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EVALUATION OF THE MIND TRAINING PROGRAMME FOR BLUE LIGHT PEER SUPPORT CHAMPIONS

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Executive Summary

The project

Mind was awarded LIBOR funding, administered by the Cabinet Officer, to deliver a major new programme of mental health support for staff and volunteers from the Police, Fire, Ambulance, and Search & Rescue services. Developed in collaboration with Blue Light personnel, the programme has been delivered across England between April 2015 and March 2016. The programme has had five strands. Strand 5: Improve pathways to services and support has a dual focus: Training personnel to act as Blue Light Champions, providing peer support and signposting colleagues to further mental health services and support; and Commissioning local Blue Light Mental Health Networks – sharing learning and increasing co-ordination between Blue Light employers and mental health service providers from the statutory and voluntary sectors. The current evaluation focuses on the training for Peer Support Champions element of Strand 5. The training course was delivered in 9 day sessions across 6 locations between November 2015 and March 2016. The locations were London (x 2 courses), Manchester (x 2), Hull (x 1), Worcester (x 2), Oxford (x 1), Winchester (x 1).

The evaluation

Leeds Beckett University conducted an independent evaluation of this programme. The research team have sought to understand the Peer Support Champions' experience of the training; whether they found the content engaging and relevant to their work situations; whether they felt more empowered and confident to support their colleagues in the workplace; to identify whether the training met Peer Support Champions' expectations and whether they would like further guidance, support, or training; to measure the impact of the training programme in relation to their wellbeing; and to explore issues concerning the sustainability of the Peer Support Champions initiative.

Methodology

The evaluation involved mixed quantitative and qualitative approaches.

a) A before and after questionnaire survey was administered (on three occasions, including 3-8 week follow-up) to all participants.
b) Semi-structured interviews were held during project visits with 13 participants.
c) A notebook record, of participants' experiences and reflections following direct contacts with people wanting support, was completed by 8 participants.

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

The quantitative data was analysed using the statistical software package SPSS.

The qualitative interview data was analysed thematically using NVivo software. Notebooks were also analysed thematically, with hierarchical coding. The evaluation team synthesised results from the different components of data analysis to inform conclusions and recommendations.

Key findings – Survey

Overall, training participants were found to have large, statistically significant improvements in both their peer support knowledge/understanding (significantly higher levels of agreement across all of seven statements in the questionnaire) and in their self-confidence to be a Peer Support Champion (significantly higher levels of agreement across all of six statements), between baseline and the end of the course, and between baseline and follow-up. However, results in peer support knowledge/understanding decreased significantly between the end of the training and the follow-up period, and there was also a decrease between post-training and follow-up in relation to proportions of participants retaining strong confidence to undertake a peer support role in the workplace. Analysis also revealed there to be no significant change in the wellbeing of participants between baseline and the follow-up point.

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, while 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.

Key findings – Interviews with participants

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 a good mixture of methods. Scenarios were highlighted as very useful, providing practice-focused problems. Group work gave an opportunity for people with experiences to share perspectives.

Multi-service training worked well, and participants were able to network with other peer supporters. A comparative focus on implementation issues, and ways of working across organisations provided insights. Participants learned that the role involved active listening, providing support and signposting, and positive reinforcement. However, participants shared uncertainties about how the learning would be implemented in workplaces.

Ownership of training was important, participants drawing on their lived experience and organisational contexts. Training increased participants' confidence, and strengthened some participants' sense of identity. Outstanding aspects included a focus on 'soft skills'; the group experience, networking, take-away resources, and gaining legitimacy. Clear guidance over competencies and referral routes is needed.

The services were organisationally distinct, but share complex tasks and roles; resource constraints and structural pressures leading to raised stress; and organisational hierarchies and rules. Barriers and enablers to implementing peer support vary by service and context. Organisational culture was said to be a key challenge. Cultural change is not fast; 'managed' change is needed. 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. Managers might need 'empowering' to provide effective support.

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, demand overload, and privacy. The potential vulnerability of Peer Support Champions is an important risk. Organisations need systems of risk assessment, and support for the Peer Support Champion. Ongoing support needs include networking; refresher events; clear lines of accountability. Validating the role requires identifying boundaries; resolving relationships with other health roles. The need to increase peer support capacity is paramount. For sustaining the programme internally, key themes include: having committed advocates; senior leadership support; an organisational framework; more inclusive 'internal' training events with peer supporter and health professional input and senior health and management roles involved. There are ongoing needs for: peer support for peer supporters; attention to resource requirements; wider networking and liaison between regional forces; evidence of effectiveness.

Key findings – Notebooks

Participants reported improved confidence in making an approach when they thought a colleague may be distressed or require support. This presented itself through improved identification of issues and improved techniques of engagement. Several participants reported increased confidence once they had engaged with people. 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 and understanding own needs, the importance of 'checking in' and how to appropriately disengage. Active listening was a prominent skill practised by participants. The need to find quiet and/or private safe places was noted. Raising issues subtly was sometimes used effectively to make conversations about mental health more appropriate and natural. Support was seen as an ongoing process. The course gave some the confidence to be proactive in raising mental health more widely within their work setting, and there was an increased awareness of resources, actual and potential, for 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. The various skills learnt through the training tend to be integrated in practice, to provide the required support.

Conclusions and Recommendations

The report has highlighted that the course proved very effective in increasing participants' peer support knowledge and understanding, and their self-confidence for the role, though not necessarily their wellbeing. Most participants found the training met their expectations and was useful. Interview findings highlighted the rewarding experience of most participants on the value of inter-agency interactions, and impacts around confidence and skills developed such as active listening. Notebooks show excellence in practice resulting from training, in relation to identification of issues and techniques of engagement in particular, as well as knowing when to disengage and learning to care for their own wellbeing. To sustain and expand on excellent practice will involve ongoing work towards developing health promoting organisational environments.

Issues arising include the following. *Firstly,* the course *trained far more people from Police services* than Fire and Ambulance services, with very few Search and Rescue personnel involved. Inter-agency networking and shared learning in this area could be beneficial to different organisations. *Second*, interview findings suggest that *organisational contexts* for delivery still present *serious challenges* to trained Peer Support Champions. *Third*, while twice as many front-line staff were trained as support staff, cultural and practical challenges for implementation were raised, particularly on the front-line, but also in some office contexts, e.g. call operators, concerning *confidentiality, trust* and *safe space* for contacts*.* Within particular services, it seems important to develop protected space and safe practices to ensure coverage. *Fourth*, while similar numbers of men and women were trained, overall, fewer than one-fifth of support staff trained were male, whereas over a third of front-line staff trained were female. *Gender issues* need careful consideration. Cultural concerns around stigma and talking about vulnerability at work intersect with normative practices of 'traditional masculinity'. Men and women need to be supported in gender-aware ways to develop excellent peer support communication practices. *Fifth,* there is a risk that Peer Support Champions may struggle with their own *vulnerability* if they are over-stretched and insufficiently supported. Fall-off (in questionnaire results) during the month after training concerning gains in peer support knowledge/understanding, and lowered proportions retaining strong confidence to undertake a peer support role in the workplace, access resources, and signpost colleagues to relevant services, suggests participants' isolation in the role. *Peer support for Peer Support Champions* need to be developed and strengthened in workplaces. Managers need to be trained, boundaries clarified, and networks of support developed. *Sixth*, the vast majority of those trained were *aged over 30*. Consideration needs to be given to mental health awareness training appropriate for young entrants, as potential agents of cultural change. *Seventh*, a limitation, this evaluation has not directly studied the organisational environments. However, our evidence from notebooks exemplifies pockets of outstanding local practice, while our interview data shows that *mental health-promoting organisational environments* have to be developed if individuals are to become successful trained Peer Support Champions.

Recommendations.

- Integrate development of health-promoting - including mental health-promoting - organisations further with development of Peer Support Champions in emergency services
- Support should be provided for internal development of positive Peer Support Champion practice.
- Leadership support and systems approaches are needed to include Peer Support Champions within organisational practice
- Peer Support Champions need further peer support in their places of work. Further training, internally driven, could expand networks of Peer Support Champions
- Training should include a strong focus on cultural factors and gender-awareness and skills for context-specific practice
- Systems or frameworks for encouraging Peer Support Champions to thrive need to be in place alongside the peer support training, with managers, and key staff e.g. in leadership, HR and Occupational Health roles trained, and support networks developed
- Best practice should be shared across services, and inter-agency support networks encouraged

- Evidence is needed, grounded in specific contexts, of effectiveness over a period of time.

1. Introduction

1.1 Background to the research

Blue Light emergency services include Police, Fire, Ambulance and Search and Rescue services. Blue Light emergency service personnel face risks to mental health in terms of emotional and psychological stress, from dealing with fatalities and injured people; interaction with people in mental distress or crisis; and taking responsibility for the lives of others (Bengel, 2004). Organisational risk factors in emergency services are highly significant: e.g. service cuts, time pressures, and working patterns and hours. Emergency services staff may also (varying by service) confront further hazards e.g. hazardous work environments and physical strain (European Agency for Safety and Health at Work, 2011). High workload and time pressures, confrontation with serious physical injury, stress and mortality, requirement to suppress emotions while working and yet be empathetic, are all risk factors for burnout - a long-term reaction to emotional stress - involving emotional exhaustion, sense of reduced accomplishment and depersonalisation (Mitani et al., 2006; Maslach and Jackson, 1981). Prolonged stress among emergency workers heightens emotional reactions (shock, anger, guilt, emotional numbness), cognitive reactions (disorientation, lack of concentration, memory loss, guilt), physical reactions (tension, fatigue, pain, rapid heart-rate) and psycho-social reactions (avoidance of socialising, isolation, being distant) (Rhoads et al., 2008). The demographic profile of front-line emergency services staff (high proportion of young males) among front line emergency staff (less among office staff) is also a significant factor affecting resilience in relation to stress.

Mind's research has shown that the 250,000 emergency services staff and volunteers – 'Blue Light' personnel – working in England are more at risk of developing a mental health problem but less likely to seek support. There is an overlap between groups at greater risk of developing mental health problems and Blue Light personnel. These risk factors include their demographic profile (e.g. young men), working patterns (e.g. shift work), organisational pressure (e.g. service cuts), and frequent exposure to traumatic situations. Mind's research has shown a far higher level of lived experience amongst Blue Light personnel, compared to the general workforce. Research for the Time to Change campaign has shown that the workplace is the second most common source (after family and friends) of mental health stigma. In particular, fear about fitness to work can prevent emergency services personnel from seeking support for a mental health problem. This group's disproportionate interaction with people in mental health crisis can also impact on their perception of the issue. Mind's research has shown that it can lead to misconceptions, stigma, and self-stigma that can prevent personnel reaching out for help.

Mind's aim is for everyone with a mental health problem to get both support and respect. Mind recognises that effectively managing workplace mental health is critical to both the wellbeing of Blue Light personnel and to the wider mental health of the population they serve. Mind was awarded LIBOR funding, administered by the Cabinet Officer, to deliver a major new programme of mental health support for staff and volunteers from the Police, Fire, Ambulance, and Search and Rescue services. Developed in collaboration with Blue Light personnel, the programme has been delivered across England between April 2015 and March 2016.

The programme has had five strands: Strand 1: Tackle stigma and discrimination; Strand 2: Embed workplace wellbeing; Strand 3: Increase the resilience of Blue Light personnel; Strand 4: Provide targeted advice and support; Strand 5: Improve pathways to services and support.

Strand 5, has a dual focus: Training personnel to act as Blue Light Champions, providing peer support and signposting colleagues to further mental health services and support; Commissioning local Blue Light Mental Health Networks – sharing learning and increasing co-ordination between Blue Light employers and mental health service providers from the statutory and voluntary sectors.

The current evaluation focuses on the peer support training for Champions element of Strand 5.

The training course was delivered in 9 day sessions across 6 locations between November 2015 and March 2016. The locations were London (x 2 courses), Manchester (x 2), Hull (x 1), Worcester (x 2), Oxford (x 1), Winchester (x 1).

The Institute for Health and Wellbeing, at Leeds Beckett University was appointed to conduct the evaluation of the Mind Blue Light Peer Support Champions training course. The key evaluation aims, as set out in the evaluation brief were: to understand the Champions' experience of the training; in particular, whether they find the content engaging and relevant to their roles; to identify whether the training met Champions' expectations and whether they would like further guidance, support, or training, and to measure the impact of the training programme on Champions in relation to a number of health and wellbeing indicators.

