interventions are not proving successful because they are not sufficiently targeting predictors of resilience or poor mental health. Further research is now underway to review interventions that have already been proven to be successful with other groups and redevelop Mind's approach to delivering resilience courses.

Information needs

There is high demand for more mental health information

The initial scoping research revealed high demand among blue light staff for more information about mental health – particularly on how to support a colleague with mental health problems. This information was particularly popular amongst ambulance service personnel.

Strand four aimed to address this demand by providing targeted advice and support. This included the wide dissemination of the written information – over 300,000 booklets. The evaluation of this strand looked into how effective the information was, how it might be further developed or improved, and why people might not engage with it.

Positive feedback on Infoline but low awareness due to poor workplace visibility

Despite a high awareness of mental health problems in the workplace, less than a third of personnel were aware of the Blue Light Infoline by the end of the programme. Most of those who were aware did not know how to contact it. Personnel did not feel that the service was sufficiently advertised in their workplace, and suggested a number of strategies that could help to boost awareness (including information from line managers and Mind representatives or Champions visiting their workplace).

Those who were aware of the Infoline tended to view it positively, and most commonly described it as confidential, supportive, and helpful. Those who were unaware of the Infoline were keen to hear more information about it. Most commonly, they wanted reassurance about the confidential nature of the Infoline. More than two-thirds said they would be likely to use it in future for information and advice – those who said they would not tended to feel they had adequate support options elsewhere.

A qualitative element of this evaluation involved testing Mind information booklets with blue light staff. These appeared to be unfamiliar to most of those who participated in the research, although they were positively received, with positive feedback on their content – the information, links to other support resources and guidance for friends and family that they provided. The style was also well received, with their concision, simple, non-patronising language, and use of images appreciated.

Mind's information videos were also praised, as they prompted further discussion on mental health issues, and encouraged help-seeking behaviour. The presence of personnel in the video from different services was appreciated. There were calls for the videos to include further information, particularly more specific information on ways to access additional support.

Key learning

This research shows that the Blue Light Programme is a high-quality initiative that had a markedly positive effect on most of those it reached. However, it also illustrates the challenge in achieving large-scale cultural and behavioural change over a short period of time.

1. In tackling stigma, it is clear that an initiative such as the Blue Light Time to Change Pledge can have significant benefits for the relatively small number of individuals who are closely exposed to it – the pledge leads and Champions. These individuals generally found the initiative valuable, would recommend it to others and think it has benefited their own mental health. However, the evidence suggests that effecting cultural change on a larger scale may be a longer process.

Efforts to raise the profile of mental health will need to be sustained, and supported by organisational investment as well as visible endorsement by senior management, if scepticism is to be overcome and attitudes are to be shifted across the blue light workforce as a whole.

2. The results of this evaluation suggest that the face-to-face training sessions and the appointment of Peer Support Champions can help to boost confidence and knowledge among staff, help them to manage their own mental health better, and help line managers to recognise and address evidence of mental health conditions among their staff – although opportunities will need to be provided to ensure that staff get to use the new skills they acquire soon after the training to avoid the positive effects dissipating.

3. Webinars appear a less successful tool, though the primary obstacles to success revealed here – problems with IT access and scheduling – may not be insurmountable with further refinement. Webinars were well-received by the small number who used them, even if there was an over-representation of those who were already well-informed about mental health.

The Blue Light Infoline initiative, similarly, attracted positive feedback among those who had used it, but its impact was hampered by low awareness – challenging to build in a short period of time. If the Infoline initiative is to be taken forward, and if it is to establish itself as a popular support route for blue light employees experiencing mental health difficulties, a high-profile and sustained messaging campaign will need to be put in place that emphasises the supportive, and above all confidential, nature of the service.

4. The group-based resilience intervention attracted positive feedback from participants but it had limited success in achieving its aim of boosting the resilience, wellbeing, self-efficacy, and social participation of employees.

Mind is developing a more targeted intervention that takes greater account of the way emergency service workers experience resilience (or the absence of it) in the face of stress and more specifically targets predictors of poor mental health and resilience.

Methodology

This section provides an overview of the approach to evaluation taken by each partner. Full methodological details are available within each partner report, while research objectives are detailed within the summary of each strand.

Strand one: tackling stigma and discrimination

Partner: Future Thinking

The focus of strand one was to tackle stigma and discrimination using a multi-pronged approach and multiple channels. The table below details each of the target audiences surveyed, and the approach taken in each case. N stands for the number of participants.

Figure one: target audiences for strand one evaluation

	Baseline (beginning)	End of phase	Qualitative research
Pledge leads – leads within the organisations who have signed the Blue Light Time to Change Pledge and are responsible for developing action plans	Introductory calls (n=9) and online pre-survey (n=4)	Reminder telephone calls (n=12) and online post-survey (n=12)	
Pledge associations – blue light associations who are supporting the work of Mind or those who have signed the pledge		Online survey (n=5)	
Employees – staff working within those organisations that have signed the Blue Light Time to Change Organisational Pledge	Online pre-survey (n=195)	Online post-survey (n=111)	Telephone depth interviews (n=30)
Champions – individuals within the emergency services who are championing the Blue Light Programme	Online pre-survey (n=122)	Online post-survey (n=76)	Telephone depth interviews (n=20)
Family and friends – friends and family of Champions to examine the wider impact of the Blue Light Programme		Online post-survey (n=21)	

Strand two: embedding workplace wellbeing

Partner: Institute for Employment Studies

A mixed-methods approach to the evaluation was adopted, which focused on training participants and comprised a range of paper and web-based surveys, in-depth qualitative interviews, and case studies. The aim was to represent views and experiences in relation to the webinar and the face-to-face training across all blue light services.

The evaluation comprised of the following stages:

1. Evidence review – a rapid review of relevant literature was undertaken prior to primary data collection, both within and beyond mental health, focusing mainly on UK literature and including a review of previous Mind training programmes.

2. Quantitative research – a range of surveys of training participants were developed to evaluate the different types of training and, through a mix of baseline, post-training and pulse (short) surveys, to explore immediate as well as long-lasting outcomes. Surveys relating to the webinar-based training were administered online, while those relating to the face-to-face training for blue light managers were administered face-to-face on the training days themselves (followed up online). The table below shows response rates for each element of the survey research.

Twenty-two face to face and telephone interviews were also conducted with blue light employees who had viewed (or registered for) webinars and with line managers who had received face-to-face training. These were supplemented with seven case studies, to provide further context, which were focused on training participants and those in key roles within selected employers.

Figure two: strand two survey response rates

	Responses	Response rate as % of original baseline sample
Webinar baseline	285	N/A
Post-webinar (total across all three versions)	18	6.3
Webinar three month pulse	27	9.4
Webinar six month pulse	45	15.7
Face-to-face training baseline	1,631	N/A
Post face-to-face training	1,597	97.6
Training three month pulse	261	16.0

Strand three: increasing resilience

Partner: University of Oxford

The evaluation of strand three used a randomised controlled trial and qualitative interviews. Participants (n=430) were randomly allocated in a 3:1 ratio to receive Mind's face-to-face resilience course (n=317) or a control course delivered online (n=113).

Participants were asked to complete a number of questions via a secure digital programme at three distinct time points: baseline (pre-intervention), post-intervention, and at a three-month follow up. A random sample of 24 participants (12 resilience intervention participants, 4 control intervention participants and 8 course facilitators) were invited for in-depth qualitative interviews throughout the delivery of the intervention.

Strand four: providing targeted advice and support

Partner: BMG Research

The evaluation of strand four involved a mixed method approach comprising quantitative and qualitative research. Initially, the research intended to explore the views of users and non-users of the Blue Light Infoline. However, due to low uptake of the Blue Light Infoline, the research was conducted with non-users of the Blue Light Infoline only.

The quantitative element of research involved an online survey of 463 participants living in England who had not used the Blue Light Infoline. The research was conducted from December 2015 to February 2016. Participants who took part in the quantitative research included emergency service personnel from the ambulance service, fire service, police service and search and rescue service.

The qualitative research involved 27 in-depth interviews and 5 online focus groups that were conducted in February 2016. Participants included a range of emergency service personnel including paramedics, fire-fighters, emergency call handlers and emergency centre operations staff.



West Midlands Police

Strand five: improving pathways to services and support

Partner: Leeds Beckett University

The evaluation of strand five sought to understand the Peer Support Champions' experience of the training. It involved mixed quantitative and qualitative approaches:

- A before and after questionnaire survey was sent (on three occasions, including three to eight week follow-up) to all participants.
- Semi-structured interviews were held during project visits with 13 participants.
- A notebook record of participants' experiences and reflections following direct contacts with people wanting support was completed by eight participants.

In addition, two training sessions were observed by members of the evaluation team.

Initial scoping research

December 2014 to January 2015

Background

To inform the planning and development of the Blue Light Programme, Mind commissioned a programme of scoping research (conducted between December 2014 and January 2015). This included:

- an online survey of 3,627 emergency services personnel (approx. 1.5% of workforce)
- four focus groups with personnel from across the blue light services
- focus groups with representatives of the Search and Rescue service
- in-depth interviews with emergency services personnel from a BME background
- document reviews and stakeholder interviews to scope the availability of clinical support pathways
- stakeholder interviews to scope the information needs of blue light services.

This sections provides more detail on the findings from all components of this scoping work. Full methodological details are provided in the full reports.

Mental health at work

Blue light personnel were disproportionately affected by mental health problems

- Emergency services personnel experienced more mental health problems than the general workforce but they were less likely to take time off work as a result.
- Emergency services personnel were twice as likely to identify problems at work as the main cause of their mental health problems – compared to the general workforce population.
- 87.6% of personnel said they had experienced stress and poor mental health whilst working for blue light services.

Workload and management pressure were bigger triggers than exposure to trauma

- Emergency services personnel worked hard to prevent their mental health problems affecting their performance, but this came at a large personal cost (including relationship breakdown and effects on physical health).
- Excessive workload (56%), pressure from management (55%), organisational upheaval (52%), and long hours (45%) were all considered bigger triggers of poor mental health than exposure to traumatic incidents (42%).
- Front line staff were concerned about the mounting pressure experienced by front line staff in the form of reducing budgets and more challenging targets. This underpins the experiences of blue light personnel at work – elevating the risk factors for poor mental health while simultaneously reducing the opportunities for informal support amongst peer colleagues.





Stigma

Stigma was common across emergency services

- 71% of emergency services personnel thought that their organisation did not encourage them to talk about mental health – this was much more negative than the general workforce population (45%).
- There was limited understanding of poor mental health and little open discussion in the workplace, which contributes to the stigma associated with it.
- Emergency services were disproportionately exposed to people in mental health crisis and this shaped their understanding of mental health problems.
- 44% thought their colleagues would be treated differently (in a negative way) if they disclosed a mental health problem at work. This answer was the same if respondents had personal experience of mental health problems or not.
- 79% thought colleagues would be more comfortable talking about physical health than mental health.
- Stigma surrounding mental ill health was widely reported across the blue light services by focus group participants, arguably in part because of a perception that being the ones who 'fix it' means they can't be seen to have vulnerabilities themselves. Search and Rescue personnel were described as an exception to this.

Sources of support

Blue light staff were generally unaware of mental health support at work, or thought it was poor

- The majority of emergency services personnel (53.3%) were not aware of the mental health support their organisation offers.
- Of those who were aware, 48% thought the quality of this support was poor or very poor.
- Support around a critical or traumatic incident was described as strong, but it was perceived that there was little provision for the 'drip drip' effect of role pressures – both on the frontline but also in control rooms.