Objectives included:

a) To assess the extent to which Champions feel more knowledgeable and empowered to support their colleagues at work as a result of their training.
b) To measure changes in Champions' knowledge, confidence, self-esteem and self-efficacy as a result of their training.
c) To ascertain whether Champions are equipped and confident to signpost colleagues to mental health information and support as a result of their training.
d) To explore Champions' views and perceptions of the training provision in relation to matching their expectations and its relevance for their role at work.

Outcomes which were evaluated

The evaluation team sought to identify to what extent:

- Champions find the training engaging and relevant to their work situations
- Champions feel more empowered to support their colleagues in their workplaces
- Champions feel more confident to share their lived experience in their workplaces
- Champions have improved wellbeing

The evaluation therefore sought to develop an understanding of Champions' views of the training programme and identify the ways Champions have benefitted from it. The evaluation focuses on processes (i.e. how the training was received, its relevance to implementation of peer support in the workplace, and how it could be improved) as well as outcomes (i.e. the impact it had on participants). Based on the evaluation aims and objectives and our prior experience of evaluating a similar programme, a mixed-method approach was used. This allows for 'triangulating' different types of data (e.g. questionnaire data and interview data) in order to seek corroboration of findings and expand the breadth of our inquiry (Creswell and Plano Clark, 2011).

1.2 Report structure

This report includes the findings of research across the three main methodological components: the questionnaire, the interviews, and the notebooks.

An overall methodology is included, followed by findings for the survey research, then for the interview research, and lastly for the notebooks. Finally, in Section 6 we present the conclusions and recommendations arising from this independent evaluation.

1.3 Timings

The evaluation began in November 2015 and was completed in April 2016.

2 Methodology

2.1 Overall methodological approach

The evaluation design was one of mixed quantitative and qualitative approaches to address the evaluation aims.

a) A before and after questionnaire survey was administered (on three occasions, including three month follow-up) to participants on the Mind Blue Light Peer Support Champions training. In total 78 participants returned data for at least 1 of the 3 stages.

b) Semi-structured interviews were conducted during visits with 13 participants. Members of the evaluation team visited three locations to conduct interviews. The sample was purposive, in order to include female and male participants, and to include those from different services. 9 male participants and 4 female participants were interviewed, including participants from four different training programmes.

c) A notebook template (Appendix 5) was sent to 11 participants who volunteered to keep an anonymous notebook record of any episodes of peer support they provided, and to reflect on how the training made a difference to the support provided, in the month following the course. 8 participants returned notebooks.

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

Data analysis

All questionnaire responses were numerically coded and entered in SPSS. Descriptive analysis of the data was carried out and tests performed to examine the relationships between a range of variables. Results were analysed to examine, among other factors, the role of age and gender and condition.

Qualitative interview analysis.

The evaluation team conducted thematic analysis of interviews within and across phases, supported by NVivo software. Notebooks were analysed thematically with hierarchical coding (see Appendix 6). This approach allowed for a more realistic evaluation approach that asks what works, for who, in what contexts, and how (Pawson and Tilley, 1997). To this extent it provides insight into the mechanisms and processes (within the training setting and the working environments of Blue Light services) that are likely to underpin the outcomes from an intervention, vital given evidence that effective peer support is highly context-sensitive (Faulkner and Kalathil, 2012). Combining interviews with reflective diary/notebook data has been widely used to capture people's experiences in research projects (eg. Mort et al, 2005; Radcliffe, 2013).

Data Synthesis

The evaluation team synthesised results from the different components of data analysis to inform conclusions and recommendations.

Further detail

Prior to collecting data, the training coordinator overseeing data collection was briefed thoroughly about the purpose of questions, and sampling, reiterating guidance about ethics and consistency of approach.

Mind and the evaluation team agreed on a questionnaire with sections containing items related to knowledge and understanding of peer support and the role; items related to self-confidence to be a Peer Support Champion; items related to wellbeing; and items concerning acceptability of training (See Section 3.1). The questionnaire is shown in Appendix 3. The interview topic schedule is Appendix 4.

Ethical considerations

All interview and notebook participants received an information sheet detailing the following aspects: what the evaluation was about; why it was being conducted; what would be done with the information; their contribution; the fact that participation was voluntary and that they could withdraw at any time; confidentiality and anonymity. Consent was taken prior to all interviews. Ethical approval was applied for and attained via the Leeds Beckett University Local Research Ethics Coordinator. All interview participants received a £20 high street voucher to thank them for their time.

3 Survey Methods and Findings

3.1 Methodology – questionnaire design

To assess the impact of the intervention, Champions' **knowledge of peer support, self-efficacy to be a Peer Support Champion** and **mental wellbeing** was measured via a questionnaire across three data collection time points (pre-training, post-training and at a 3-8 week follow-up). **Acceptability of the training** and **Champion role** was also explored. Therefore, whilst some measures were employed at all 3 data collection points, others are specific to pre-training, post-training and/ or follow-up. Where available, previously validated or tested questions were used in the questionnaire, whilst other items were designed/ amended for the purpose of the evaluation.

The questionnaire was distributed pre-training (up to 1 week prior to delivery), post-training (within 1 week of completing training) and at a 3 to 8 week follow-up post-training (mean length of follow-up was 5 weeks) and was available to complete using the online platform SNAP or via paper copy. Pre- and post-training questionnaires were distributed by MIND. Follow-up questionnaires were sent out by the evaluation team. Questionnaires were designed to take 5 to 10 minutes to complete.

The questionnaire was designed to measure the following concepts:

Demographic information was collected pre-training and included measures to capture age, gender, transgender status, sexuality, ethnicity, location and experience of mental health. Standardized MIND demographic questions were employed.

Questions surrounding ***knowledge of peer support*** were designed for the purpose of this evaluation, in line with learning outcomes of the training, and were utilized at all 3 data collection points. Respondents were given a set of 7 statements and asked to what extent they agreed or disagreed with each (using 5 response options including: 'strongly agree', 'agree', 'neutral', 'disagree' and 'strongly disagree'). Knowledge items covered: definition of peer support, benefits of peer support, techniques to deliver peer support, boundaries of a peer supporter and where to access help/ support if needed.

Items used to measure ***self-efficacy to be a Peer Support Champion*** (pre- and post-training and at follow-up) were modified from Lane et al's (2002) measure of self-efficacy. The questionnaire included 6 items surrounding being a Peer Support Champion with 5 response options ('strongly agree', 'agree', 'neutral', 'disagree' and 'strongly disagree'). The question stem 'I am confident in my ability to…' was employed for each item (Lane et al., 2002), in line with previous research surrounding the measurement of self-efficacy (Bandura, 1997; Hilland et al., 2015; Garnham-Lee et al., in press). Items developed were aligned with the training learning outcomes.

Wellbeing was measured pre-training and at follow-up using the validated Short Warwick-Edinburgh Mental Wellbeing Scale (NHS Health Scotland, University of Warwick and University of Edinburgh, 2008). This tool included 7 related items to measure wellbeing over the previous 2 weeks with 5 response options ('none of the time', 'rarely', 'some of the time', 'often' and 'all of the time').

Post-training, Champions were given 9 items that explored the ***acceptability of the training*** and related to expectations of training, usefulness and strengths and weaknesses. Perceived expectations of the training were assessed using 1 item, 'Did the training meet your expectations' ('in full', 'in part', 'not at all'). To explore the usefulness of the training, Champions were asked 'how useful did you find the training?' ('very useful', 'useful', 'not at all useful') and 'would you recommend the training to other colleagues wanting to be a Peer Support Champion?' ('definitely yes', 'probably yes', 'probably not', 'definitely not'). Strengths and weaknesses of the training were explored using the following open items: 'what did you like best about the training?', 'what did you like least about the training' and 'how could the training be improved?'. Moreover, Champions were asked to comment on the length of the training ('was the training: too long, about right, not long enough') and the amount of information given ('thinking about the information given during the training, was it: too much, about right, too little'). Champions were also given the opportunity to detail anything else about their experience of the training.

The follow-up questionnaire included 5 additional questions surrounding the ***acceptability of the training*** and ***Champion role***. Champions were asked if they had provided peer support on the project since the training. If Champions had, usefulness of the training was explored via the item 'on a scale of 0-5 (0= not relevant at all, 5=very relevant), how relevant was the training to support you in your role as a Peer Support Champion?'. In regard to the Champion role, items relate to support required and acceptability of the role. Two items were included to assess support required for the role ('do you require any additional support to continue your role as a Peer Support Champion?' ('yes' or 'no'); 'what additional support would you like to continue your role as a Peer Support Champion?'). Acceptability of the Champion role was assessed by asking 'would you recommend becoming a Peer Support Champion to colleagues in the emergency services?' ('definitely yes', 'probably yes', 'probably not', 'definitely not').

3.2 Methodology - analysis

The data were analysed using the statistical software package SPSS. Baseline and follow-up questionnaires included 3 sections each made up of a series of related statements:

- Section 1 had 7 questions related to knowledge and understanding of peer support and the peer support role
- Section 2 had 6 questions related to self-confidence/self-efficacy to be a Peer Support Champion
- Section 3 had 7 questions related to levels of wellbeing.

The end of training (Post) questionnaire included Sections 1 and 2 only. Responses to each statement in Section 1-3 were assigned a value from 1 to 5. For all statements the least positive option scored the lowest and the most positive the highest.

For each participant the response scores were added together to give a total for each section.

- The maximum possible score in section 1 (peer support) was 35 and the minimum was 7.
- The maximum possible score in section 2 (self-confidence) was 30 and the minimum was 6.
- The maximum possible score in section 3 (wellbeing) was 35 and the minimum was 7.

To maximise the use of available data, analyses assessed change separately between baseline and the end of the training (post stage), and between baseline and follow-up. Repeated Measures Anova tests were also used to compare change over all 3 time points (baseline, post and follow-up).

95% confidence intervals of the mean change in the scores from baseline to post stage and baseline to follow-up were calculated. Paired (related samples) t-tests were also used to assess whether there was a statistically significant difference in the mean scale scores from baseline to end of training and follow-up stage. Wilcoxon signed-rank test was also used to examine change in the responses to each individual statement comprising Section 1 on peer support and Section 2 on self-confidence/self-efficacy.

A confidence interval provides an indication of the range within which the true effect is likely to be. The width of a confidence interval is affected by the size of the sample, with smaller samples tending to have larger confidence intervals than bigger ones. A confidence interval of a mean difference that does not pass through 0 is indicative of a statistically significant change.

For clarity, the number of responses on which analyses were calculated is provided (n=). For all inferential tests a p value of 0.05 or less was taken to be statistically significant.

3.3 Data returns

In total, 78 participants provided some data for at least 1 of the 3 stages. Overall:

- 49 participants provided baseline, post and follow-up data

- 22 provided baseline and post data only
- 3 completed baseline only
- 4 provided no baseline data (2 provided post data only and the other 2, post and follow-up data)
- One additional post questionnaire was returned far too late to be included in the analysis

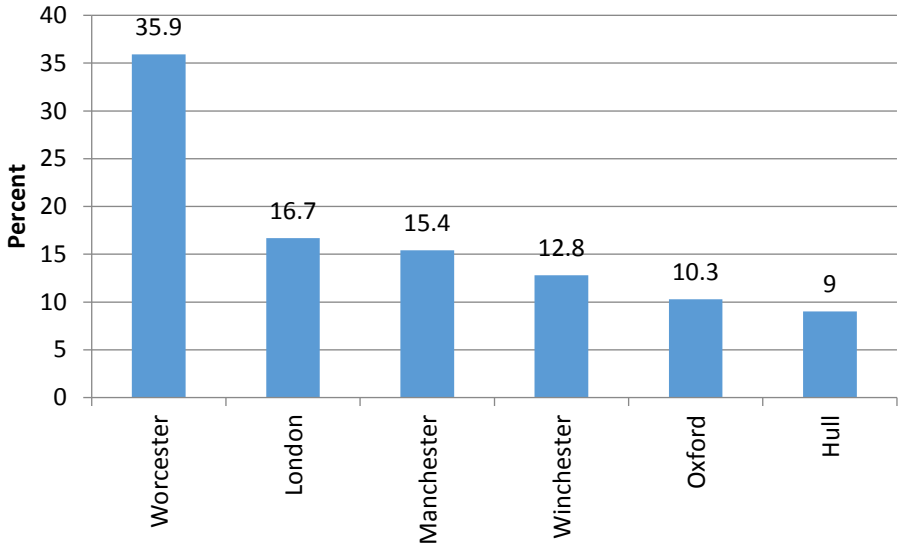
3.4 Demographics

The following demographics relate to the 78 participants for whom some data were returned.

Training location (n=78)

Figure 1 shows the location of training attended by participants. It can be seen that the largest proportion (36%) attended a training day in Worcester (West Mercia). A similar proportion attended in London (17%) and Manchester (15%).

Figure 1: Location of training



Service (n=78)

Participants were asked to indicate for which service they worked or volunteered and the results are showed in Table 1. Approximately three quarters of participants worked or volunteered for the Police service (76%). An equal proportion of individuals worked for the Ambulance & Fire services.

Table 1: Service for which participants worked or volunteered

	Frequency	Percent
Police	59	75.6
Ambulance	9	11.5
Fire	9	11.5
Search & Rescue	1	1.3

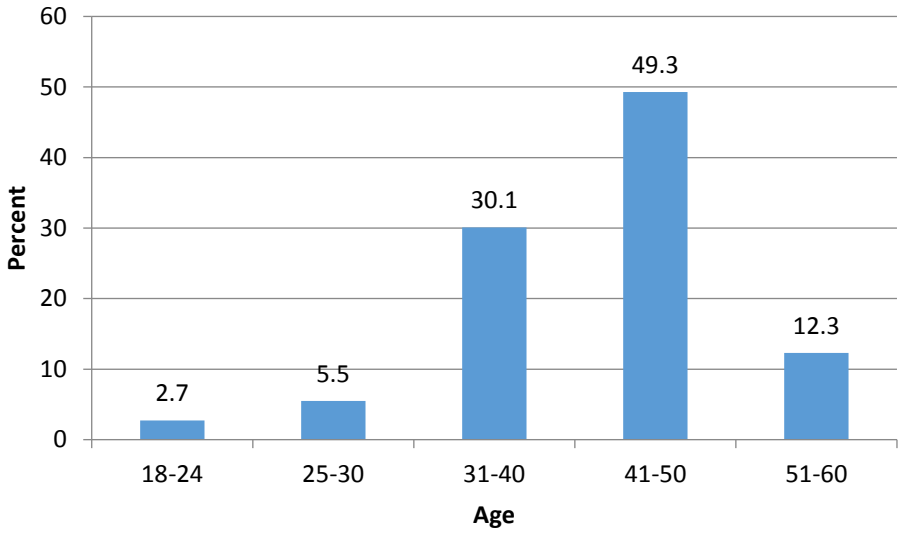
Sex (n=78)

In total, 54% were female and 46% male. Nobody identified as transgender (n=73).

Age (n=73)

Figure 2 shows that almost half of the participants were aged between 41-50 years (49%) and a further 30% were 31-40 years old. Overall, 92% of participants were between 31-60 years old.

Figure 2: Age of participants



Ethnicity (n=72)

In total, just under 92% of participants were White British, and a further 3% White Irish (n=2). Three individuals indicated they were of mixed ethnicity, and 1 was of an Asian background.

Sexuality (n=73)

As showed in Table 2, most participants (85%) identified as heterosexual, and a further 8% were bisexual.

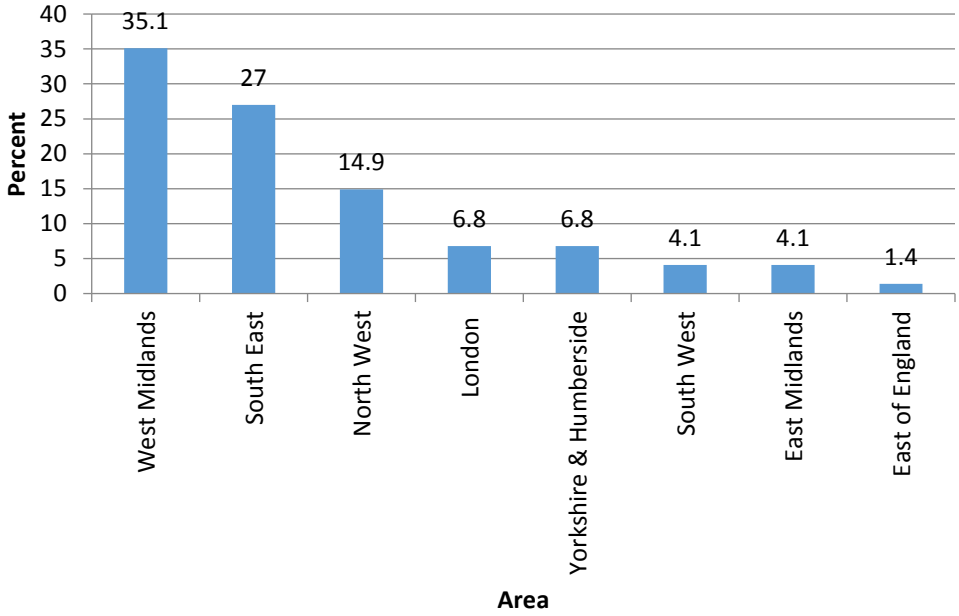
Table 2: Sexuality of participants

	Frequency	Percent
Bisexual	6	8.2
Gay	2	2.7
Heterosexual/straight	62	84.9
Lesbian	1	1.4
Other	2	2.7

Area of residence (n=74)

Participants were asked to state the area in which they lived and the results are shown in Figure 3. The majority of individuals lived in the West Midlands (35%) and the South East (27%).

Figure 3: Area of residence



Experience of mental health problems (n=74)

Participants were also asked to indicate their experience of mental health problems. The analysis revealed that:

- 97% had personal experience of mental health problems
- 61% use or had used mental health services
- 16% use or had used the services of a local mind
- 50% had a family member who has experienced mental health problems
- 66% were a friend to someone who had experienced mental health problems
- 15% cared or looked after someone with mental health problem

(NB: individuals could tick multiple responses)

All participants answered yes to at least one of the options.

3.5 Results - Peer support knowledge & understanding

Table 3, page 6 shows the percentage responses to each of the 7 statements on peer support over time. It can be seen that there was sizeable increase in the percentage of respondents who agreed strongly to each statement from baseline to post stage, and baseline to follow-up. However, the proportion who agreed strongly decreased notably from post stage to follow-up.

Baseline to end of training (post stage)

Table 4 presents the average change in scores from baseline to post stage for participants. It shows statistically significant improvement in peer support knowledge and understanding from baseline to post stage. The size of the improvement was large (d>0.8).

Analyses were also conducted to examine change for males and females, and emergency service separately. For both sexes, there was statistically significant improvement from baseline to end of training for peer support. Similarly, when the data were analysed separately by emergency service, there was statistically significant improvement for all 3 services. In all cases, the size of the improvement was large (d>0.8).

Table 4: the average change in peer support score from baseline to end of the training

	Mean score at baseline (SD)	Mean score at post (SD)	Mean Change (SD)	95% confidence interval	Statistically significant change	
All participants (n=71)	24.86 (3.91)	33.41 (2.47)	8.55 (3.94)	7.617-9.481	✓	t=18.29, df=70, p<0.001
Males (n=33)	24.64 (3.52)	32.91 (2.75)	8.27 (3.48)	7.040-9.505	✓	t=13.67, df=32, p<0.001
Females (n=38)	25.05 (4.26)	33.84 (2.14)	8.79 (4.33)	7.366-10.213	✓	t=12.51, df=37 p<0.001
Police (n=52)	24.10 (3.30)	33.44 (2.48)	9.35 (3.58)	8.349-10.343	✓	t=18.82, df=51 p<0.001
Fire (+ search &rescue) (n=10)	26.20 (4.10)	32.60 (2.59)	6.4 (3.69)	3.76-9.038	✓	t=5.49, df=9, p<0.001
Ambulance (n=9)	27.78 (5.45)	34.11 (2.32)	6.33 (4.82)	2.627-10.04	✓	t=3.94, df=8, P=0.004

Table 3: percentage responses to peer support statements

	Baseline (%) (n=74)					Post training (%) (n=75)					Follow-up (%) (n=49)				
	SA	**A**	**N**	**D**	**SD**	**SA**	**A**	**N**	**D**	**SD**	**SA**	**A**	**N**	**D**	**SD**
I am able to explain what is meant by peer support	8.1	68.9	20.3	2.7	0	81.3	18.7				55.1	44.9			
I am able to describe the benefits of peer support in the workplace	8.1	66.2	23	2.7	0	77.3	22.7				61.2	38.8			
I understand the role of self-management in mental health	28.4	59.5	10.8	1.4		73.3	26.7				61.2	34.7	4.1		
I am able to identify the key skills required of a Peer Support Champion	8.1	36.5	47.3	8.1		73.3	26.7				57.1	38.8	4.1		
I am able to identify a range of support techniques I can use in my role as a Peer Support Champion	4.1	33.8	41.9	20.3		72	26.7	1.3			42.9	49	6		2
I am aware of the boundaries and limits to peer support in the workplace	6.8	27	45.9	20.3		77.3	22.7				57.1	38.8	2		2
I know where to go if I need to access help or support in my role as a Peer Support Champion	8.1	24.3	45.9	18.9	2.7	73.3	26.7				61.2	32.7	2	4.1	

SA=Strongly agree; A=Agree; N=Neutral; D=Disagree; SD=Strongly disagree

Differences in baseline and post responses for individual peer support statements

Participants expressed significantly higher levels of agreement at the end of the course than at baseline for all 7 statements relating to peer support (all p values were <0.001).

Baseline to follow-up stage

Table 5 presents the average change in scores from baseline to follow-up stage for participants. It shows statistically significant improvement in peer support knowledge and understanding from baseline to follow-up. There was statistically significant improvement for both males and females and for members of the Police force. The size of all improvements were large (d>0.8). There was no significant change for the Fire or Ambulance service, but the sample size for both was very small (n=6 & n=5).

Table 5: Average change in peer support score from baseline to follow-up

	Mean score at baseline (SD)	Mean score at follow-up (SD)	Mean Change (SD)	95% confidence interval	Statistically significant change	
All participants (n=47)	24.77 (4.11)	31.62 (3.75)	6.85 (5.15)	5.339-8.363	✓	t=9.12, df=46 p<0.001
Males (n=17)	24.88 (4.09)	31.06 (4.45)	6.18 (6.22)	2.980-9.373	✓	t=4.10, df=16 p=0.001
Females (n=30)	24.70 (4.20)	31.93 (3.33)	7.23 (4.51)	5.55-8.917	✓	t=8.79, df=29 p<0.001
Police (n=36)	23.75 (3.52)	31.64 (3.25	7.89 (4.19)	6.470-9.308	✓	t=11.29, df=35 p<0.001
Fire (+ search &rescue) (n=6)	27.67 (3.72)	29.33 (6.47)	1.66 (7.55)	-6.26-9.59	✗	t=0.54, df=5 p=0.612
Ambulance (n=5)	28.60 (5.32)	34.20 (0.837)	5.6 (5.27)	-0.947-12.147	✗	t=2.38, df=4 p=0.076

Differences in baseline and follow-up responses for individual peer support statements

Participants expressed significantly higher levels of agreement at follow-up than at baseline to all 7 statements related to peer support (all p values <0.001).

3.6 Results - Self-confidence/self-efficacy

Table 6 shows the percentage responses to each of the 6 statements related to self-confidence over time. For all 6 statements a much larger proportion of individuals agreed strongly at both post and follow-up compared to baseline. Between the end of the course and the follow-up point, the proportion who agreed strongly decreased for statements related to confidence in ability to: undertake a peer supporting role in the workplace; use personal experiences to provide support to others; access resources to support others in the peer support role and signpost colleagues to relevant services and organisations.

Table 6: percentage responses to self-confidence statements

	Baseline (%) (n=)					Post training (%) (n=)					Follow-up (%) (n=)				
	SA	**A**	**N**	**D**	**SD**	**SA**	**A**	**N**	**D**	**SD**	**SA**	**A**	**N**	**D**	**SD**
I am confident in my ability to undertake a peer supporting role in the workplace	23.3	60.3	16.4			61.3	36	2.7			51	44.9	4.1		
I am confident in my ability to use my own personal experiences to provide support to others	35.6	61.6	2.7			65.3	33.3	1.3			59.2	40.8			
I am confident in my ability to be an active listener	45.2	52.1	1.4	1.4		73.3	26.7				75.5	24.5			
I am confident in my ability to access resources to support others in my peer support role	20.5	49.3	23.3	6.8		62.7	36	1.3			46.9	44.9	6.1	2	
I am confident in my ability to signpost colleagues to relevant services and organisations	19.2	43.8	30.1	5.5	1.4	57.3	41.3	1.3			53.1	38.8	4.1	4.1	
I am confident in my ability to deal with challenges as a Peer Support Champion	16.4	56.2	26	1.4		46.7	46.7	6.7			46.9	46.9	6.1		

SA=Strongly agree; A=Agree; N=Neutral; D=Disagree; SD=Strongly disagree

Baseline to end of training (post stage)

Table 7 presents the average change in self-confidence score from baseline to post stage for participants. It can be seen that there was statistically significant improvement in self-confidence from baseline to end of training. Furthermore, when analysed separately, there was statistically significant improvement from baseline to end of training for both males and females and all 3 emergency services. The size of all improvements was large (d>0.8).