Widespread aversion to seeking support from HR or manager

- Personnel were reliant on friends and family for support – there was a big aversion to seeking support from HR, managers, and occupational health.
- 79% of respondents said they would 'never' seek help from HR if they experienced a mental health problem. Only 15% said that they would feel happy talking to their manager about their mental health.
- Respondents were just as likely to seek help from a colleague as from a GP.
- Ambulance personnel were much more likely to seek support from their colleagues than police respondents.

Isolation, drink, and drugs featured among coping strategies

- Emergency services personnel used a mix of coping strategies – talking to friends and family was the most common (64%). However, isolation (58%) and drink/illegal drugs (28%) were worryingly popular.

Information needs

Widespread demand for more information – particularly on how to support colleagues

- There was high demand for more information about mental health. Between 70% and 80% of respondents rated a range of information topics as 'useful' or 'very useful'.
- The most popular information topic was how to support a colleague who is experiencing mental health problems – ambulance personnel were least confident to provide support to colleagues.
- 74% of Champions had personal experience of mental health problems.
- Focused line management training on mental wellbeing was very popular. Little provision was currently in place to support wellbeing and resilience training.



Experience of Search and Rescue (SAR) personnel

Search and Rescue personnel less affected than other emergency services

- Search and Rescue personnel reported much better levels of mental health and mental health support than the other blue light services. Some respondents said that their voluntary role improved their mental health because it provided purpose, comradeship and community.

Search and Rescue felt they face different issues from other blue light personnel

- SAR personnel saw themselves as distinct from other blue light services. In addition, individual SAR organisations had unique features differentiating them from each other (e.g. mountain rescue compared to RNLI). Although some issues discussed resonated with other blue light services, participants felt that the Blue Light Programme should reflect this (perception of) difference.
- The fact that SAR is a volunteer-led service may also mean there was less leverage to monitor and safeguard staff.

Shortage of time, and potential for isolation, were concerns

- SAR personnel have multiple demands on their time. In order for the Blue Light Programme to be effective, delivery needed to take account of time pressures. For example, daytime services would not be suitable for a SAR volunteer who was working in another full-time role.
- Whilst participants described strong peer support networks, it was also recognised that someone in distress could just drop out of the service with no follow up.
- Two needs in particular were identified:
 - awareness of the signs and symptoms of mental health problems to enable personnel to recognise any issues amongst colleagues
 - information on how to access support without the organisational support of a large blue light employer.

Experience of BME personnel

BME personnel may have additional mental health needs – but were anxious that they were not singled out

- Many personnel from a BME background do not have a strong ethnic, cultural, or religious identity and, in some cases, deliberately attempted to distance themselves from the label 'BME'. In all cases, the discourse of ethnicity and 'difference' (including terms like Black, Asian, BME, Mixed and minority) had negatively been associated with these personnel during their careers. Most were fed up of being perceived as different and avoided engaging in any behaviour that would further emphasise their differences. Most had adapted their behaviour to 'fit in', within a predominantly white organisation.
- Even though the research revealed that BME personnel may have additional mental health needs and increased barriers to accessing support services, none of the personnel had any desire to be singled out, or for these differences to be highlighted.

Discrimination, community or family pressures, and religious and cultural factors can all impact on BME personnel

- The most important factors in the mental health of BME personnel were largely similar to their white colleagues: heavy workload, management pressure, exposure to trauma, and personal problems (particularly relationship breakdown).
- However, BME personnel could also experience additional pressures, including:
 - perceived barriers to progression in the blue light services, caused by intentional or unintentional discrimination, which could affect the mental state of individuals, and cause them to take on extra work to prove themselves
 - perceived and actual racism and discrimination, which could have a cumulative or direct impact on mental health issues
 - community and family pressures that could cause individuals to take on greater

workloads to meet these expectations

- religious or cultural factors, such as fasting, which could make long shifts more arduous.

Some perceived increased mental health stigma in BME communities

- Some personnel believed that there was increased mental health stigma in BME communities, including reduced understanding and an increased propensity to hide mental illness and not access support.
- However, in general, the BME personnel had a good understanding of mental health issues, and many felt that their own families would have similar levels of understanding and stigma, compared to the general UK population.
- However, even unconscious or slight pressures from the community have meant BME personnel would be less likely to access support and speak out about mental illness than their white colleagues.

Blue light support services rarely accessed by BME personnel, partly due to reluctance to draw attention to their differences

- Current blue light support services were rarely accessed by BME personnel. Most personnel feared being perceived as different, and were unwilling to access internal services that could draw attention to their differences. Many were sceptical about the confidentiality of employer-provided mental health services. In some cases personnel were required to be referred by a manager or the HR department, but were unwilling to speak to these individuals about their issues for fear of stigma.
- Personnel felt internal, and particularly peer-led, services lacked expertise. Most felt managers needed more training, both in terms of understanding and recognising mental health problems, and responding empathetically to these issues. Some personnel were involved with BME associations, but never in relation to mental health issues. Other personnel were unwilling to be associated with an organisation which emphasised their differences.

Strand one: tackling stigma and discrimination

Objectives

The evaluation of strand one aimed to measure the following programme outcomes:

- increased awareness and understanding of mental health problems
- fewer people experiencing mental health stigma or discrimination in the workplace
- increased confidence to communicate with colleagues, friends or family about mental health
- Champions within blue light services feeling more empowered and confident to share their lived experience
- employees feeling that their mental health is supported by their organisation
- members of the Peer Learning Network finding it useful for sharing best practice.

Employers evaluation

A good start – but still some way to go to embed change

The findings demonstrate that the Blue Light Programme has gotten off to a great start, but while the seeds of change have been planted, there is still a long way to go. This is not really surprising given that the evaluation was conducted just one year on from the launch.

Pledge leads' expectations exceeded, and most report positive impact on organisation

All pledge leads said that the programme had either met or exceeded their expectations and 66% would recommend it to other emergency service organisations, giving an impressive Net Promoter Score (the number of people who would recommend the service minus the number who wouldn't) of +42%. Moreover, 91% reported that the Blue Light Programme has had a positive impact on the organisation and 25% say that the mental health of the workforce is now better than this time last year.

But many employees are still reluctant to speak out about mental health

While pledge leads are very positive about the programme and report positive organisational change, the findings also indicate that it will take time for this to filter through to employees and for the long-established cultural ethos to change. Just 27% of employees agree that there has been a positive impact on the organisation and the findings suggest that employees are still hesitant to speak out about mental health.

I think it's just something that they can say they've done. Something they can say to politicians and that they can present on the outside world... I believe it had senior buy-in but I'm not sure who it was from. I guess they just laid their name to it?

Employee: Police service, Sergeant



Evidence of ongoing mistrust of management motives, but senior buy-in is driving some good practice

In some instances, as highlighted in the qualitative depth interviews, there is deep rooted mistrust of management and cynicism about the organisation using the Blue Light Programme as a PR stunt. Personnel also felt that stigma and taboos relating to mental health would take time to break down. However, there are pockets of good practice where positive change has already been evidenced. Successes are attributed to buy-in at a senior level, going hand-in-hand with the powerful influence of peers undertaking the Blue Light Champion role.

It's better definitely, I think staff are more able to speak out so although statistically it may be higher I do firmly believe it's because people feel a bit more comfortable coming forward Employee: Fire service, HR

Pledge leads positive about support provided by Mind

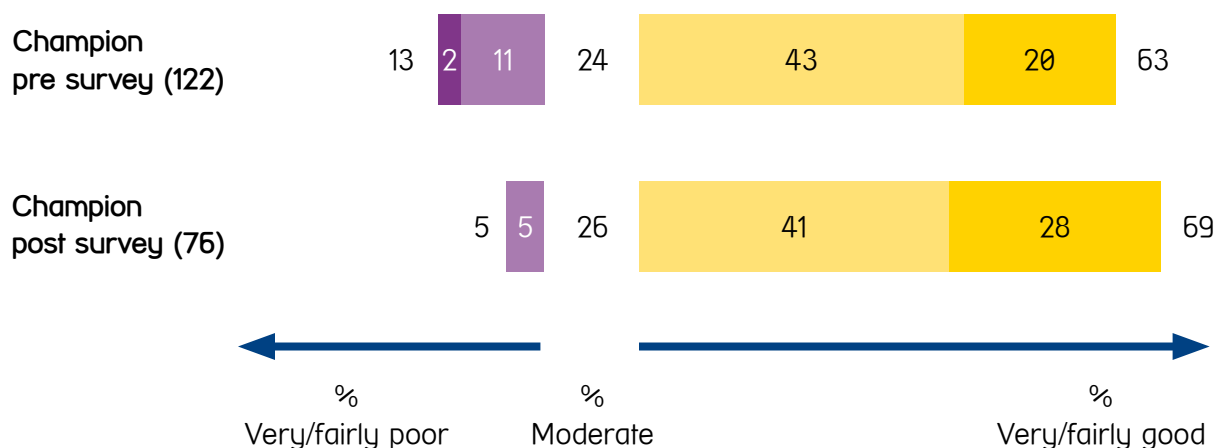
Pledge leads were extremely positive about the support provided by Mind. Three-quarters rated the support provided by Mind prior to signing the pledge as good. Similarly, in their post-survey, all rated the support provided by Mind throughout the longevity of the Blue Light Programme as good. Pledge leads were also very complimentary about the resources provided by Mind, with the Blue Light Information booklets and resilience courses were especially well liked.

Champions evaluation

Major boost to Champions' self-efficacy and confidence apparent

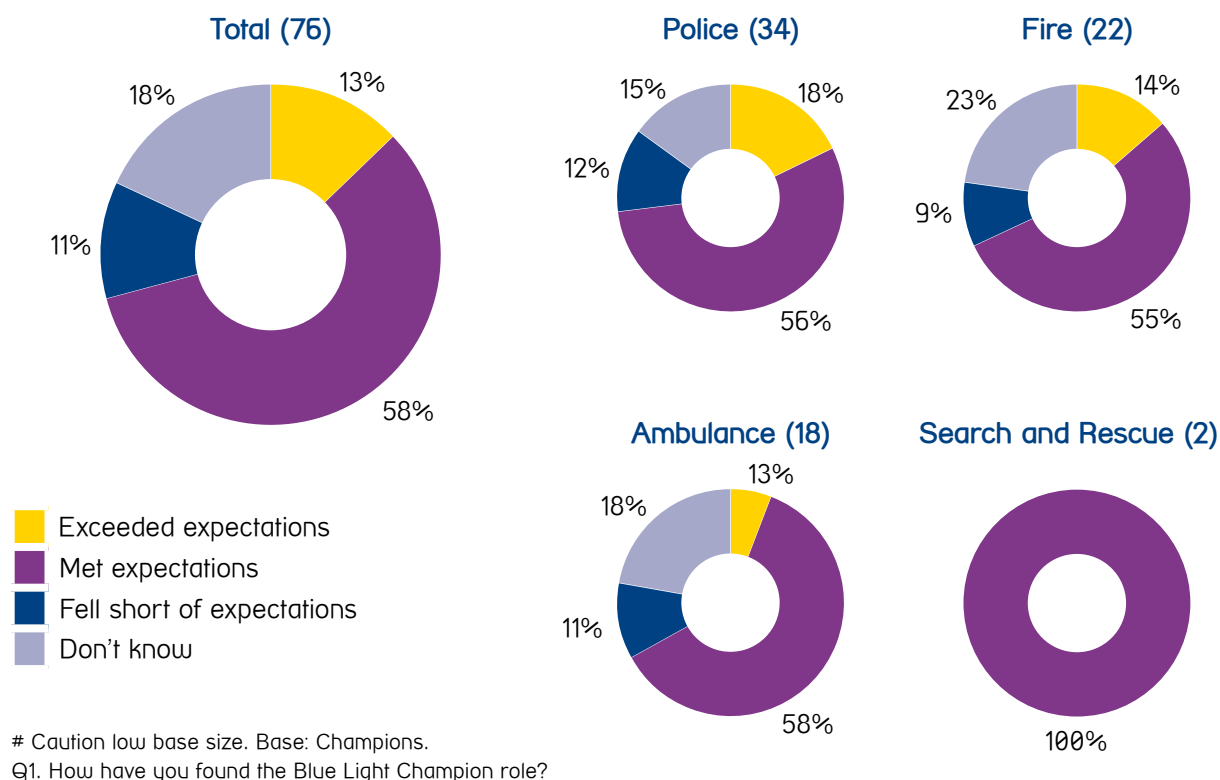
The research clearly highlights the extremely positive impact that the Blue Light Programme has had on the Blue Light Champions themselves. These include improvements to self-efficacy (with a score of 31.04 recorded in the baseline survey versus 32.40 post-survey)

Figure three: mental health of Champions (pre- and post- surveys)



Base: Champions
Q8/Q14. How would you describe your current mental health overall?

Figure four: Champions' experience of their role



and increased confidence scores for both empowerment and social capital (overall scores of 55% and 47% respectively).

Evidence of improved mental health

There was also a decline in reported mental health problems (from 13% saying that they had poor to moderate mental health in the pre-survey to just 5% in the post-survey) and evidenced improvements regarding seeking support for mental health issues from more formal sources (e.g. +12% boost for seeking help from a GP).

Champions' friends and family confirm positive impact of programme

Moreover, friends and family have also noticed the positive impact that the Blue Light Programme has had on their loved one, with 57% reporting that it has had a positive impact on them. This is supported by the finding that 71% of Champions said that their blue light role had either met or exceeded their expectations and over half would

recommend the champion role to someone else working in the emergency services, giving an impressive Net Promoter Score of +44%.

Champions are positive about support received from Mind but more critical about backing from their organisation

Similar to the pledge leads, Champions were very positive about the support they received from Mind, with 87% of Champions rating the support provided as good. However, Champions are decidedly less positive about the support provided by their organisation, with just 51% rating it as good.

More vocal support from senior management required

The findings suggest that better communications and more vocal support in the Blue Light Champion role from management is required – in particular, senior management speaking out about their own mental health. This would be greatly appreciated by Champions and go some way

towards breaking down the 'us and them' division between staff and management. The success of the Blue Light Champion role and peer networks should be built upon and extended.

Breaking down taboos and achieving cultural change is a key objective

Looking towards the future, there is a strong desire among pledge leads, Champions, and employees to continue their work. They all recognise that it will take a long time to achieve sustainable change to organisational culture and ethos to protect the mental wellbeing of emergency service staff. However, all groups felt that the Blue Light Programme had made a strong start.

Please keep the Blue Light Programme going. It's our emergency service.

Blue Light Champion

Outcomes

In terms of the desired programme outcomes, there has been mixed success, with actions and activities taking time to filter through to staff:

- **Increased awareness and understanding of mental health problems**
 - Positively, 92% of pledge leads say that there has been increased awareness about mental health among personnel as a result of the Blue Light Programme. However, just 31% of employees agree with this.
- **Fewer people experiencing mental health stigma or discrimination in the workplace**
 - While 45% of employees think that mental health-related stigma and discrimination has decreased in the past year, 45% say that there has been no change and 2% report an increase.
- **Increased confidence to communicate about mental health**
 - Positively, 51% of Champions in their post-survey agree that the 'organisation encourages staff to talk openly about mental health' versus just 43% in the baseline survey, demonstrating a positive shift of +18%. However, just 46% of employees agreed with this.
- Similarly, 34% of Champions in their post-survey agree that 'people feel able to talk with colleagues about mental health at my organisation' while 21% say that 'people feel able to talk with managers'. The pre-survey figures were 14% and 9% respectively (rises of +20% and +12%). However, employees are notably less positive, with just 15% agreeing that they feel able to talk to colleagues and 10% with managers.
- **Champions feeling more empowered and confident to share their experience**
 - As reported above, the Blue Light Champion role has had a very positive impact, most notably by increasing confidence and empowerment. Indeed, in their post-survey, 14% spontaneously commented in an open-ended question on their increased confidence as a consequence of taking part in the Blue Light Programme and the measured overall empowerment score one year on was 66% feeling a lot or a little more confident.
- **Employees feeling that their mental health is supported by their organisation**
 - Over a third (36%) of employees agree that the 'organisation supports employees who experience mental health problems'. The figure rises to 48% among Champions and 83% among pledge leads, again highlighting that it will take time to filter through to the overall workforce at large.
- **Members of the Peer Learning Network find it useful for sharing best practice**
 - Just two pledge leads interviewed had participated in the Peer Learning Network. Albeit based on a low base size, both rated it as good.

Strand two: embedding workplace wellbeing

Objectives

The evaluation of strand two aimed to measure the following programme outcomes:

- Personnel are more aware and responsive to their own and colleague's mental health issues.
- Personnel are more resilient and better able to manage their own mental health.
- Employers are better equipped to support the mental health of their staff.

The Institute for Employment Studies' evaluation for strand two was designed to assess the impact of the workplace wellbeing initiatives of the Blue Light Programme – particularly webinars and face-to-face training. The research not only aimed to establish whether this strand was well received, but also to understand its lasting impact on blue light personnel and culture.

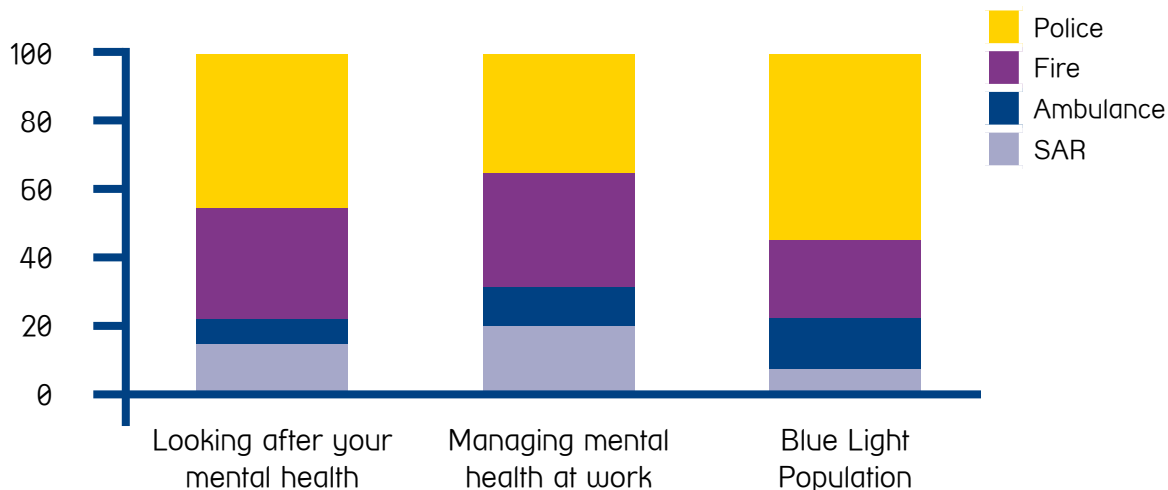
Reach of the training

High demand for face-to-face training

Demand for face-to-face training exceeded Mind's expectations and bookings reached capacity. The training was delivered to over 5,000 line managers. The training was offered for free and this was popular with employers who had often made large cuts to their training budgets in the face of significant financial pressure. However, many employers reported that they would be willing to pay for the training.



Figure five: breakdown of webinar viewers by service¹ (% sample) compared with blue light population



Disappointing engagement with webinars

In contrast, viewing numbers for the webinars were disappointing. The webinars received 482 views by March 2016. These were predominantly from blue light professionals (the figure includes other interested individuals such as retired blue light professionals, trainers, Mind employees and researchers).

IT difficulties and nature of blue light roles key factors in low webinar take-up

Webinar views were hindered by IT-related difficulties – such as not having access to the right software (in many organisations unauthorised downloading of software is prohibited) or hardware (the webinars worked best on PCs and laptops which were not available to all potential users). The hectic nature of many blue light roles proved to be a barrier. Many struggled to find the time and space to watch a webinar due to a combination of being on the move (i.e. to respond to emergency calls) and/ or high work demands.

Over-representation of Fire and SAR services among webinar viewers

Figure five above shows how webinar views differed across services. It can be seen that the

spread across services is not exactly reflective of the background population of blue light workers.¹ The Fire and Search and Rescue services are over-represented, while the Police and Ambulance services are under-represented. It is not possible to determine whether this mismatch results from poorer awareness of the webinars in under-represented services, less interest in them, lack of time to watch them, or access issues.

Awareness and understanding of mental health problems

Line manager training boosted understanding of mental health problems and attitudinal changes

According to the survey findings, self-reported understanding of mental health problems increased as a consequence of the face-to-face line manager training. There was also evidence of important attitudinal changes, as the table on the next page illustrates. Significant increases were seen in participants' assessment of their ability to recognise signs and symptoms of common mental health conditions. The high response rate for these surveys means that the findings can be interpreted with confidence.

1. Percentages working in Police, Fire, Ambulance and Search and Rescue estimated as 60 per cent, 21 per cent, 16 per cent, and 5 respectively.