Table 7: Average change in self-confidence score from baseline to end of training

	Mean score at baseline (SD)	Mean score at post (SD)	Mean Change (SD)	95% confidence interval	Statistically significant change	
All participants (n=70)	24.40 (3.04)	27.61 (2.36)	3.21 (2.72)	2.566-3.862	✓	t=9.89 df=69 p<0.001
Males (n=32)	24.22 (2.66)	27.72 (2.32)	3.50 (2.59)	2.566-4.434	✓	t=7.64 df=31 p<0.001
Females (n=38)	24.55 (3.35)	27.53 (2.41)	2.97 (2.83)	2.042-3.905	✓	t=6.47 df=37 p<0.001
Police (n=52)	24.17 (3.05)	27.50 (2.26)	3.33 (2.70)	2.576-4.078	✓	t=8.89 df=51 p<0.001
Fire (+ search &rescue) (n=9)	24.78 (2.59)	27.78 (3.03)	3 (2.74)	0.895-5.105	✓	t=3.29 df=8 p=0.011
Ambulance (n=9)	25.33 (3.46)	28.11 (2.37)	2.78 (3.07)	0.416-5.140	✓	t=2.71 df=8 p=0.027

Differences in baseline and post responses for individual self-confidence statements

Participants expressed significantly higher levels of agreement at the end of the course than at baseline to all 6 statements relating to self-confidence (all p values <0.001).

Baseline to follow-up stage

Table 8 presents the average change in self-confidence scores from baseline to follow-up stage for participants. It shows statistically significant improvement in self-confidence from baseline to follow-up. Analysis also revealed that there was statistically significant improvement from both males and females and for members of the Police & Ambulance services. The size of all improvements was large (d>0.8). There was no significant change for the Fire service.

Table 8: Average change in self-confidence score from baseline to follow-up

	Mean score at baseline (SD)	Mean score at follow-up (SD)	Mean Change (SD)	95% confidence interval	Statistically significant change	
All participants (n=46)	24.24 (2.88)	27.04 (2.78)	2.8 (2.80)	1.972-3.636	✓	t=6.79, df=45 p<0.001
Males (n=16)	23.88 (2.03)	26.81 (2.88)	2.94 (3.26)	1.203-4.672	✓	t=3.61, df=15 p=0.003
Females (n=30)	24.43 (3.27)	27.17 (2.77)	2.73 (2.59)	1.768-3.699	✓	t=5.79, df=29 p<0.001
Police (n=36)	24.11 (3.03)	26.94 (2.70)	2.83 (2.78)	1.892-3.775	✓	t=6.11, df=35 p<0.001
Fire (+ search &rescue) (n=5)	24 (2.74)	25.40 (3.44)	1.4 (3.13)	-2.487-5.287	✗	t=1, df=4 p=0.374
Ambulance (n=5)	25.40 (1.95)	29.40 (0.89)	4 (2.55)	0.834-7.166	✓	t=3.51, df=4 p=0.025

Differences in baseline and follow-up responses for individual self-confidence statements

Participants expressed significantly higher levels of agreement at follow-up than at baseline to all 6 statements relating to self-confidence (all p values <0.001).

3.7 Results - Wellbeing

Participants completed 7 questions related to wellbeing at baseline and follow-up stage. Analysis revealed there to be no statistically significant change in wellbeing from baseline to follow-up. The findings also showed that there was no statistically significant change in wellbeing score for either sex (see Table 9).

Table 9: Average change in wellbeing scores from baseline to follow-up

	Mean score at baseline (SD)	Mean score at follow-up (SD)	Mean Change (SD)	95% confidence interval	Statistically significant change	
All participants (n=46)	26.98 (SD=3.57)	26.93 (SD=3.93)	-0.05 (3.01)	-0.938 to 0.851	✗	t=-0.98 df=45 p=0.92
Males only (n=16)	27.19 (SD=3.71)	27.50 (SD=4.63)	0.31 (3.50)	-1.551 to 2.176	✗	t=0.36 df=15 p=0.73
Females only (n=30)	26.87 (SD=3.55)	26.63 (SD=3.55)	-0.23 (2.76)	-1.265 to 0.798	✗	t=-0.46 df=29 p=0.65

3.8 Repeated measures analysis

a) Peer support knowledge and understanding

Analysis revealed there to be a significant change in peer support knowledge and understanding over the 3 time points (see Table 10). Post hoc tests using Bonferroni correction found that scores at both post stage and follow-up were significantly higher than at baseline (baseline vs post stage, mean improvement =8.89 ;

and baseline versus follow-up, mean improvement =6.85, p<0.001). However, peer support scores at follow-up were significantly lower than at post stage (mean difference=-2.04, p=0.001).

For both males and females there was statistically significant change over time, with scores at both post stage and follow-up being significantly higher than at baseline:

- Female baseline vs post stage, mean improvement =9.33, p<0.001; baseline versus follow-up, mean improvement =7.23, p<0.001.
- Male baseline vs post stage, mean improvement =8.12, p<0.001; and baseline versus follow-up, mean improvement =6.18, p<0.001).

Mean peer support score was significantly lower at follow-up than post in females (mean difference= 2.10, p=0.005). In males, mean peer support score was also lower at follow-up than at the post stage, but the difference (-1.94) was not statistically significant (p=0.245).

Table 10: Average peer support score over time

	Mean score Baseline (SD)	Mean score post (SD)	Mean score follow-up (SD)	F (df)	Sig P
All participants (n=47)	24.77 (4.11)	33.66 (2.38)	31.62 (3.75)	107.35 (1.71)*	<0.001
Males (n=17)	24.88 (4.09)	33 (3.12)	31.06 (4.45)	25.17 (1.48)*	<0.001
Females (n=30)	24.70 (4.20)	34.03 (1.79)	31.93 (3.33)	87.59 (2)	<0.001

*degrees of freedom were adjusted using Greenhouse-Geisser estimates of sphericity

b) Self-confidence/self-efficacy

Analysis revealed there to be a significant change in self-confidence over the 3 time points (see Table 11). Scores at both post stage and follow-up were significantly higher than at baseline (baseline vs post stage, mean improvement =3.39, p<0.001 and baseline versus follow-up, mean improvement =2.80, p<0.001). There was no significant change between post stage and follow-up (p=0.38).

For both males and females there was statistically significant change over time. Scores at both post stage and follow-up were significantly higher than at baseline:

- Female baseline vs post stage, mean improvement =3.37, p<0.001; baseline versus follow-up, mean improvement =2.73, p<0.001.
- Male baseline vs post stage, mean improvement =3.44, p<0.001; and baseline versus follow-up, mean improvement =2.94, p=0.008).

There was no significant change between post stage and follow-up for either sex (Female mean change=-0.63, p=0.372; Male mean change = -0.50, p=1.0).

Table 11: Average self-confidence score over time

	Mean score baseline (SD)	Mean score post (SD)	Mean score follow-up (SD)	F (df)	Sig P
All participants (n=46)	24.24 (2.88)	27.63 (2.29)	27.04 (2.78)	42.62 (2)	<0.001
Males (n=16)	23.88 (2.03)	27.31 (2.58)	26.81 (2.88)	12.21 (2)	<0.001
Females (n=30)	24.43 (3.27)	27.80 (2.16)	27.17 (2.77)	30.39 (2)	<0.001

3.9 Acceptability of the training

Meet expectations (n=71)

Out of the 71 participants who provided a response, 59 (83%) indicated that the training met their expectations 'In full'. A further 11 (16%) felt their expectations had been met 'in part'. One person responded 'Not at all'. This person provided additional comment to explain their response. They wrote

"I expected it to be a rundown of what to do but found it not in place yet at all for our organisation".

Usefulness of training (n=71)

Overall (99%) of participants found the training 'Very useful' (85%) or 'Useful (14%). One person thought the training was 'Not at all useful'. They wrote.

"I get the concept but it put more questions in place than answers to be honest as it is more like mental health awareness and I've done mental health first aid training"

Length of training (n=71)

A large proportion believed that the length of training was 'About right' (83%). Nine individuals (13%) thought the training was 'Too long'. Conversely, 3 individuals didn't think it was long enough.

Information given during the training (n=70)

In total, 97% of participants thought the amount of information given during training was 'About right'. One person said 'Too much' and another 'Too little'.

Recommend training to others (n=71)

Participants were asked if they would recommend the training to their colleagues wanting to be a Peer Support Champion. In total, 82% said 'Definitely yes', and 18% 'Probably yes'.

Like most about training

The opportunity to ***meet***, ***interact*** and ***network*** with other individuals from the emergency services was often mentioned, as was the sharing of ***experiences***, ideas and stories. The use of a range of learning activities was appreciated. Participants often commented on the interactive nature of the training, and the group activities/discussions. A number of comments referred to groups having positive discussions that were open and honest. Several mentioned ***active listening skills***, and the ***case studies*** were described by one participant as a "good knowledge check".

The training was largely described as ***well-structured*** and presented, informative and conducted in a relaxed atmosphere. The relaxed atmosphere was considered to have helped participants open up and share experiences. Specific areas of learning were also mentioned such as gaining an improved ***knowledge*** of the role, the responsibilities and boundaries, how to implement peer support, engage with others, and learning what resources are available to support the role. Several participants spoke of gaining more ***confidence*** to offer peer support as a result of the training.

Like least about training

Several participants simply wrote "nothing" when asked what they liked least about the training. Some felt the day was long, with lots to cover in a short length of time. One thought that some of the content felt a bit rushed, and another felt there was quite a lot of repetition. A couple of individuals mentioned the long distance they had to travel to get to the training.

Some didn't feel the training fully met their expectations. One person wanted it to be more like *"this is how it'll work, this is who to expect to speak to. This is where to signpost…"*. In addition, a participant who worked for the Ambulance service did not believe all outcomes were relevant for that organisation and there was a suggestion that better knowledge of emergency service culture was needed by trainers. It was also reported that 2 Fire services personnel at one of the training days were unaware they were the only employees being trained for the whole of the county.

In terms of specific aspects of training, a couple of people disliked the role-play element/role-play based scenarios, and a few mentioned that they liked sharing (personal) experiences the least. It was suggested that there was some ambiguity over the scenarios and what constitutes peer support. In one group, active listening scenarios were apparently not conducted due to small numbers.

A small number of individuals on one course mentioned issues related to the room where training was conducted. It was described as: cold, windowless, with uncomfortable seats.

Improving training

Participants were asked to offer suggestions on how training could be improved. The most common response was to suggest that the training was ***fine*** and no changes were necessary. A few suggested that the training could be spread over 2 days. One suggested that this would allow longer for discussion. However, another suggestion was that the training could be shortened to half a day. Having more training ***locally*** to cut down on the distance travelled was mentioned, as was altering the timing of the training so that it was held after ***support structures*** were put in place in organisations. There was a suggestion that training could be made more ***bespoke to organisations*** based on their HR policies/occupational health policies, and that there was a need for ***managers*** from each service to attend the training. One person thought that a second trainer would be useful to assist with the group work. Having trainers with personal experience of working in the emergency service environment was suggested. Other suggestions included: more videos; less reliant on slides; more case studies; faster pace; a workbook to be given before attending; a mental health expert to give a short presentation.

Any other comments about training

Participants were given the opportunity to add further comment about their experience of the training. ***Numerous individuals wrote positively*** about the training, and expressed their enjoyment. Others described it as: “excellent”, “brilliant”, “very useful”, “informative”, and “well presented”. The opportunity to network with other emergency services was also appreciated. There was a suggestion it should be provided to all staff and one person would have liked to have received a certificate of attendance. Additional positive comments were also given about the trainer, described as personable, professional, positive and enthusiastic.

Training was also described as “intense” by one person while another felt a bit of “a drift”. There was a suggestion that it was not focused sufficiently on the emergency services. Several individuals raised questions about the extent to which their ***organisation would support the role*** in practice.

Role as a Peer Support Champion (n=49)

Out of the 49 participants who provided follow-up data, 30 (61%) indicated they had provided peer support to others in the workplace. There was no significant difference in the proportion of males and females who had provided peer support (X^2=0.965, df=1, p=0.326). In total, 67% of females had provided peer support compared to 53% of males.

Relevance of training to support the Peer Support Champion role (n=30)

Those who had provided peer support in the workplace were asked to indicate on a scale of 0-5, how relevant the training was in supporting them in the role of Peer Support Champion, where 0 was ‘not relevant at all’ and 5 ‘very relevant’. Overall, the median rating was 4, with the highest rating being 5 and the lowest was 2. There was no significant difference in the rating of males or females (U=98.0, p=0.924).

Additional support for the Peer Support Champion (n=49)

Overall, 29% indicated that they required ***additional support*** to continue in the Peer Support Champion role.

The 14 individuals who indicated they would like additional support were asked to give further details about the type of support they would like.

Several individuals mentioned information needs including having better ***resources*** available to support the Peer Support Champion role. One suggested having a directory of support services, website or telephone

number that can support the role. There was uncertainty expressed about who to contact for additional support. One person suggested having a designated person at Mind who Champions could contact directly for any support or information they might need in their role. Better information around the signposting of individuals who Champions are supporting was further suggested. The idea of having “quick guides to peer support” that could be used to encourage others in the emergency services to become peer supporters was mentioned. Having an app. through which to access support was also suggested.

Additional ***training*** was mentioned by several participants along with opportunities to network with other Peer Champions, and provide each other with support: “*ongoing Peer Support for the peer supporter*”. Improved organisational support and recognition of role from the emergency services, including from Chief Officers, was highlighted.

Recommend the Peer Support Champion role to colleagues (n=49)

Nearly three quarters of participants (74%) would definitely recommend becoming a Peer Support Champion to colleagues in the emergency services. The remaining 26% would probably recommend the role. There was no significant difference between males and females in the likelihood they would recommend the role (U=261.5, p=0.528).

4 Interview Findings

Key messages from interviews (1) – Training expectations and delivery

- **Motivating factors** for participants to attend included personal mental health experience and a desire to share learning from these experiences to help and support others
- **The Peer Support Champion role** was understood as involving supporting people and helping to identify early indicators of mental health problems. A crucial role is to signpost people to help and information
- **Mental health experience** was identified as helping Peer Support Champions to empathise and relate
- **Expectations** of training included: to gain a deeper understanding of what the role entailed; to gain clarity about the extent and boundaries of the role; to learn when it was appropriate to 'escalate' a problem or seek professional help; to interact with others with similar experiences; to obtain practical guidelines
- **The training content** was valued for the resources it provided; for stimulating discussion around good practice in supporting people, rather than for providing clinical information
- **The trainer** was praised for her facilitation skills, being professional, managing the emotions of the group, being flexible, and helping everyone to feel 'at ease' in a relaxed environment
- There was a **fair balance** between PowerPoint and varied group activities, **'a good mixture'** of methods
- **Scenarios** were highlighted as very valuable, as context- and practice-focused aspects
- **Group training and exercises** provided an opportunity for people with individual but comparable, challenging experiences to share perspectives
- **Multi-service training** worked well, except if one service tended to dominate. A comparative focus on cultures, implementation issues, and ways of working across organisations provided insights
- Participants shared **uncertainties** about how the programme would be **implemented** in their workplaces
- **Listening to others' experiences** and speaking with the trainer, enabled some to gain clarification about the role
- The role involved **active listening**, providing **support and signposting**, and some **positive reinforcement**
- Participants were able to **network** and make contacts with other peer supporters
- **Ownership** of training was important, which involves participants drawing on their lived experience and their organisational contexts, exploring similarities and differences
- Training increased many participants' **confidence**, through recognising shared experience, with the scenarios viewed as building confidence to apply the role in practice. The main barrier to confidence was uncertainty that services would support peer support
- Training was perceived to have enhanced **some** participants' **wellbeing**; through strengthening identity; shared experience; and feeling better equipped for the role
- **Outstanding** aspects of training included a focus on 'soft skills'; the group experience, networking, take-away resources, and gaining legitimacy

Key Messages from Interviews (2) – Implementing in organisations

- **Training should be extended** more widely, its scope modified beyond one-to-one support to supporting others to become Peer Support Champions, guided by those with experience. Clear guidance over competencies and referral is needed
- The **different services** were organisationally and culturally distinct, but **common factors** include the **complexity** of operations and staff roles; **resource constraints** and **structural pressures** conducive to **raised stress**; organisational **hierarchies** and **rules** to be dealt with
- **Barriers and enablers to implementing** peer support are context-dependent, varying by service. Common themes include: need for **senior leadership** advocacy, and an **organisational framework** with input from Peer Support Champions, endorsed through the organisational hierarchy; potential for **'internal' context-specific training** events with health professional input to materials and key roles involved; e.g. managers, HR; needs for: making the **role legitimate**, joined-up; expanding **support networks**; evidencing a business case
- **Managers** are vital to the success of peer support. Some might need to be 'empowered' to provide effective support for the role
- **Organisational culture** was said to be a key challenge for implementation. The cultural setting was woven in with (unspoken) rules for social behaviour, and (written) rules for action. There were cultural distances between the management and front-line. It was recognised that organisational cultural change is not fast; 'managed' change is mandatory
- **Stigma** around mental health, linked to attitudes about 'absenteeism', and fitness for work, was a major organisational cultural barrier to front-line staff engaging with Peer Support Champions
- **Gendered practices** influence how the peer support role can work in 'masculine' organisational cultures. People with mental health experiences were reflective about the interaction between gender and organisational cultures in deterring talk about vulnerability
- Proposals for **spreading peer support** through organisations focused on internal training; connecting with the wider Blue Light Champions; drawing in less 'experienced' (around mental health) people; including key senior roles; validating the role
- The **potential vulnerability of Peer Support Champions** with mental health experience, adding this role to their workload, is an important risk. Organisations need systems of risk assessment, and of peer, management and resource support for the Peer Support Champion
- **Ongoing support needs**, to be developed within organisations, include networking within and across services; refresher events; lines of accountability within organisational structures.
- **Clarifying the Peer Support Champion role** within the organisation involves identifying boundaries; resolving relationships with other health roles; publicising the role
- The need to develop **peer support capacity** and address **resources issues** is paramount.
- Providing peer support on the **front-line** involves managing **competing real-time pressures**, such as divided attention, demand overload, issues of control, and lack of privacy. A (possibly gendered) issue is that it is a real challenge to provide peer support, with the emotional work this involves, around front-line work duties
- For **sustaining the programme**, key themes include: having **committed advocates** within organisations; **senior management support** to promote structural and cultural change; further **training** within organisations; formalising **policy**; peer **support** for peer supporters; attention to resource requirements; **line managers'** support; **wider networking**; **liaison** between regional forces; **evidence** of effectiveness. **Mental health-promoting organisational settings** have to be developed if individuals are to support peers effectively

4.1 Introduction

Interviews were held with 13 participants on the training programme. These participants had taken part in training courses in four regions (Oxford, London, Manchester, and Winchester), and the interviews were conducted over the weeks after completion of the courses, face-to-face during visits to three of the regions (Oxford, London, Manchester), and by telephone. Six participants belonged to the Police service, four to the Fire service, and three to the Ambulance service (see Appendix 2). Nine men were interviewed and four women. The interviews with participating individuals were conducted using a semi-structured interview schedule (Appendix 4). This schedule asked individuals about how they became involved; their expectations; their experience of the training programme; what they learned; how prepared they felt for practice; any impacts on their confidence and wellbeing; barriers and enablers to putting training into practice in the workplace; support for the role in the workplace. All interviews were digitally recorded, transcribed and analysed thematically by the research team.[1]

4.2 Motivations for taking part and expectations for training

Motivations

For most participants having personal mental health experience was a motivating factor for attending the training. Participants expressed a desire to share their learning from these experiences to help and support others who may be experiencing mental health problems.

> *Myself and* [name] *have had mental health problems. So… I wanted to give something back. I thought I'm going to … be there for someone who might need a bit of help* (F4)

> *It's supporting others, slightly selfish - if we do good things, we feel good and you can never have too much self-esteem* (P2)

Some participants had previously received training around mental health and had experiences of being a Champion. Some had informal roles where they 'chat' about mental health with their colleagues.

> *Becoming a Blue Light Champion was the same as being a Time to Change Champion only it involved the emergency service, it was more specific to my own employment role* (A1)

Expectations

Participants had varying expectations of the training. Some wanted to gain a deeper understanding of what the peer support role entailed. Others wanted clarity about the extent and the boundaries of the role; how to signpost people for further help; when it was necessary to 'escalate' a problem or seek professional help. Many hoped to interact with others with similar experiences: 'like-minded people'. A resounding theme emerged of wanting guidelines around how to deliver the role.

> *I think what I wanted to get out of it was a better knowledge of, say when I do become a peer supporter, how to sign post people and things to look out for* (F2)

[1] Codes appearing after the quotes in this section identify the service the participant works within, followed by a number for each participant. Codes (A1-3) indicate Ambulance service participants, codes (P1-6) indicate Police service participants, codes (F1-4) indicate Fire service participants.

> *For me it was about interacting with like-minded people, so other people who were keen to support. To share our stories and then get some help from MIND on how we could be peer supporters really and some guidelines* (P5)

One participant explained that she expected the training to help her clarify whether being a Peer Support Champion is appropriate to her work role. A key expectation was that the training would provide practical information about how the programme could be delivered within different organisations.

> *I can be a bit of a pragmatist* […] *how is this going to be delivered so that I can manage it and fit to my existing role and other bits and pieces* (P2)

4.3 Recruitment

Participants found out about the training through a variety of different sources. Some were recruited internally through adverts and posters in their workplace. Two participants were approached by their manager and asked to take part. Others heard about it through other courses such as the MIND Resilience course, while some contacted MIND directly and were signposted to the training.

> *When it initially started up it was advertised on our internal internet and I was quite interested in it anyway I'd done the mental health awareness course* (F2)

> *My manager pushed us to go, because he had heard about it and he is interested in that sort of thing. He thought myself and my mate would be the candidates to carry it through with the little bit of history that we have got* (F3)

> *I've done various bits of training through MIND … and they were always looking for volunteers…mental health is always something that's interested or intrigued me* (P5)

4.4 Understandings of the role

It was highlighted that the Peer Support Champion role could be interpreted differently within different organisations. The role was described as helping others in need and working with other Blue Light Champions. The Peer Support Champion role is to support people and help to identify early indicators of mental health problems. A crucial aspect is to signpost people to access help and information. However, the role of Peer Support Champions was not to give clinical advice as they are not trained professionals.

> *I think the Champions is more about those early indicators* (P5)

> *I will be helping people* […] *the supporter is exactly that, there to support* (F2)

> *We are only signposting people, we are not giving any advice or professional opinion, because we are not professionals at the end of it* (F3)

One participant emphasised that, depending on the level of involvement participants wanted, the overall 'Champion' role could be separated into two roles. The 'peer support role', which could involve face-to-face or telephone support or support through social media, provided on a one-to-one basis, is not suitable for all. A wider 'Champion role' would consist of more promotional and administrative functions; raising awareness, maintaining media bulletins and notice boards, and monitoring mental health. Participants discussed how the peer support role should be delivered, and considered that different methods are needed to suit the needs of the person accessing support.

> *Peer support might be better for some people, some people might not want face-to-face, might be the last thing they want to do. Some people might want a question and answer session on the intranet…you know as they can fire a questionnaire and get a response back and you know that might be much better, much more beneficial to that person simply because they wouldn't put themselves in that environment* (P3)

When delivering the role of a Peer Support Champion, mental health experience was considered advantageous, as it can help Champions to empathise and relate better.

> *I don't think there is any point being a peer supporter if you haven't been there and done it…how can somebody support you if they haven't been through the same scenario?* (P1)

> *I think it makes me better at my job* […] *from my own lived experience I know what it's like to be in that situation and* […] *feel those feelings so I really empathise with people* (A1)

4.5 Training content

The training provided many resources that participants could take away and refer back to.

> *There were quite a lot of agencies and there were handy hand-outs that have lots of signposting to different agencies and support resources, which is great* (P2)

The training content stimulated discussion around the boundaries of the role and confidentiality issues. It gave an overview of what peer support is, and how to support someone with mental health problems, rather than a typology or clinical guidance.

> *I think other training that we have done around mental health...it was more identifying types of mental illness and being aware of them. This was more based on how to support somebody with mental illness* (F2)

In contrast, one participant would have liked the training to be more in-depth concerning different types of mental illness and how to handle different scenarios, and it was suggested a wider range of information could be delivered, and that one day was not long enough.