Figure six: impact of training on awareness and attitudes

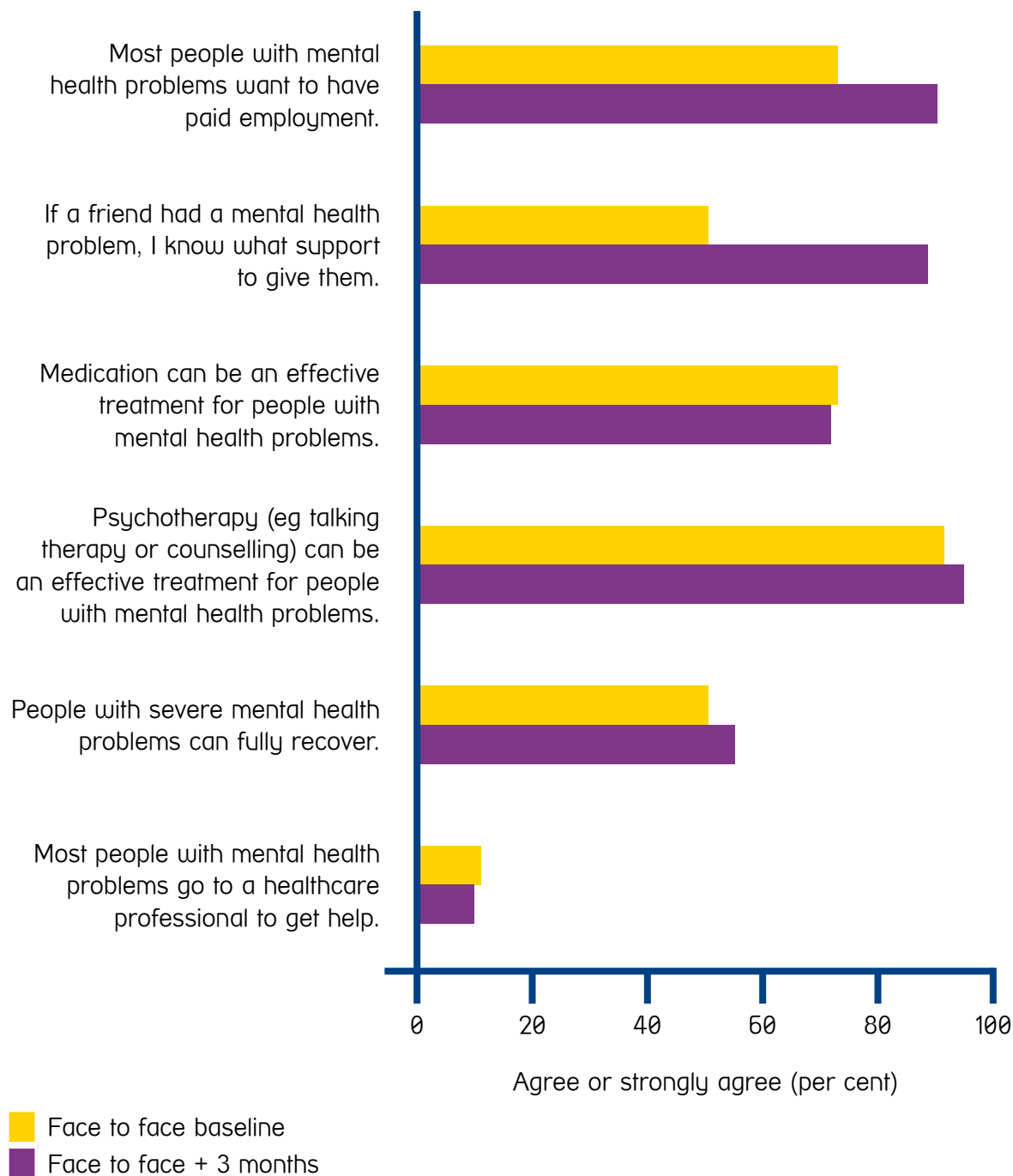
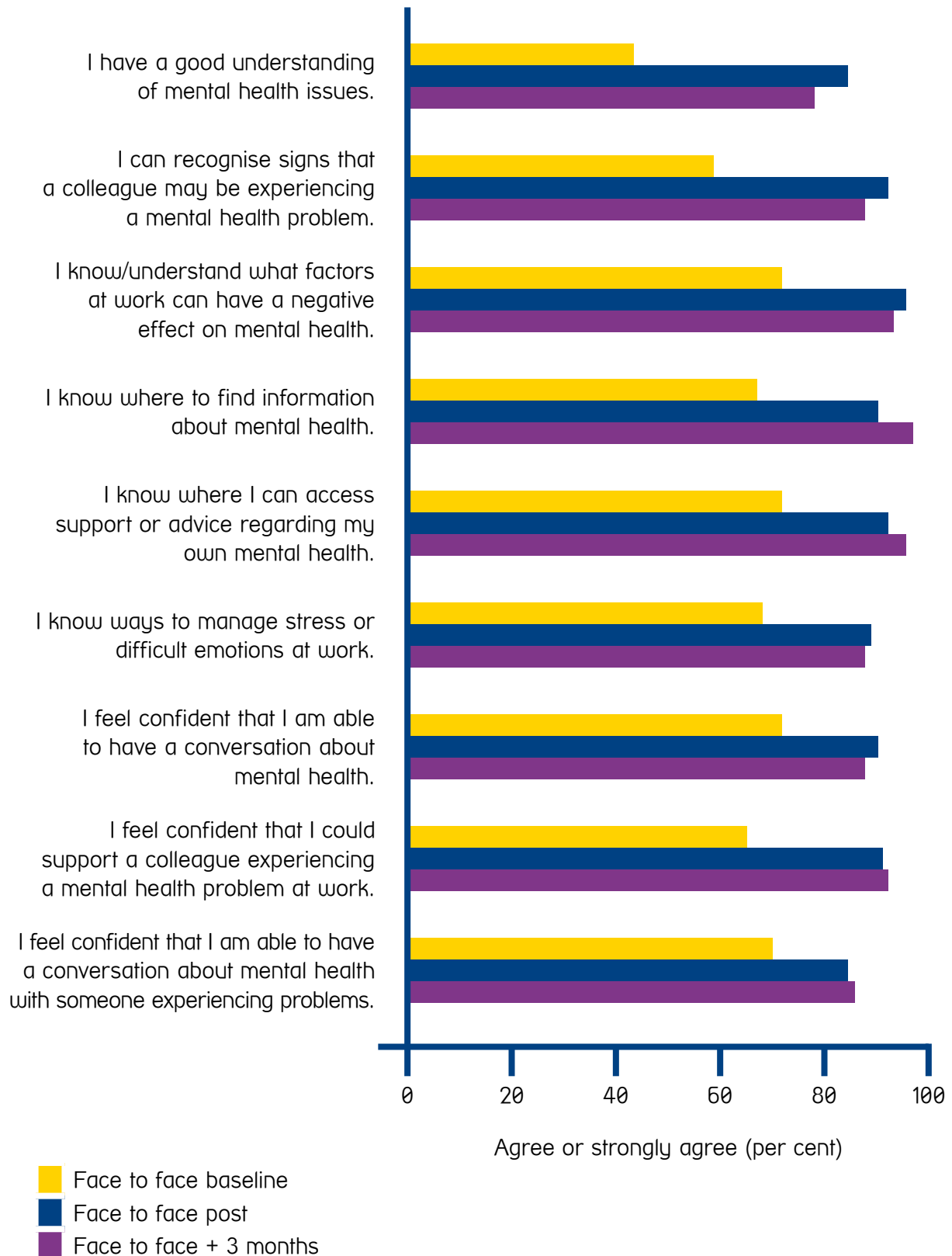


Figure seven: impact of training on understanding and dealing with mental health issues at work



Managers gained – and retained – new appreciation of extent and drivers of mental health problems in their profession

Managers came away from the training with a new appreciation of the prevalence of mental health problems in their profession and an understanding of the elements of their own service's work that put people's mental health at risk. Follow-up survey findings indicate this learning was sustained over subsequent months.

Some indications that inclusion of blue light professionals' own stories in webinars helped to bring issues to life

The low number of responses to the webinar surveys limits the conclusions that can be drawn about their impact. However, among those who participated in the evaluation interviews, the inclusion of blue light professionals' own stories in the webinar was felt to bring issues to life and underline the importance to take action to support affected workers. There was a strong feeling that the material presented in the webinars would be beneficial to colleagues who had not seen them, particularly those with relatively low levels of awareness of mental health issues.

Confidence to manage own mental health

Face-to-face training drove improved confidence to manage own mental health

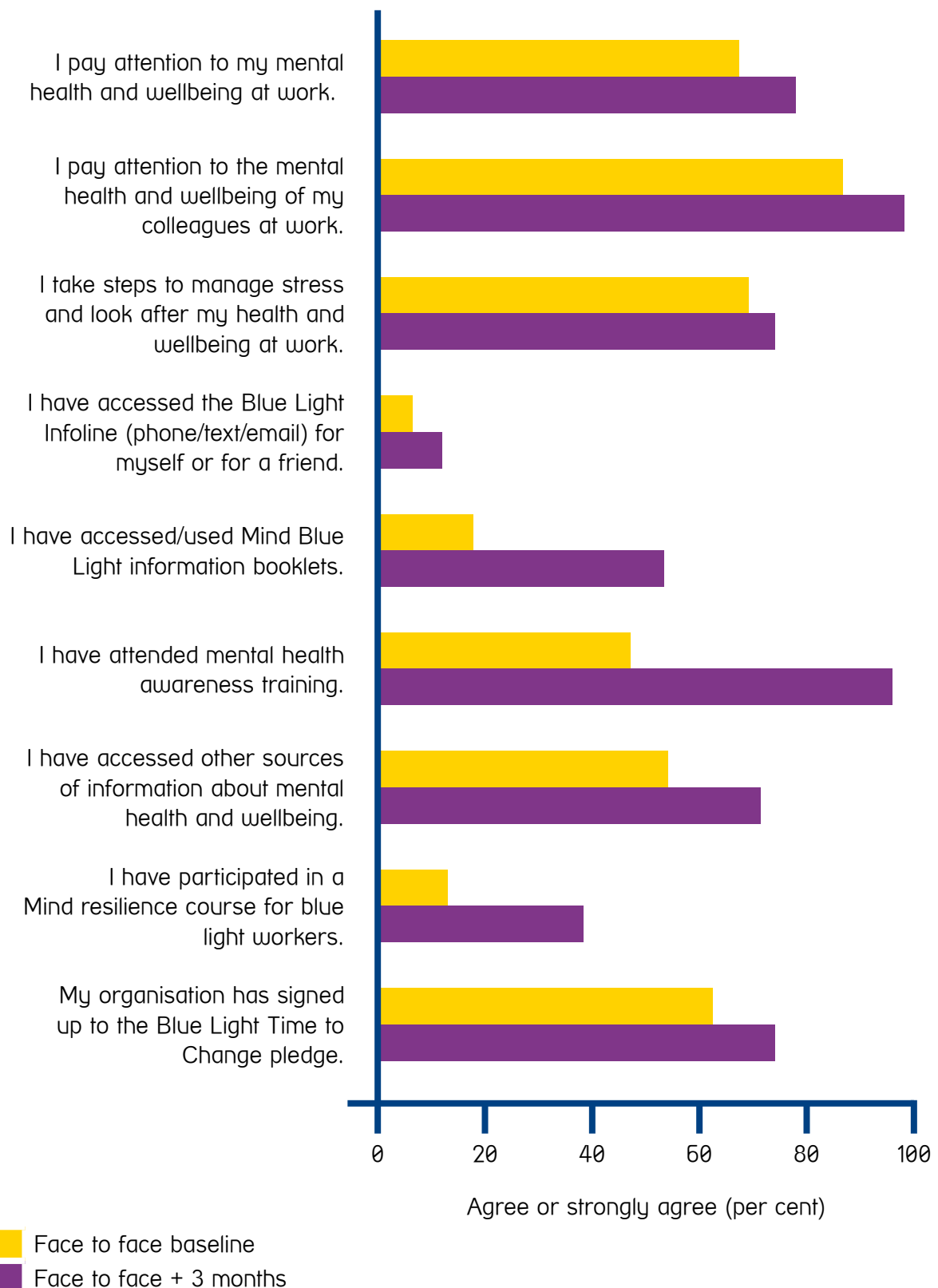
Self-reported confidence to manage one's own mental health was found to increase among those who attended the face-to-face training. Participants in the qualitative research felt they had gained a new awareness of the importance of taking breaks from work, taking steps to manage their workload more effectively, and of seeking support where necessary. The training sessions were successful in encouraging participation from trainees who had experienced mental health issues themselves. They felt comfortable to disclose what had helped them recover and stay well.

Evidence that webinars had positive influence – but impact across blue light services hampered by low viewing numbers

There was weaker evidence that the webinars had made a difference but trends in the data suggested they had a positive influence. The videos presented high quality, relevant content but their potential impact across the blue light services is likely to have been limited as a result of low viewing numbers.



Figure eight: impact of training on work behaviours





Using the training

Face-to-face line manager training seen as useful and relevant – but many have not yet had the opportunity to apply it

There was strong evidence that the face-to-face training for line managers was useful and relevant. Immediately after the training, 95 per cent reported that they had found it useful. Three months after the training, 90 per cent still held this view. Due to the short-nature of the Blue Light Programme and delays to the start of training delivery, the follow-up period was short so participants in the qualitative work had not always had the opportunity to apply what they had learnt.