> *You could start off with depression and PTSD and anxiety and give a little outline of each, I know my Living With Trauma Days* [training] *that I've done and it has been invaluable because that covers those specific topics* (A1)

4.6 Training process

The trainer was praised for her facilitation skills, being professional, managing the emotions of the group, and helping everyone to feel 'at ease' in a relaxed environment.

> *I felt she was very friendly, very able to listen and compassionate* (F1)

> *Everyone was passionate about what they did and had been through or wanted to set up. So a less experienced facilitator would have maybe lost it, so* [name of trainer] *was able to control that in some sense* (P3)

Scenarios were highlighted as among the most valuable aspects of the training, as they provided an opportunity to think about how the training would be translated into delivery of the peer support role. They were cited as 'practical' and a 'useful' method to explore the boundaries of the role. Scenarios encouraged interaction and provided a good platform to stimulate debate. However, a small number of participants became uncomfortable with the

dynamics of using scenarios, and it was then important the facilitator was flexible, and changed to a different approach.

> *If you're having actual interaction with other people you're getting other people's input,… like those scenario cards sparked our own debate about boundaries* (A1)

> *There were certain members of the group that weren't overly comfortable with doing scenarios. So they got missed out. But there was a heck of a lot of discussions and it was good to hear everyone's different views of what is peer support* (P1)

The dynamics of the group training and exercises provided an opportunity for people with individual but comparable, challenging experiences to share their perspectives in an environment that they trusted, a safe space.

> *We had mental illnesses but there was nothing to be ashamed of or anything. It was good to talk to other people who have been through similar things and totally different things, to get a different perspective on things* (F4)

> *So there was an open atmosphere if you like. People shared some very difficult things and there was no concern about whether it would go outside of the walls* (P4)

Some participants commented that they feel 'more relaxed and at ease when talking in a group'. Group exercises provided a welcomed contrast to a more didactic PowerPoint-based teaching style. Most participants stated there was a fair balance between PowerPoint and varied group activities, 'a good mixture' of methods. A small proportion of participants asserted that the training was slightly PowerPoint-focused, but also acknowledged that this can be inevitable as key messages need to be communicated.

> *We wasn't staring at PowerPoint all day. We did sticky labels on the walls as well* (F2)

> *Little bit PowerPoint but that's the effective way to get key messages along. A good mixture of methods. There was a good mixture of, front of class, heads up, PowerPoint, group discussion, group exercises, breakout groups and breakup work* (P2)

It was clear that including participants from across agencies was valuable, as it provided a platform for people from distinct services to share opinions and experiences, and be challenged by differences, rather than always voicing agreement. A comparative focus on distinct cultures and conditions provided insights into positive alternatives, and persistent challenges, and revealed a common interest in progressing mental health agendas.

> *It's nice to have common ground and know it's not just the Police struggling with this …It's nice to hear there are other services going 'it's not just you it's the same for us', and then sharing those pockets of good practice* (P4)

> *Maybe a few more Fire service would have been helpful. …It was mostly Police.. that was almost agreeing with each other* (P1)

> *One thing I took from it is how different the Fire is to the Police and the Ambulance…for things like mental health we do have structure we do have a bit of support there* (A3)

With courses that were delivered mainly to participants from one service, it was said that participants may be pre-occupied by obstacles in the service rather than the peer support role.

> *So we were complaining about our processes more than anything, where I think if you've got outside people you are sharing that, or 'have you tried this and that'*

whereas we got ourselves stuck in a bit of cycle of 'oh we are bound by these processes' (P5)

4.7 Learning on the day

It was said that on the day participants shared a 'common uncertainty' around how the programme would be implemented in their workplaces. The programme had not been fully developed in many organisations, so there seemed no gold standard model to follow.

> *The common ground was probably around the uncertainty, the doubt how do I do this, what's MIND's role in informing and designing how* [Far South] *Police or the* [Urban] *Police or Fire service are going to roll this out* (P2)

Many participants were unaware of the amount of support available for people experiencing mental health problems. The training highlighted the varied sources of information and resources that can be passed on to people.

> *It's opened my eyes to how much there is out there for people, places they can turn to* (F4)

The training provided an opportunity for participants to listen to the experiences of others and to speak with the trainer, which enabled some to gain clarification they were delivering the role appropriately. Many participants suggested that they had learnt about the boundaries within the role, focusing on confidentiality, levels of responsibility and their own wellbeing. These practical skills could be transferred into the wider working environment.

> *Protecting yourself from taking on too much, promising the earth, thinking you're a counsellor when you're not, that was stuff that was really helpful to me* (P3)

Participants learned that the scope of the role involved vital aspects such as active listening, supporting and signposting, and that the process could also involve reinforcing positive factors; making people aware of their strengths and abilities, and not focusing on negatives.

> *I didn't expect that we're highlighting people's positives and what they're good at rather than just listening* (P1)

The multi-agency training provided a further opportunity to share understandings, for example about de-briefing, and discuss implementation issues between the different organisations.

> *We talked about the Samaritans model where you know the volunteers before they go off shift, they've been talking to people on the telephone, they will de-brief with the shift supervisor. We talked about that might work* [for the Peer Support Champions] (P3)

Participants were able to network and make contacts with other peer supporters. In the future, one participant wanted to see a multi-agency peer support network that could provide support to peer supporters and share innovative ideas.

> *Sharing email addresses, that's going to really help us in the future because I think we can try and galvanise something into a multi-agency peer support network* (P3)

4.8 Ownership of the training process

It was reported as vital that the training process supported people to draw on their own experience, and their organisational context, so taking ownership of learning. Each person held a particular formal organisational role, and had unique personal experiences, including

mental health experiences, affecting their interpretation of peer support and their likely practice. Participants, it was said, drew on personal experiences in thinking about problems and scenarios. This brings out the importance of developing the role in a personal way. For example, discussion of setting boundaries to practice made participants think about their own limits in the light of their recovery. There was reflection about bringing personal experience into play during contacts, to establish common ground.

> *I do sometimes admit to people and say 'a few years ago I had a* [mental health episode]*, I was in exactly the same position as you and I know you don't feel like it, but you'll get there'. I've had quite a good reaction from that* (A1)

> *That's where the personal experiences were coming out because as we were asking a certain question, we're going back to how we experienced it, which we found useful, because, it was asked how would you deal with this particular problem and I said that each one of us being individuals would deal with it differently* (A2)

Ownership also meant considering organisational, cultural factors in discussions.

> *It worked really well, lots of discussions, feeding back, and I think that's the only way it could have worked with the cultural difficulties. And I think that feedback probably was useful to Mind* (P4)

Coming from different organisations apparently also helped participants to own the training, by comparing the organisational contexts influencing their experience. Rearrangements of groups during the day helped this process. Training involving different organisations showed where practice was more advanced in one service than another. This was considered important where the trajectory of an organisation (e.g. Fire service) in some regions was towards greater collaboration with another service (e.g. Police).

> *It was good to talk to other people who have been through similar things and totally different things, to get a different perspective on things* (F4)

> *Obviously the Police are miles ahead than us on stuff like that [mental health] and it's good to see what they do… they are taking it seriously…a guy from* [H] *Police…, he's invited us to some further training we're going to go on because we don't have anything like that …we are altogether now down here, the Police and the Fire are merged more or less* (F4).

4.9 Impacts of training

Impact on confidence to carry out peer support

Most interviewed participants said that the programme had increased their confidence in taking on a Peer Support Champion role. It was said that one aspect of confidence is recognising individual experience, and not attempting to be the expert on everyone's experience. For participants with previous involvement in the Blue Light programme, or in Time to Change, confidence had been growing, so the course allowed them to continue building on experience through participation and training. For some, this process coincided with recovery time, which allows confidence to grow.

> *It's allowed me to come alongside people and understand from my own experience and theirs. It's also made me understand that you're not an expert in what they're going through, that they're the expert* (P3)

> *My confidence has grown and of course, as your recovery time grows things become easier to talk about. I think before the peer support training I was already confident*

enough to speak to people, but the actual training that Mind has given me has been absolutely brilliant and has encouraged me and given me confidence (A1)

A challenge to some participants' confidence came as they worried that mental health support was not really embedded in the organisation. Anxiety that the peer support programme was not strongly impacting on or legitimized by the wider organisation might deter the trained Peer Support Champion from active engagement.

I don't know really where I am, I'm not sure how much I can do. I certainly would like to promote myself that I've done the peer support program, but I don't know how well it will go down with the service at the moment. Apparently it hasn't been rolled out … I've not actively put myself forward and said this is what I would like to do and this is who I am (P1)

Confidence came from drawing legitimacy from having done training, having met others who identify with the role, and having considered the boundaries.

I think I would be able to do peer support, so I wouldn't become their counsellor but I can say though I don't understand that particularly well, this is my experience of it (F1)

Now that people know I've been on this course, they would understand that is more than just passing the time of day (F3)

Knowing that these supporters are helping. So, that's what I got out of the course, and I now know that when we get it up and running I will be helping people (F2)

Scenarios were seen as especially confidence-building, as they encouraged participants to consider how peer support would work in practice situations.

At the end of the scenario 'woo this has gone really really', it covered every aspect of what you could be called upon to do as a peer supporter. So that was good us doing the scenarios. We split up, one was a listener, one was a talker, and one took notes. …Confidence comes with practice, keeping on top of it and keeping doing it. By doing the first one, even though we knew it was only practicing, it does give you more confidence to keep doing it (F2)

Impact on feelings of wellbeing

Some participants reported that the training had been good for their wellbeing. This occurred through feeling their identity was enhanced; being among others with experience; and feeling better equipped to do the role.

Yeah it has. When I came back I was buzzing from it at first. I thought I really want to get out and do this now (F2)

One aspect of enhancing wellbeing concerns identity: communicating with others about mental health experience, and having been on the course were seen as altering others' perceptions positively in regard to self. Another aspect was 'being among friends' with mental health experience who are coping and progressing, and sharing thoughts and feelings.

It already changes a bit of identity because I've been on these courses. An email I sent round I put in a bit of my past experience of mental health, I think it opened a few people's eyes (P1)

It's always good to be amongst other people who had similar experiences and are in…, a form of recovery. So yeah, it's good to be amongst friends (P2)

> *You know those negative things that kind of intrude, actually then seeing other people and how we get through as best we can. That is really empowering, really helpful just to see that you're not the only person* (P3)

Wellbeing was enhanced where participants felt better equipped for the role; learning skills and developing safe practice increased security. It felt good to share a process bringing change for others.

> *I felt like I've got extra skills and it's in a safe area. I feel a bit more secure now when I speak to people because at least I've done some training* (A3)

> *Set out down the line to change things, and this validates that there is change coming, not to me, but I've been part of that and that's ticked a lot of boxes for me: people are now speaking about mental health in the emergency services* (A3)

A small number of participants said that the programme did not impact positively on their wellbeing. Reasons for this concerned the work environment: its unpredictability; resource challenges; cultural and structural barriers, and stressors. There was a view, from a Fire service participant, that the impact of training on wellbeing was limited by a middle-management culture which indirectly endorsed people not treating the role seriously.

> *No, it hasn't* [impacted on wellbeing]*. I think work is work and things happen unexpectedly which rocks the apple cart, and that's where everything is running smoothly and all of a sudden something happens, and unfortunately recently one of the big contributory factors is that on our team we've had quite a few who've left and have not been replaced* (A2)

> *It was a bit of a joke at first…but on our Watch they know we are Champions... The governor has been good,… but it's just above tha*t [the problem] (F4).

4.10 Key factors for success

Outstanding features

Considering the training event, participants identified outstanding aspects: including a focus on 'soft skills'; the group experience, networking, take-away resources, and gaining legitimacy as a trained peer supporter. The focus on active listening, turning negative conversation into something positive and setting boundaries was said to be very valuable.

> *For me it was the active listening. Because I'm used to listening to 2 things at once* (P1)

> *And the soft skills, like the stuff on listening, and turning a negative conversation into something a little bit more uplifting* (P3)

Group interaction was highly beneficial. Sharing a day with peers from other services and building contacts was valued. Common ground was noted: e.g. cuts, workloads and changing roles leading to greater stresses.

> *The best feature is that whole day together really. It's a commonality with other public authorities, other people trying to do the same thing* (P2)

> *Getting together in groups and talking was like on the job training, actually doing it* (F2)

> *Creating this network of people not just within* [regional service] *but other services around us who we're now starting to see on a more regular basis…having the same issues as we were because …cutbacks and workload has increased* (A2)

> *Would say that interagency and liaison is the most important feature. We do have different problems. …but that's the most important thing. Having those little connections, meeting the people that are inviting us to go there* (F3)

Handouts and a website section to review resources later on were also found to be very useful.