Some evidence that managers began initiating discussions about mental health and spotting warning signs of mental health problems among their staff

Despite the limited time for follow-up, examples were provided of managers initiating open

discussions about mental health within teams for the first time. There were also reported instances where managers felt that they had been able to spot warning signs in staff that they might otherwise have missed and who had acted on these concerns to support them. Other tangible impacts included more active monitoring of one's own mental health and that of others. Over time this would be expected to result in positive health effects.

Webinars useful as 'refreshers' for those with existing knowledge

There was some evidence that the webinars were useful as 'refreshers' for those with pre-existing knowledge. Many personnel who watched the webinars appeared to have relatively advanced knowledge about the management of mental health issues. For this population the webinars appeared to be successful in reinforcing other messages, and as a good reference source complementary to other Blue Light Programme support.

Strand three: increasing resilience

Objectives

The evaluation set out to determine the effectiveness of Mind's group-based resilience course. A randomised controlled trial was conducted in which participants were randomly allocated on a 3:1 ratio to receive the face-to-face resilience group course or the online information only control option. The hypothesis was that the face-to-face resilience course would demonstrate sensitive and specific effects – that is, that the face-to-face resilience intervention would lead to greater improvements in resilience, wellbeing, coping and social capital compared to the online information only control group.

More specifically, objectives of the strand three evaluation were to:

- establish the effectiveness of Mind's resilience intervention
- isolate the intervention-specific effects from Mind's broader work available to emergency service personnel

- link changes in key outcomes to specific course material to identify the most effective parts of the intervention for further development
- identify predictors of success to further develop the intervention for future delivery and to inform future training
- inform the development of evaluation tools for continued use by local Minds.

Establishing the effectiveness of Mind's resilience intervention

No specific effects on resilience of the group-based resilience intervention – although some showed improvements

There were no specific effects associated with the group-based resilience intervention. The majority of participants showed no reliable change on any of the outcome measures in

Figure nine: average resilience scores in each group (course vs online) over time

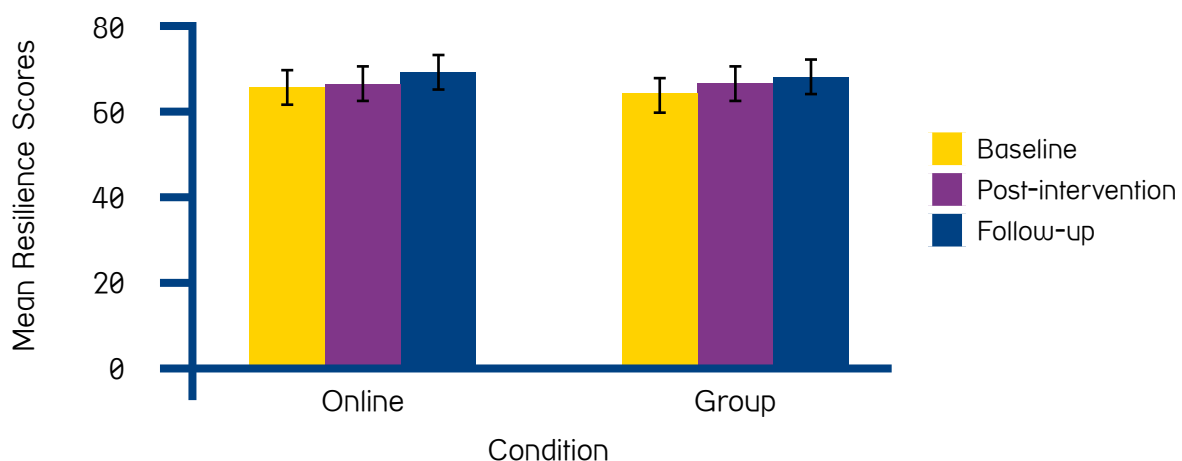
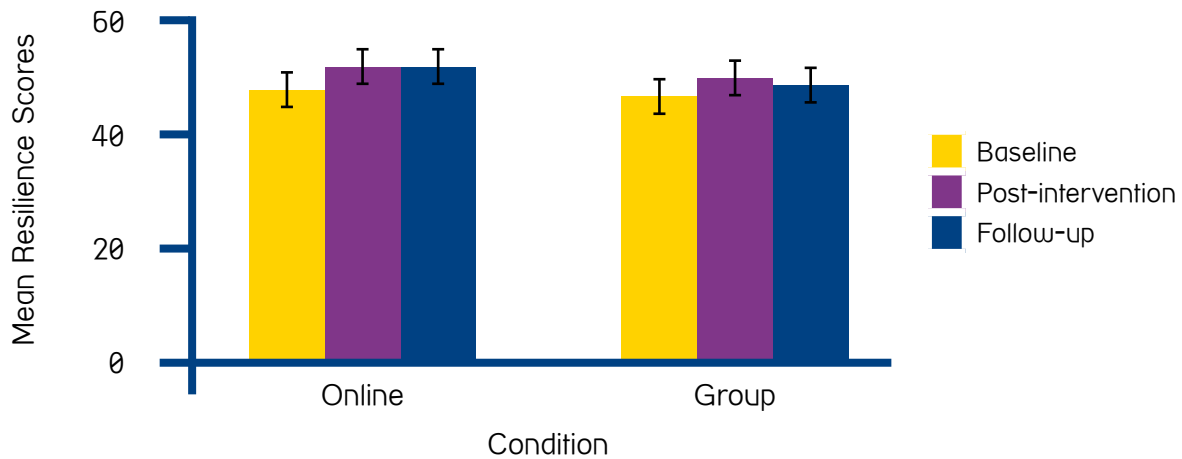


Figure ten: average wellbeing scores in each group (course vs online) over time



either the course group or the online info-only group. However, a small proportion of individuals reported reliable improvements in resilience, wellbeing, self-efficacy, social participation, ability to problem-solve, use of social support at home, confidence in managing their mental health, levels of low mood, and frequency of depressive attributions, and of rumination. Those individuals who showed a positive impact tended to have higher levels of need at the beginning of the intervention.

Wellbeing appears to fluctuate over time

The evaluation included a small natural wait-list group (i.e. a group whose course was delayed by eight weeks and completed two baseline measures). This group provided some clues about the possible pattern that may be seen over time without any intervention.

It would seem that wellbeing does fluctuate over time to a similar level as was seen in the group and online interventions. Without tracking the natural fluctuations of these outcomes over time in a larger wait-list group, it is difficult to conclude whether improvements are linked to the interventions or to the natural passage of time.

A few individuals showed a deterioration – but other factors may have been at play

A small proportion of individuals experienced reliable deteriorations from baseline to after the interventions that could not be explained by exposure to critical incidents, number of sessions attended, or topics completed. However, other factors may have contributed to their deterioration, such as financial difficulties or a deterioration in physical health. There is no evidence that the course causes harm.

Group-based resilience intervention no more effective than reading online mental health topics

The evaluation demonstrated that there were no specific effects linked to the group-based resilience intervention. Reading the online mental health topics linked to Mind's broader work was as effective as attending the group-based resilience intervention. The majority of participants experienced no change in either the course or info-only groups. However, a small proportion of participants did report reliable change in resilience, wellbeing, self-efficacy, social participation, ability to problem-solve, use of social support at home, confidence in managing their mental health, levels of low mood, and frequency of depressive attributions and of rumination.

Identifying predictors of success

Most vulnerable participants tended to show more reliable improvement

To identify predictors of success, data from participants who reliably improved as a result of the intervention were analysed in more detail. A general pattern emerged in which participants who were most likely to make reliable improvements were also most likely to be more vulnerable at the outset. They tended to have significantly lower resilience, wellbeing, self-efficacy, and problem-solving scores than participants who did not improve. Participants who were most likely to make improvements in mental health outcomes were also most likely to have scores that were in the clinical range on the mood and anxiety measures. The baseline measures for depression, anxiety, wellbeing, and confidence in managing mental health were the most significant indicators of reliable improvements in mood at post-intervention.

Those with history of PTSD or depression also more likely to show improvement

Detailed analysis was also conducted on data from participants who were initially excluded because they were above clinical cut-off on measures of PTSD, anxiety, or depression. Some of these people were reincluded into the study after clinical interview established that their symptoms were not causing interference or distress, they did not wish treatment, and were not at risk. This group of participants who completed the group and online courses were compared to participants who had been immediately eligible for the study. Consistent with the general pattern described above, participants who had initially scored above clinical cut-off on measures of PTSD, anxiety, or depression were more likely to make significant improvements in resilience, wellbeing, social capital, depression, and rumination. **It is possible that the resilience group and online courses may be best placed to support emergency workers who are more vulnerable.**

Difference between participants' feedback and outcomes

Improvements in wellbeing observed likely a consequence of passage of time

Emergency services personnel were very positive about the course and provided glowing comments about the quality and relevance of the material.

However, the outcome measures demonstrate that the majority of participants did not experience reliable improvements in resilience, wellbeing, coping or social capital. Depending on the outcome measure, the proportion of responders ranged from 8% (social participation) to 30.1% (wellbeing). The largest proportion of participants showed improved wellbeing. However, the degree of improvements in wellbeing was comparable to the degree reported by participants in the natural wait-list group. This suggests that the improvements in wellbeing were related to the passage of time rather than the effect of the group. The effect of the interventions on all outcome measures was small, which suggests that the group-based resilience intervention in its current form is not cost effective.

Findings consistent with other emergency services studies

The findings in this trial are consistent with the results of other evaluations of interventions aimed at improving emergency workers' mental wellbeing. For example, randomised controlled trials found that trauma risk management, (TRiM) a peer support system widely available to the police and ambulance services in England, and critical incident stress debriefing widely used by UK fire-services, had no effect on resilience or rates of poor mental health.