> *Yes, I've read the resource pack a few times. I like to get it firmly in my head* (F2)

> *Putting Mind's stamp on doing peer support so I can now go back to work* (F1)

Suggested innovations

It was suggested that the reach and scope of training could be extended more widely, to include a focus on supporting Blue Light Champions or others to become Peer Support Champions, with mentoring from those with experience. This would improve coverage, while clear guidance over competencies and referral was needed.

> *Is there a way that the knowledge and skills from this course can be delivered other than people that have been on the course like me, and try and train others* (P3)

> *Only eighty people in England or… yeah its crazy, that's not enough* (F3)

More training, it was said, needs to be provided centrally within services, during working hours. This will be discussed in later sections.

> *If you approach the brigade and say we can offer this training you could almost offer it out to the service and get people who aren't former sufferers, who work in this field anyway, I think that would be of big importance* (F1)

Training and development of peer support, it was said, needs to take full account of budget cuts and changing working conditions, as well as of potentially traumatic emergency situations.

4.11 Implementation of learning: Challenges and facilitators of organisational practice

Our analysis of organisational factors which influence the implementation of peer support in practice takes some account of the different agencies participants come from. Participants from distinct services experienced similar and distinct organisational barriers and enablers to practice. It is important to recognise limits of research which was not able to directly study the organisational environments, due to resource constraints. However, themes from interviews confirm how pivotal organisational variables are for making change happen.

4.11.1 Implementation factors: overall organisational context

Participants discussed the overall organisational context in which they worked as an influence on their participation, and their capacity to implement what they learned. The services were organisationally and culturally distinct, but common factors include: the diversity and complexity of operations and staff roles to support; resource constraints and structural pressures conducive to stress; organisational hierarchies and rules needing to be dealt with.

The largest number of participants on the Peer Support Champions training came from Police services. In the [Southern region] Police force it was emphasised, there was organisational support for Blue Light mental health interventions. One participant observed that this force had trained 150 people on the resilience course, 260 managers, and 11 Peer

Support Champions at that time. But peer support as a practice was not yet fully promoted. The organisation's change management approach was viewed as systems-focused, and hierarchical. Officers were not allowed in a Union, but Fed Rep. represents members. Challenges in providing peer support include the dispersed, diverse Police activities. [Southern region] Police was said to include a dog section, roads, Firearms and counter-terrorism work, with particular boundaries and conditions. [Urban] Police have operations abroad, and undercover. There were considerations of how such organisations can manage confidentiality challenges of the role.

> *With the peer support program, I did that off my own back and attended although* [Southern region Police] *were aware that I was attending, it wasn't promoted yet* (P1)
>
> *I've got to think how as an organisation with people who quite often, will work abroad. How do we reach those people who maybe work undercover, never go in uniform, never feel necessarily part of the service? How is it accessible to everyone?* (P3)
>
> *My own personal experience, I thought you know what, are they just going to refer me to somebody else, are they going to refer me here, there and everywhere? I got on better talking to my colleagues and talking in the car and sharing with family, and that's how I dealt with it. I think that's why a lot of people keep it under their skin* (P1)
>
> *Well we cover the whole of* [O, B and B]. *But also as a force area…we hold responsibility for counter terrorism and things like that. Although we have got officers from* [K and S], *that work in that field they all transfer to us to be managed as a central. So as a force it's the three counties, but we kind of creep out a lot. We have a lot of our specialist units like the dog section, roads Police and Fire arms, part of a joint operations unit with* [Z] *constabulary* (P4)

Shift systems and long working hours put pressure on staff across all services. For example (mainly female) civilian communications operators, (call operators, radio operators) within [Southern region Police] were working diverse shifts. There was a perception shift allocations did not always suit them.

> *You can nominate your preference. So some people prefer their earlies…you put your preference down, and then the machine will automatically give you the opposite* (P6)

Cuts, reorganisations and target cultures as stressors are threats to capacity for Peer Support Champions to work effectively. A key consideration in the Ambulance service is how overstretched the service is. After a major incident, it was said, the Ambulance service could not always attend multi-organisational briefings. It was claimed to be easier for a person off the front-line to monitor and manage contacts, given how front-line work in small teams involves high intensity multi-tasking. The pressured front-line work climate with day-in-day-out contacts was said to produce a draining effect: 'drip-drip-drip mentally'; with risk of burn-out.

> *Even the Fire service were saying every time we have a major incident debrief there's always empty chairs for the Ambulance service and Police…we're that stretched* (A1)
>
> *You're doing that day-in day-out and it's going to build up to a point where you just crack, but yeah, we need to kind of make that normal. And that's a completely normal reaction but we just don't admit to it because we're the Ambulance service* (A1)

If I was on the road I would not necessarily be able to answer my phone or get back to them. Whereas in this [office] *role I am able to monitor emails, monitor calls and reply* (A2)

If we don't hit the target next year, we're going to be hit by a three million pound fine and these targets are based upon times, so there is an awful lot of pressure on front-line crews to see patients quickly and make themselves available quickly so that they can go to the next one. From a corporate point of view we have the same sort of pressures in the work. There's been a reorganising from the corporate side last year and we lost quite a few members of staff, we had to make ten million pound of cuts, and it has affected an awful lot of staff members including myself (A2)

Fire service participants described changes in their work. There were fewer fires, and more other rescue work, for example road accidents, CPR, more floods. Periods of intensity followed by spaces of training or waiting gave people time to feel uncertain. There might be fewer opportunities for the validation of 'saving a life'. Yet any normal anxieties could not easily be shown, given the overall 'masculine' culture of robust humour ('micky-taking'), within a tightly collective realm, with people keeping close quarters at the station. The crew were very well trained and drilled. The nature of the work was said to involve daily grind, pay freezes potentially lowering morale, and a culture which found it hard to celebrate call-out successes.

It's not how people imagine it to be, like London's burning, out the door (F3)

When you join the Fire and rescue service you want to fight fires and rescue people and we're doing less and less of it, which is good from a public point of view, but…it gives people a lot more time in their own head to dwell on little things… (F1)

We was going to more incidents …in the Fire service we tend to save a life. We go to a fire to save a life. We go to cardiac arrests now and it's not the norm for us to get there and there's nothing we can do. We always like to do something. It is having its toll on the crews (F2)

No, it's the Fireman's culture… it's a very, very sort of mickey-taking, robust atmosphere and you're also, you're expected to be so much for the job that you do (F1)

I find it always gets focused on that people are going to horrible incidents and that's affecting them, whilst there's much more to it than that, the day to day grind of budget cuts, we're about to start negotiations to go to eight hour shifts, pay's not gone up for seven years now, your lifestyle's getting worse, night shifts really tires you out... (F1)

We don't celebrate at all. I don't think the Police or the Ambulance do either, but a lot of the time, 99% of the things that we do is put out bin fires, false alarms, it's very routine very mundane, so the chance to celebrate something great isn't there (F1)

4.11.2 Implementation factors: stigma

Stigma around mental health was felt to be a major organisational cultural barrier to front-line staff engaging with Peer Support Champions. Across services this stigma, widely perceived and internalised, was linked to ignorance, and to attitudes about alleged absenteeism, and fitness for work with the general public.

In the (highly gendered) Fire service, there was a view that 'it is always perceived as a sign of weakness' (F4). The stigma over talking about mental health was said to be linked to a lack of understanding. It was stated that organisational stigma around acknowledging stress was tied in with a view that people are 'playing the stress card', 'swinging the lead', and

making ‘an excuse to do a sickie’. It was asserted that front-line staff (wearing ‘yellow helmets’) are mistrustful of non-front-line managers, including watch, station, group and area managers (‘white helmets’) around mental health and job security. There was a view that if front-line staff talk to officers, it will ‘go on their record’. There was fear that Occupational Health would get involved, and this could lead to job loss.

> *The problem is stress in particular is seen as an excuse to do a sickie. In some cases it is but in most cases it’s not…I think people see it as yeah he’s playing the whole stress card and thinks he’s untouchable and stuff like that… Obviously…you can see the signs, that someone is under stress and when someone is not and they are swinging the lead… there’s disciplinary cases going on, a couple of them have been suspended but they’ve been suffering from stress. And they think they are playing the stress card, and that’s their default mode* (F4)

It was important, from this perspective, to provide peer support ‘on the ground’, that doesn’t bring out the ‘white helmet syndrome’; the alleged management cultural practice of prejudicial formal treatment of people experiencing and talking about mental health issues. Peer support is viewed here as implemented against the grain of a resistant organisational culture.

> *It’s good for people on the ground to have someone to talk to that doesn’t bring out their white helmet syndrome, and they have a white helmet that would show they are an officer. People don’t want to talk to officers particularly, they don’t want it to go on their record. They have all this fear about Occupational Health and trying to get rid of people, and I think …there is a place for people that are …before any official line of sickness, absenteeism, all of that* (F3)

> *Unfortunately because we’re Firefighters we haven’t got any clout in the service. The problem is if you put officers in it, if you excuse my French they will bastardise it and come up with something totally different to suit themselves* (F4)

> *People are a bit reluctant to say anything and there’s always that mental health ‘he’s gone wibble’ kind of thing, ‘get him off the run and send him up to the funny farm’, stuff like that… People are quite reluctant to say ‘I’ve had enough I need a break’* (F4)

> *But people just don’t want to ask in case it opens up a can of worms, people think I don’t know that you’re going to break down and cry and stuff like that* (F4)

Within the Ambulance service some participants highlighted the struggle for people having difficulties, not wanting people to know their problems. Mental health experience was made worse by both perceived and internalised stigma, it was reported. A pressing need is to build up the numbers of Peer Support Champions talking openly about mental health to challenge this stigma.

> *Should be mental health is as readily accepted as ‘that chap’s got a broken leg’, that’s the bit when I was off I struggled with because I didn’t wish anyone to know what I was off for* (A2)

Within the Police, it was said, there is still considerable fear of open talk, and managing someone who is not well. It was said fatalistically that ‘comments’ around mental health are seen as inevitable within the experience of working with specific (i.e. troubled) clientele on a daily basis, especially among front-line staff (Police officers). Given this ‘normative’, enduring cultural environment around work routines, it is daunting for Police staff to talk about their own experience.

> *Part of the challenge is getting away from the stigma to start with on everyday life.*

> *Unfortunately it'll always… I'd like to think it isn't always going to be there; there'll always be comments made just because of the clientele that we deal with on a daily basis. And it might not be offensive, it might not be nasty and not meant to be nasty but people will always make comments and I think when somebody hears that, they're not going to come forward* (P1)

> *I think people are still fearful of the consequences if they raise it as an issue. Maybe people are a bit fearful of managing somebody who's saying I'm not coping whatever it is. Because it can be hard to manage somebody you know who's not well* (P1)

It was said that there may be less stigma than there used to be, and, positively, new entrant young staff have a 'completely different mind-set'. However, challenges lay in the stressful work, and the need to retain the 'confidence' of the public. People were said to fear a perception that if they say they are 'not coping' they should not be doing Police work.

> *We are asking certain people in certain roles to take on real stress, to do the job even though there is lots of stress and to have the confidence of the people around them and confidence of Londoners. And actually if you're putting your hand up and saying I'm not coping, I'm unwell…it might be right to take you away from that, right that you shouldn't be doing that. There will be people, not putting their hand up when they should do* (P3)

4.11.3 Implementation factors: gender

Participants across services were aware of gender factors influencing how the Peer Support Champion role can work in practice. Gendered practices - more or less subconscious ways of thinking, feeling and behaving - were seen as reinforced within broadly traditional masculine organisational cultures. People with mental health experience training to be peer supporters might have become more aware of this. Women were being trained as Peer Support Champions in similar numbers to men, but it was assumed that many front-line staff facing mental health challenges might be male.

Wide issues about upbringing were touched on – some male participants highlighted that more recent mental health experience had led to a re-consideration of the costs of taking a '*man-up*' view. Sustaining a traditional 'masculine' ideal created unrealistic expectations which had high costs for many individual men. The training scenarios were an opportunity to share stories from perspectives that had been re-evaluated: male participants have braved mental health experiences which challenge 'traditional' aspects of masculinity.

> *I was definitely more of a 'man up', you know 'get on with it', what's your problem, it can't be that bad. And then having gone through it myself I've definitely got a better appreciation. In the training and I think that went for the majority of people in the room, because we were able to share stories we were able to offer advice to each other* (P5)

Participants with mental health experience were well placed to consider the interaction between specific gendered expectations and organisational cultures in influencing any reluctance to speak about mental health. Lived experience resulted in some male participants espousing a 'big build' understanding, apparently lacking in their organisations, of mental health problems.