Figure eleven: likelihood to recommend the course to a colleague

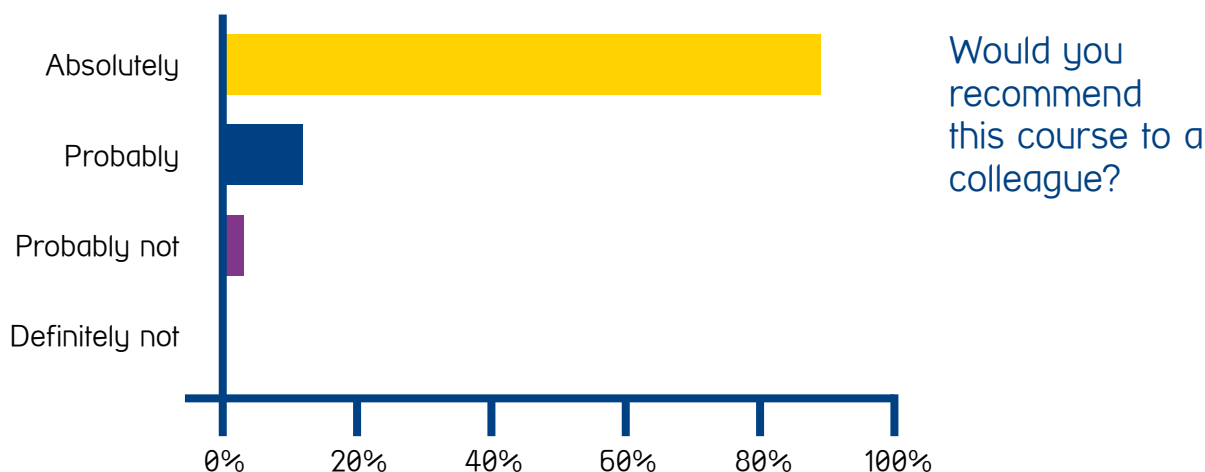
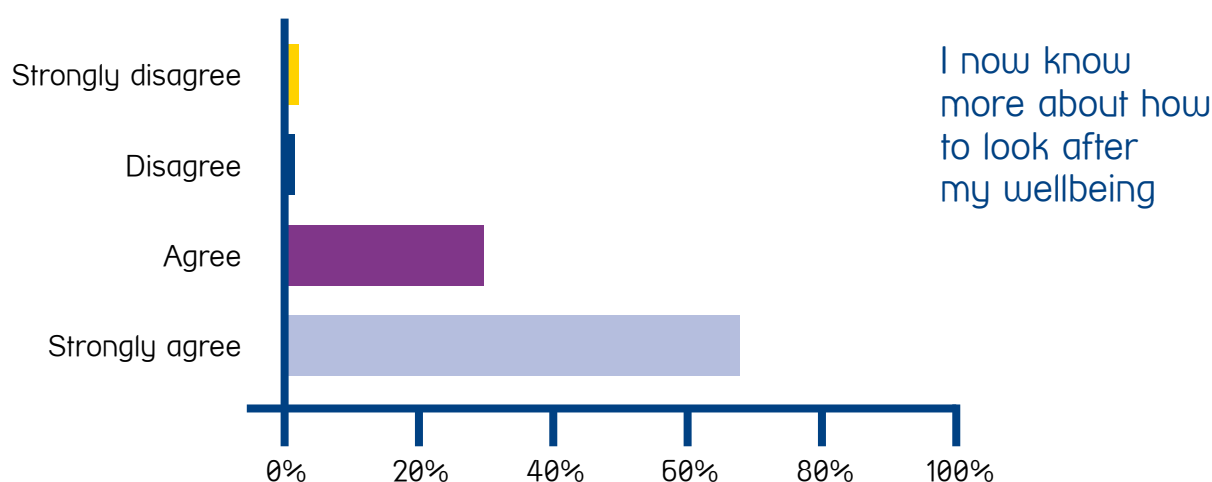


Figure twelve: self-reported confidence to manage wellbeing (post-survey)



Range of factors may be limiting success of resilience interventions

Current resilience interventions could be limited in success because they (1) fail to target predictors of resilience or poor mental health; (2) are evaluated with measures of resilience or wellbeing, which may not relate well to wellbeing, resilience, or coping as they are experienced by emergency workers; (3) do not include follow-up training to sustain gains; and/or (4) do not include strategies that could help emergency workers cope with typical stressors.

For example, previous research has shown that exposure to stressful scenarios through imagery reduces anxiety for police officers and other at risk populations. Including exposure to imagery of stressful scenarios could be made part of future resilience interventions for emergency workers to increase their impact. Future resilience interventions will need to be tailored to strengthen predictors of resilience and to modify predictors of poor mental health.

Strand four: providing targeted advice and support

Objectives

The evaluation of strand four explored the different elements of the information provision strand in order to assess:

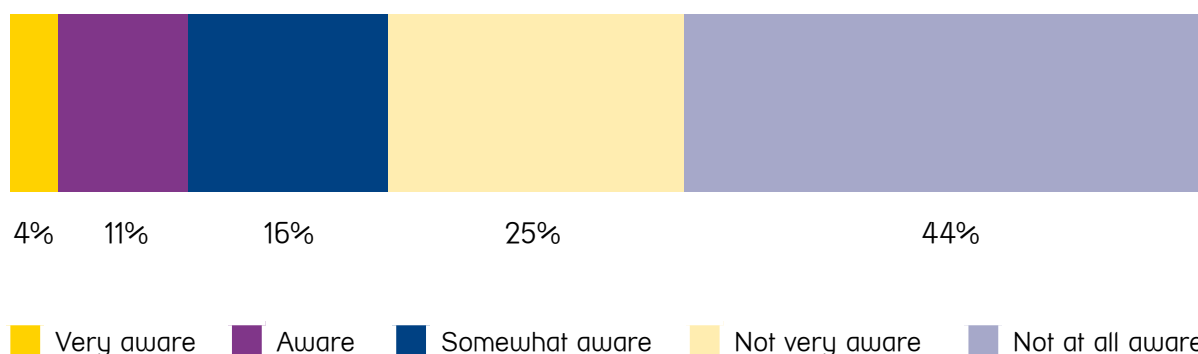
- how effective the information provided has been (in terms of its availability, visibility, and impact on individuals and actions taken etc)
- why people may not engage with the support
- how the support may be further developed or improved; and
- the impact of the Blue Light Infoline and the quality of written and audio-visual materials designed to support the programme.

Awareness of the Blue Light Infoline

High awareness of mental health problems in the workplace, but awareness of Blue Light Infoline is low

Overall, there was a high awareness of mental health problems in the workplace (87%); this was particularly high amongst older participants between the ages of 50-59 years (92%). However, awareness of the Blue Light Infoline was still low at the end of the programme. Only 31% of participants indicated some awareness of the Infoline whilst the rest of respondents were not aware of it at all (69%).

Figure thirteen: awareness of the Blue Light Infoline at end of the programme





Most became aware of Infoline through employer

Most personnel who were aware of the Infoline heard about it through their employer (44%) whilst other participants became aware of it through various other means such as the internet (16%), colleagues (14%) and marketing material (13%).

Most personnel do not know how to contact the Infoline and feel it is not effectively advertised in their workplace

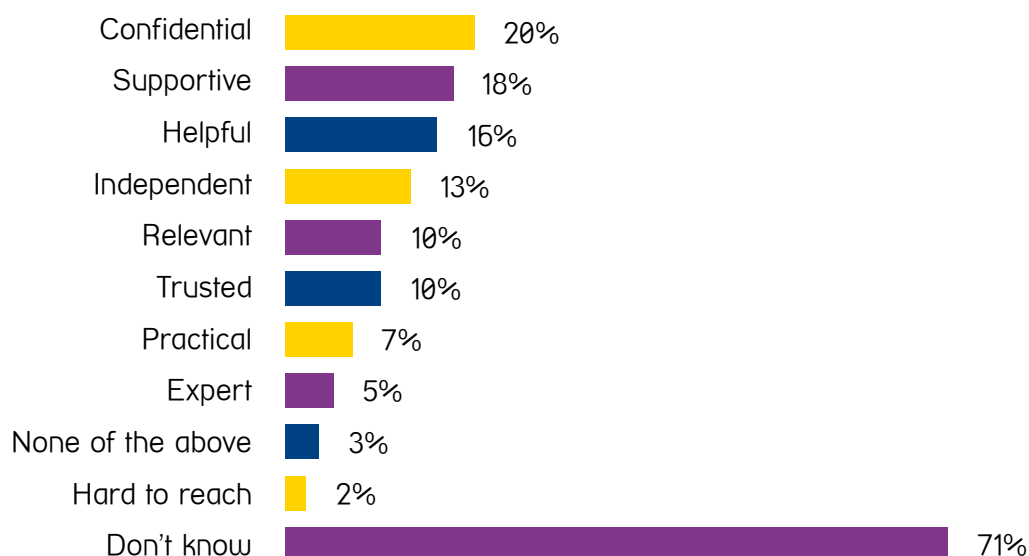
- The vast majority of participants (83%) were not aware of how to contact the Blue Light Infoline.
- 84% of participants believe that the Infoline is not effectively advertised in their workplace.
- Participants in the qualitative research were slightly more aware of the Infoline and reported that they saw it promoted mainly through internal communication, such as emails, booklets, and flyers.

Usage of the Blue Light Infoline

Numerous reasons for non-usage

- Lack of awareness was by far the largest reason why emergency services personnel had not used the Infoline.
- A variety of other reasons were also given, including: difficult to access (6%); concerns regarding anonymity (10%); support/information is accessed elsewhere (14%); or they did not want telephone support (14%).
- GP (26%) and counselling services (21%) were the most popular services if participants already accessed support and information.
- Similarly, qualitative findings revealed that most participants would be likely to use the Infoline, particularly if it was available 24 hours a day, they were assured of confidentiality, the representative they spoke to listened and understood their situation, and signposted them to relevant organisations for support.
- Although personnel who participated in the qualitative and quantitative research had not used the service, most participants would recommend (54%) or would be very likely (33%) to recommend the service to a colleague.
- This suggests that there is not a single blocker to accessing the service other than low awareness. When research participants were made aware of the Infoline they were overwhelmingly in favour of using it in the future.

Figure fourteen: words associated with the Blue Light Infoline



Perceptions of the Blue Light Infoline

Those aware of the Infoline are likely to see it as confidential, relevant, helpful – and most want more information to be provided about it

Participants who were already aware of the Blue Light Infoline used positive words to describe the service, including: confidential (58%); helpful (52%); and relevant (36%).

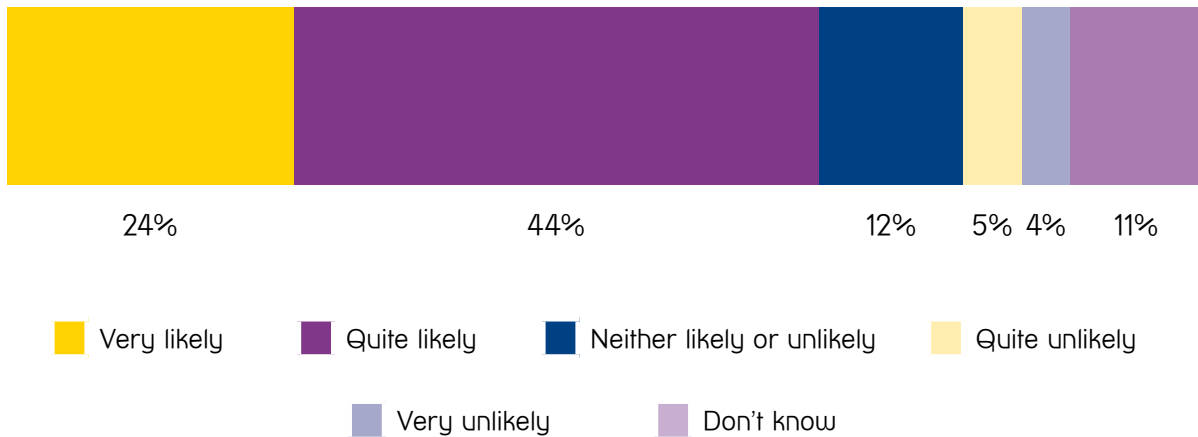
Most participants state that more information should be provided about the service (68%) in order to encourage them to use the Infoline. Under half the sample of participants (49%) stated that providing reassurance of confidentiality, respecting and listening to their concerns (43%), or ensuring their issue is understood (40%) would encourage them to use the service.

More than two-thirds say they would be likely to use the Infoline for information and advice on mental health problems

- Once made aware of the Infoline, a large majority of personnel said they would be likely to use it in future.
- 68% of participants stated that they would be likely to use the Blue Light Infoline in the future for information and advice about mental health problems in the emergency sector. A higher proportion of ambulance (73%) and fire service (70%) professionals are likely to use the service compared to those in the police service (48%).
- The small proportion of participants (9%) who reported that they would not use the service were currently using another service (22%) or stated that they do need to use the service (19%).

Trusted Confidential Relevant
Practical Helpful Expert
Independent Supportive

Figure fifteen: likelihood to recommend the Blue Light Infoline to a colleague

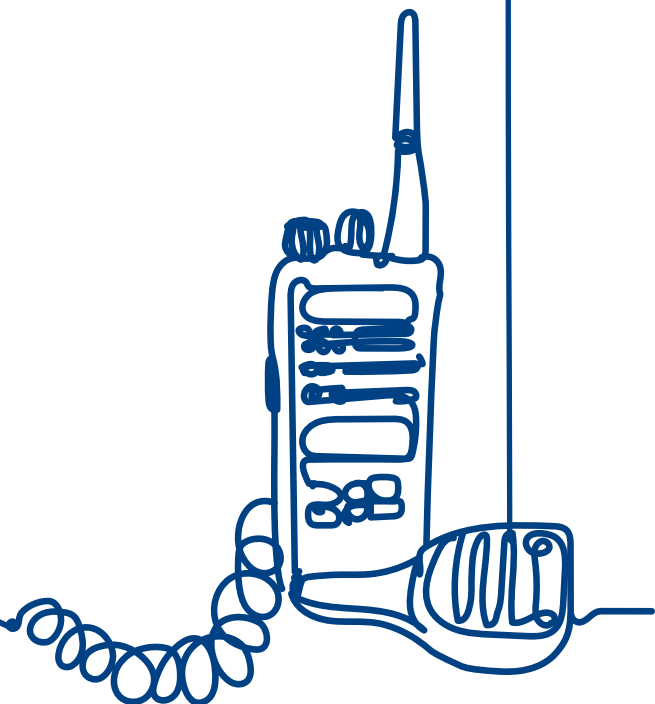
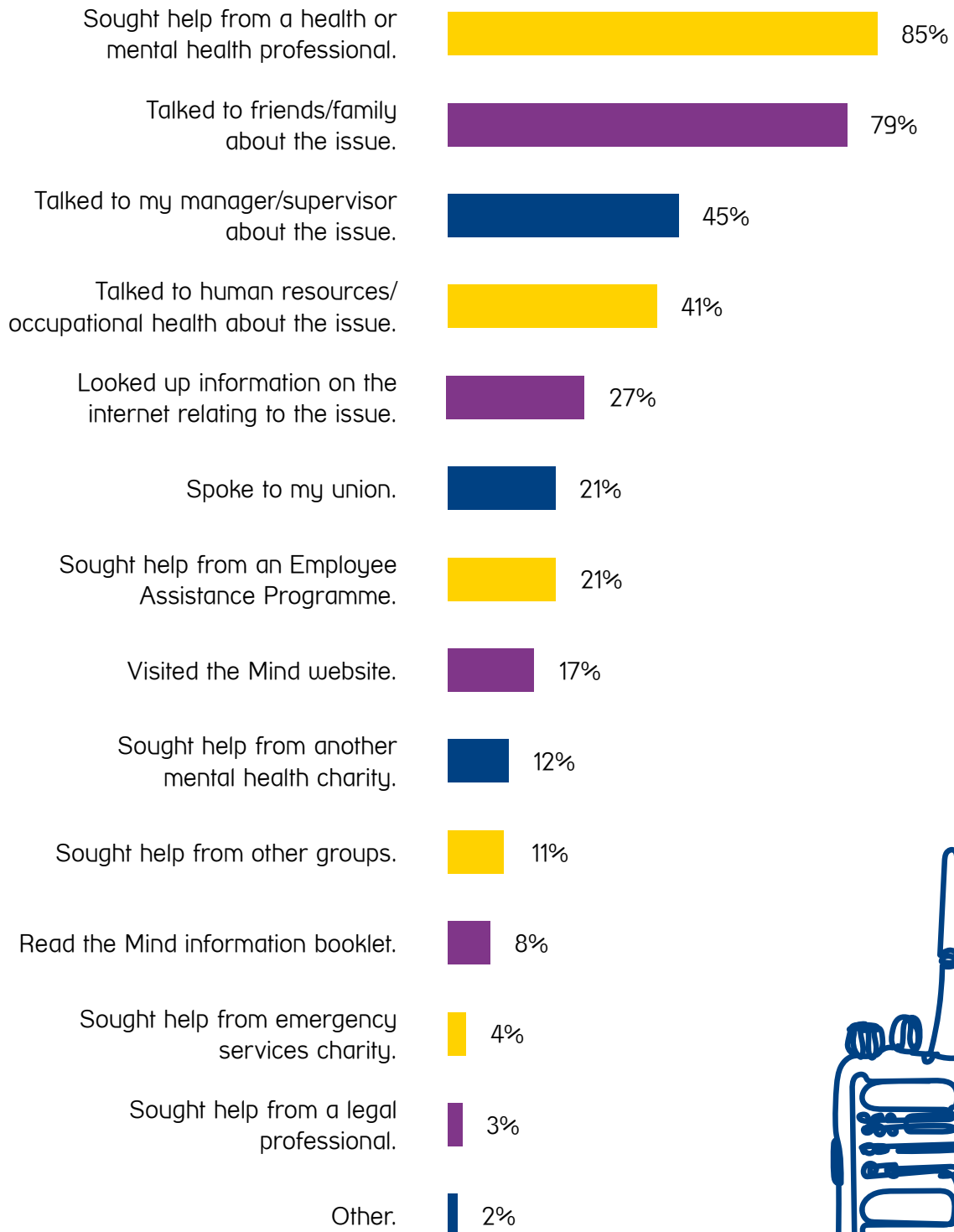


Other sources of support

Nearly half had accessed support from another provider – most often from GP, social worker, or counsellor

- 45% of participants had accessed support from another provider. A higher proportion of ambulance service professionals (51%) had sought support from another provider compared to those in the fire service (38%). This was also the case for females (57%) who had accessed more support compared to males (40%).
- The majority of participants who had received support state that they accessed it from a health or mental health professional. For example, a GP, social worker, or counsellor (85%). Many participants had accessed support from friends or family (79%) or their manager/supervisor (45%).
- Most of the survey participants (54%) suggested that they accessed support from another provider and not the Blue Light Infoline due to a lack of awareness. This finding was reinforced by the qualitative research.



Figure sixteen: alternative sources of support

Views on Mind information materials

Most participants were not aware that Mind offered information booklets prior to the research

- When presented with a range of information booklets during the focus group and in-depth interviews, all participants claimed that they would read the booklets if they needed to and would also recommend them to fellow colleagues.
- All participants perceived the content of the information booklets as useful as they believed they include comprehensive information, good links to further information and support, useful guidance for friends and family, and were blue light-specific.
- All participants stated that the information in the booklets was relevant because it was service-specific and presented relevant case studies and information in a non-patronising way.

Length, format of booklets felt to be appropriate, while images seen to aid readability

- All participants reported that the length and size of the information booklets was appropriate and included the appropriate amount of information, they also believe that the booklet was the most appropriate format to present the information due to practicality and convenience.
- Participants liked the pocket-sized format of the booklets and felt that this would improve accessibility.
- Most participants perceived the images used in the booklets positively, mainly because they made the information easier to understand and made the booklet more readable. The photos of blue light personnel were also felt to make the booklet more tailored.
- All participants reported that the booklets were very clear to understand and concise to read, including readers whose second language is English. The use of non-patronising language, simple vocabulary, and avoidance of medical jargon was also appreciated by participants.



Information videos praised and may increase help-seeking behaviour

- Most participants viewed the content of blue light information videos offered by Mind positively. They felt that they were informative, reliable, and challenged negative stereotypes of mental health.
- Participants believed that the videos used a good cross section of personnel from the different services and types of roles to convey messages in the videos. However, some participants did not realise the people who featured in the videos were real blue light personnel.
- The videos were felt to encourage people to discuss and seek support for their mental health problems.
- A minority of participants reported that the videos could be perceived negatively. They may cause people to think that emergency services personnel are emotionally unstable. Some were also surprised to see a pregnant employee pictured on the front line, which would never be expected in the ambulance service.
- Some participants thought that the videos could be improved by providing more specific information or contact details for support services.



Strand five: improving pathways to services and support

Objectives

Leeds Beckett University's evaluation of strand five sought to understand:

- the Peer Support Champion's experience of the training
- whether the Peer Support Champions found the context engaging and relevant to their work situations
- whether the Peer Support Champions felt more empowered and confident to support their colleagues in the workplace
- whether the training met Peer Support Champions' expectations and whether they would like further guidance, support or training
- the impact of the training programme in relation to Peer Support Champions' wellbeing
- issues concerning the sustainability of the Peer Support Champions initiative.

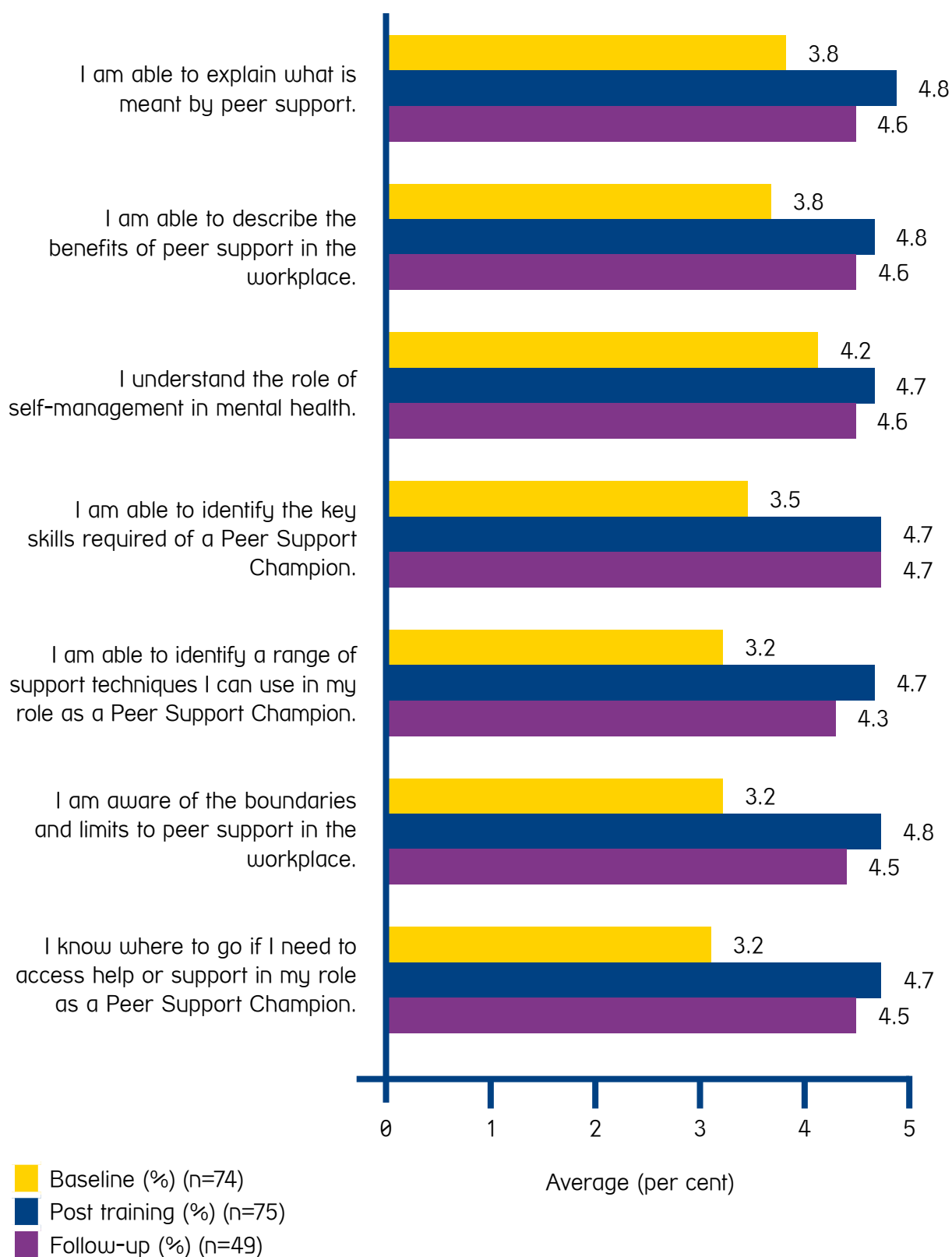
Findings from the survey

Training participants showed large increases in peer support knowledge and understanding and self-confidence

Overall, training participants were found to have large, statistically significant improvements in both their peer support knowledge or understanding and in their self-confidence to be a Peer Support Champion. These improvements occurred between the baseline and the end of the course, and were sustained between the baseline and follow-up.



Figure seventeen: average change in peer support knowledge over time



Improvements in peer support knowledge and understanding tailed off before follow-up, and no significant change in wellbeing

However, results in peer support knowledge and understanding decreased significantly between the end of the training and the follow-up period. There was also a decrease between post-training and follow-up in the proportion of participants retaining strong confidence to undertake a peer support role in the workplace. Analysis also revealed there was no significant change in the wellbeing of participants between baseline and the follow-up.

Most participants felt training met their expectations in full, went on to provide peer support to others at work, and would recommend Champion status to colleagues

A large majority of participants felt the training met their expectations in full and rated it as being very useful. The opportunity to meet and share experiences with others in the emergency services was widely welcomed by participants. At follow-up, a majority of those responding had provided peer support to others at work. Just under a third of these individuals indicated they would like additional support to perform the role. Nearly three quarters of participants would definitely recommend becoming a Peer Support Champion to their colleagues in the emergency services.

Findings from participant interviews

Positive feedback from participants on training content, trainer's skills and mixture of methods used

Participants' expectations for the training included: to understand the role more deeply; to interact with others with similar experiences and to obtain practical guidelines. The training content was valued highly for providing resources and for stimulating discussion around good practice. The trainer was praised for her facilitation skills, being flexible, and encouraging a relaxed, safe environment. There was a good

mixture of methods. Scenarios were highlighted as very useful for solving real world problems. Group work gave an opportunity for people with experiences to share perspectives.

Multi-service training also felt to be positive, including focus on implementation issues and ways of working across organisations

Multi-service training worked well and participants were able to network with other peer supporters. Participants valued discussions of different implementation issues and ways of working across organisations. Participants learned that the role involved active listening, providing support and signposting, and positive reinforcement. However, some participants had uncertainties about how the learning could be implemented in their workplaces.

Training boosted participants' confidence, with focus on 'soft skills' appreciated

Participants felt they had ownership of the training and were able to shape it based on their lived experience and organisational contexts. Training increased participants' confidence and strengthened some participants' sense of professional identity. Outstanding aspects included a focus on 'soft skills'. However, clearer guidance about competencies and referral routes is needed.

While services are distinct, resource constraints, structural pressures and organisational culture are key challenges everywhere

The Peer Support Champions came from different services that were organisationally distinct. However, they shared complex tasks and roles, resource constraints and structural pressures leading to raised stress, as well as strict organisational hierarchies and rules. Barriers and enablers to implementing peer support vary by service and context but organisational culture was said to be a key challenge. Cultural change is not fast and Champions recognised that their role would take time to fully implement. Stigma around mental

health, linked to attitudes about ‘absenteeism’ and fitness for work, was a major cultural barrier to front-line staff engaging with Peer Support Champions. Champions were keen that managers receive tailored information to improve their knowledge and attitudes. This was particularly important because Champions were often very dependent upon the support of their managers to fulfil their new role.

Peer Support Champions may be vulnerable within organisations and need support themselves

The interaction between gendered practices and organisational cultures can deter people, most particularly men, from talk about vulnerability. Providing front-line peer support involves managing competing real-time pressures such as divided attention on the Champion role and the ‘day job’, workload pressures and managing confidentiality of interactions. This can place a large burden on Champions and their potential vulnerability is an important risk – particularly if they are the only Champion in their organisation. Employers need systems of risk assessment and support for the Peer Support Champion. Ongoing support should include networking, refresher events and clear lines of accountability.

Key requirements to sustain programme internally include committed advocates, support from leadership, an organisational framework and more inclusive training events

There is a clear need to increase peer support capacity. Sustaining the role of Peer Support Champion requires having committed advocates; senior leadership support; an organisational framework that identifies a clear role for the Champion and more inclusive ‘internal’ training events with peer supporter and health professional input to ensure the Peer Supporter role is fully integrated into organisation structures and feels validated and supported. There are ongoing needs for peer support for peer supporters, attention to potential time burden of the role, wider networking and liaison between regions as well as further evidence of effectiveness.

Findings from notebooks

Champions feel better able to identify issues and have boosted confidence to approach colleagues in distress

Participants reported improved confidence to offer support when they thought a colleague may be distressed. They felt better able to identify issues and had improved soft skills to manage the initial engagement. Several participants reported increased confidence once they had engaged with people and could see their techniques working in practice. This increased confidence in interactions was based on specific practical elements including; active listening, being positive and active in support, greater knowledge of available resources, appropriate use of own experiences the importance of ‘checking in’ and how to appropriately disengage. Active listening was a prominent skill practised by participants.

Some Champions showed increased confidence to raise the topic of mental health more widely

The course gave some Peer Support Champions the confidence to be proactive in raising the topic of mental health more widely within their work setting. There was also an increased awareness of the resources, actual and potential, required to fulfil the role. Participants drew positively on their own experience, but there was recognition of a need to care for their own wellbeing, and share concerns where necessary. The need for access to support for Peer Support Champions was identified. Whilst there was no evidence that the wellbeing of Champions significantly improved as a result of taking on the new role, there is no evidence that it caused harm.



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

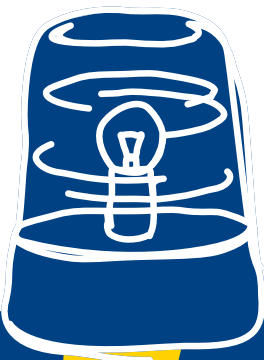
We provide advice and support to empower anyone experiencing a mental health problem. We campaign to improve services, raise awareness, and promote understanding.

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.

Mind has a diverse portfolio of activities, including training, policy and campaigning, advice lines, and supporting our network of 140 local Minds. We also coordinate the delivery and testing of innovative new services across our network.

The local Mind network spans across England and Wales, directly supporting around 380,000 people every year. By far the largest network of services and support for people with mental health problems in the country, its strength lies in its unique ability to draw on the skills and experience of a trusted national network, matched with strong local relationships, and the tailoring of services to local needs.



10 actions Mind will take

Based on the evaluation findings, in 2016 to 2017 we will:

1. **support services to improve their internal communications:** we will develop guidance and tools to support emergency services to better communicate with their staff and volunteers about their organisations engagement with the Blue Light Programme and the work they are undertaking
2. **provide guidance on recruiting and supporting your own mental health Champions:** we will develop a toolkit to enable emergency service organisations to recruit, train and support their own mental health Champions
3. **make the line managers training course available to all services:** we will redevelop the successful line managers training course based on feedback from the evaluation and make it widely available to purchase
4. **make our webinar films more accessible:** we will commit to making our webinar films on managing mental health as accessible as possible for all staff, removing as many of the barriers to viewing them as we can
5. **invest in redeveloping and testing the resilience course:** we will invest in further development and testing of our resilience course, taking learning from the pilot evaluation to make sure it is having the most impact it can. We will work with the University of Oxford to evaluate the course again
6. **support organisations to better promote the Infoline to your staff:** we will provide guidance and tools to support organisations to better promote the Infoline internally so that all staff and volunteers have awareness and access
7. **work together with associations to promote the Infoline:** we will commit to working together with all national associations to ensure they are widely promoting the Infoline
8. **provide guidance on supporting peer supporters and share best practice:** we will develop detailed guidance for emergency services to ensure that workplace Champions delivering peer support are adequately supported and will share examples of success and best practice
9. **work together with emergency services and associations to get more funding for mental health support to continue beyond 2017:** our evaluation findings show that we've come a long way together but that real change takes time. There is still much more to be done and we need more funding so that all of our emergency services can get the support that they deserve
10. **develop ways that emergency service staff and volunteers in Wales can benefit from Mind's specialist, independent mental health services:** we are working together with other organisations to develop a strategy so that Welsh emergency services get the support that they need too.

10 actions we ask emergency services to take

1. **Sign the Blue Light Time to Change pledge:** if you haven't signed yet, then make sure you do – our pledge application process for 2016 to 17 is now open. It's the best way to publically show your commitment as an organisation and by developing your pledge action plan, you will have a clear understanding of what action you need to take as an organisation to improve the wellbeing of your staff.
2. **Show the support from senior managers:** actively work to build trust between frontline staff and senior managers when it comes to talking about mental health. Encourage senior managers to publically show their support for the programme – they could become a workplace Champion, write a blog on their own experience of mental health and wellbeing for the staff intranet, or if they felt comfortable they could speak about their own experiences at an internal event.
3. **Take action to show your support:** if your organisation supports the Blue Light Programme then make sure it takes action to reflect that support. For example, you could commit to providing every new starter in your organisation with one of our printed booklets on looking after your wellbeing.
4. **Communicate the actions you take:** if you take action to improve the wellbeing of staff as an organisation, for example making changes to your policies or practices or organising a wellbeing event, then make sure your staff and volunteers know about it through internal communications.
5. **Generate change face to face:** talking about mental health face to face can have a big impact. Direct and public support from your Chief or team leader at an event or meeting can go a long way to break down barriers in talking about mental health.
6. **Promote the Blue Light Infoline:** staff need to know where they can access information and support if they need it. By making sure you raise awareness of the Infoline and other support available through the Blue Light Programme, such as our information booklets, staff and volunteers will know where to turn when they need support.
7. **Keep mental health on the agenda:** we've come a really long way together but real change takes time and the need for support is still huge. Make sure you keep mental health on the agenda in your organisation – why not set up an internal working group, commit to promoting a mental health awareness day internally or invest in providing printed information booklets in your break-rooms for all staff to access?
8. **Actively challenge your self-stigma:** everyone knows a friend or family member that has experienced a mental health problem. Try to challenge your self-stigma around mental health by considering how you would support a loved one in the same situation – would you be understanding and encourage them to seek information or support?
9. **Give workplace Champions the support they need:** individuals who sign up as workplace Champions can make a huge difference to how mental health is approached in organisations. Make sure you're giving them support in carrying out this role – for example, you could enlist HR and communications staff to support them in organising awareness raising activities or you could make sure they have a quiet and confidential space internally to talk to their peers.
10. **Make our line manager training mandatory:** our line manager training enables individuals to better support their direct reports and gives them confidence to talk about mental health. By committing to deliver line manager training and make it mandatory, line managers will be given the tools that they need to actively support their staff to stay well and prevent any problems from getting worse.



**#Ourbluelight – show your support
and take our 10 actions inside**



**Please keep the Blue Light Programme going.
It's our emergency service.** Blue Light Champion

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.

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 @MindBlueLight

 Mind

We're a registered charity in England (no. 219830)

Funding administered by:



Cabinet Office