> *People just don't understand mental health and stress and stuff like that. People just try and get through it when it just builds up and builds up when something is going to go bang. Then, by that stage, you shouldn't have got yourself in that position* (F4)

Workforce cultural practices were seen as amplifying any 'normative' masculine reluctance to speak about felt vulnerabilities. One (Ambulance service) participant spoke of the men at

highest risk of suicide being those who 'bottle it up'. Enough Peer Support Champions needed to be 'out-and-about' and vigilant for any cause for concern among men who are more quiet than usual.

> *Number of suicide attempts especially from men, and it's the quiet ones we found, we get people… they'll take something and ring for an Ambulance. …They're not as high risk as the ones who bottle it up and keep it quiet, so it's getting more people within our service able to get out and about because we want more on the road staff so they can recognise that 'oh he's been a bit quiet, Joe Bloggs, I'm a bit concerned'… Being able to be there for everyone, so we are looking to increase the number of Champions, absolutely one hundred per cent* (A2)

Another (Fire service) man spoke of the station workforce resembling 'almost' a 'wolf pack', in that the banter is relentless concerning behaviour that deviates from masculine and work-culture specific team norms. In this account, two aspects stand out: the lived context (Fire station) is likened to a house where people co-habit in a very close family-type closed environment, and, secondly 'vying for dominance' within a hegemonic male order. Rapport is strong, but tightly confined by behavioural norms. A (usually male) person's wellbeing is strongly governed by perceived social esteem within a closed cultural order: 'the X-factor or whatever goes on within the social dynamic of everything'. To practice in that environment as a Peer Support Champion, it was said, involves operating in a culture that requires stoic display in order to 'pass'. Showing vulnerability requires a baptism of fire, being 'jumped on', hard to endure, only the fittest thriving with an altered identity.

> *It's almost like a wolf pack because it is very much, if you do anything and you come in with - you cut your hair, slightly different you get ribbed for it, endlessly … You can call it banter… its name is immaterial isn't it, but yeah it's very much that and it's a very, very closed insular thing… You've got a kitchen, a dining room, a lounge, what used to be bedrooms, there are no beds anymore. So we are living together in a house, it's like a very close family, because we are very close, very, very close and close friends but with a bit of an X-factor that we're not actually family; and people are vying for dominance if you like… If I start talking about mental health, one of them will say – 'oh for f…'s sake will you shut up about that f…ing mental health stuff' – and they mean it purely as comedy, as black humour, but actually if they want to talk about it they will, so it's a very weird culture, really. Really odd yeah, so you're in an environment where vulnerability is completely jumped on but if you're strong enough and brave enough to accept that, you can be very vulnerable because that almost then becomes a strength....He* [very vulnerable former colleague] *was how he thought he was perceived….His wellbeing was completely controlled by this X-factor or what goes on within the social dynamic* (F1)

Some 'civilian' sections, e.g. Communications Operators within the Police, were mainly female. In this case, women with experience as peer supporters needed understanding of the multiple stressors on young women call operators. They are subject to intense work pressures, with possible status impacts of being in a civilian role, in a mostly female section, within a male-dominated service, and they may have gendered care pressures e.g. from being a young parent.

> *I am a communications operator, in a department called* [Q]. *Its four hundred/four hundred and fifty person women power, strong. I've done the job for* [many] *years and done all sorts of change* (P6)

> *The stuff you carry, some of it's work, a lot is not. Trying to work with the family. Some of the kids are in their late twenties have got young children... And it's tough* (P6)

Alongside gendered work-life challenges, it was implied that some services draw on very traditional 'masculine' assumptions, from senior level, where sexist attitudes endure. It was said this can be broken by working (on gender awareness) with young Police staff.

> *It's a bit like my department, until you break it up, culturally at young level, you're never going to break is at the senior level. Because they've been brought up for fifty years that actually women are behind the dog and the house and the car* (P6)

A very substantial part of the 'lived experience' of peer supporters therefore seems highly gendered, also reflecting the gendered work environments, as contexts within which peer support is offered.

4.11.4 Implementation factors: embedding in systems

Training left may participants concerned that putting what they had learned into practice was challenging because their organisational structures had not fully embraced the role, and systems for implementation and support were lacking. This section outlines, for each of three services, organisational challenges and then enabling factors highlighted for making the role work. There was common ground in the challenges faced, but it appears that more progress had been made in some services in particular regions.

Overall themes include: the need to get senior leadership (e.g. Chief Executive) and organisational buy-in; importance of an organisational framework with input from peer supporters, endorsed through organisational hierarchies; potential for organising training events embedded within organisations, ensuring key roles are incorporated e.g. Occupational Health, Human Resources, managers; importance of having the role seen as legitimate; joined-up working with other health roles and initiatives; extending the network and clarifying roles and boundaries of peer supporters and Blue Light Champions through further training; making and evidencing a business case.

Leadership and joined-up initiatives – Fire services examples

In one Fire service, the view was that people had undertaken training as a 'first step' prior to real leadership buy-in. The Health and Wellbeing team were supporting development of peer support, but all plans have to go through the leadership team, which had not happened yet. In another (different region) service, implementation had to remain very local, it was said, because of barriers to service-wide support and buy-in.

> *We have a Health and Wellbeing team that are just getting it up and running. This was the first step, get the peer supporters, get them trained and then they are putting a programme of health and wellbeing together…. So now they have got to take this plan and strategy to the leadership team. But I think they will be very supportive of it* (F2)

> *We're just doing it on a local level and trying to fight our case from here and then maybe when it comes to the time when they need to accept it we could get some help from MIND, but we've got to open up some barriers before that... it's* [regional Fire service leadership for mental health and peer support] *massively behind* [the Police], *we've got nothing…..Not from higher up, but it's early days. Hopefully there will be in the future* (F4)

Higher organisational levels did not know about the training, according to one participant (Fire service). The training, and peer support role, were said not to be well supported at senior levels in a different Fire service. There was a need for joined-up initiatives and organisational backing, including from senior people doing related work. Trauma Risk Management (TRiM), with trauma-focused peer support initiatives, was being developed across different regional services. In one, the lead person (TRiM) knew nothing about the

Mind Peer Support Champion initiative. In another, the support invested organisationally in TRiM led to reduced interest in the (not specifically trauma-focused) Peer Support Champions. TRiM, it was claimed here, was supported by Occupational Health who allegedly resent people beyond their orbit, 'only Firefighters', doing peer support work. Territorial struggles can apparently be an issue.

> [the person is] *employed to look at emotional and mental wellbeing…she's introducing TRiM….she knew about Mind Blue Light,…she didn't know the peer support was offered and she's looking to do her own version of peer support and it just seemed like, well I'm not going to be like a lone ranger on my own doing support… no, so not that joined up* (F1)

> *It was the governor's idea so it was a local thing and me and* [name] *were a bit wary because there is quite a responsibility….So, we asked if he could approach senior management and find out how far our role goes. For instance if someone is suicidal, can we take them off the run?...But we haven't really had an answer and they have kind of poo-pooed it because they do TRiM but they don't seem to understand that it's totally different* (F4)

> *I think they don't like the thought of us interfering with what they're doing; they do stress management*. *Because we're only Firefighters they are a bit loathe to give it to us… We've got our own in-house stuff, why do we need MIND*? (F4)

With this apparent lack of joined-up implementation, a participant suggested that a brigade wide-email was needed to inform people about the role. The role needed to be made legitimate through the service hierarchy, to be taken seriously. A central training day could draw participants from across the brigade.

> *It could almost become a legitimate role within services so you could have, for example I'm a Firefighter, …I'm a trauma technician, I could also be peer support. In an official legitimate role so it comes from Mind, through the organisation to the staff on the ground, … easy if you went through the top of the brigade, …the people who organise Health and Wellbeing to programme in a training day, even a central training day* (F1)

Human Resources and Occupational Health – Ambulance services examples

Within some Ambulance services, it was said that people in key positions know too little about mental health and peer support. A course should be delivered for Human Resources and Occupational Health. Nobody in Human Resources had the training to deal with these issues. Their interview techniques, it was commented, were not sufficiently differentiated, according to whether a person presents with a physical or mental health issue, which can worsen stress-related illness. Occupational Health needed to be signposting people to peer support.

> *You need to educate the people in HR, again it'd be great…a course that I suppose the service could pay for, but I think HR and Occupational Health. Occupational Health needs to understand mental health and they need to hit with information* (A3)

> *You shouldn't have the same interview techniques for somebody that's been off with an arm injury because when you have a mental illness your thought process is not the same, you're concentration and that needs to be built into the way they interview people, because that's what sends people over the edge* (A3)

A key enabler of progress in one [Northern region] Ambulance service had been a Chief Executive's support. Once the Chief Executive championed the Blue Light project overall, despite previous resistance from managers, doors began to open. It was also effective to get

the Human Resources Director on board. Otherwise, Peer Support Champions could be marginalised.

> *The biggest key thing for me was just getting the Chief Exec. on board* (A1)

> *I've actually been approached by quite a few managers to say what exactly is your role and have you got some resources I can take away?* (A1)

Managers – examples across services

Managers are vital to the success of peer support, it was emphasised. There was a sense that some line managers are less 'educated' than they might be about peer support and mental health, that they might lack understanding, and that some might need to be 'empowered' to have the 'confidence' to be more 'flexible'.

There was clearly scepticism in some sectors, whether management support was in place.

> *I don't know that my management could tell you I'm a Peer Support Champion* (P6)

In one Fire service, it was claimed by one participant that it would be 'off the radar' for a line manager if a Peer Support Champion told them about their new role and asked for support.

> *It's not something I would normally do,* I could*, where it would go I don't know, because again it's totally off the radar…I mean they're not horrible, don't get me wrong*…(F1)

In an Ambulance service context of intense work pressure, line managers needed educating not to worsen the pressure, including for Peer Support Champions, and to understand relationships between work stress and mental health.

> *To make the line manager realise that you can't keep piling work on people and expect them to carry on normally because, I know we're all under pressure but, at times you've got to, one of the big things that I learnt while I was off, …was learn to say no, I can't do it, sorry. But I think we are getting there* (A2)

> *Its lack of understanding from people that've never done your job* (A3)

In the [Urban] Police an important challenge is to 'empower' managers to adjust their practice.

> *How do we empower managers to have the confidence to help that person to be flexible? If the policy says you must* 'do that' *on that day for somebody who's gone absent… how do we empower people to be confident enough to adjust those to that individual*? (P3)

Organisational framework and further peer support training – Police services examples

In one of the Police forces involved [Southern region], although senior support may have been slow coming across the organisation, a senior Champion, (a 'fairy god-mother Superintendent'), and a supportive 'line manager' were instrumental in enabling a mental health nurse to work towards more internal peer support training.

With this senior leadership support, the mental health nurse, a key figure in Occupational Health structures, was able to initiate an organisational framework for peer support and clarifying roles of Blue Light Champions and Peer Support Champions. Suggested policies, for example concerning boundaries and guidance for the supporters' wellbeing, would then be agreed among peer supporters, with the training event part of this process. However, critically, it has to pass through the system, i.e. through a line manager, Superintendent, and Learning and Development section. This process would lead to more organisational clarity

about how Blue Light Champions and Peer Support Champions work, and about links to the line manager training. It was important the internal training is validated; it has a course code, and goes on people's PDR.

> *My fairy godfather superintendent said, what can I give you to support you*? (P4)

> *Driving, we've got an internal Blue Light Champions training day coming that myself and my colleague devised …We've been allocated a course code for it,…it goes towards their continuing professional development. This is something that you can put in your PDR, that you can evidence. It's training that the force recognises* (P4)

> *In the afternoon people that want to just be Champions are going to have a Champions workshop around what can you do as a Champion?…How do we keep the momentum going? And peer supporters are going to a peer support workshop….It won't be peer support training. It will be more around this is what it's going to look like in* [Southern region Police]… *Amongst the peer supporters we'll agree this is what we would like it to look like but then it's going to go via my line manager, Superintendent, learning and development… they will need to own that, because my role is medical not training. It needs to be something the organisation owns. But it does need initial clinical input* (P4)

In this plan, there would then be scope for delivering further peer support training within the organisation, either through Mind, or through a mental health first aid trainer in the force. Further training should differ from the original Mind peer support training by incorporating organisation-specific material that is being developed, concerning the specific practice environment at, for example, Southern region Police.

> *I think the Mind training day, if that was the model we chose to use would need to incorporate the workshop slides that I'm doing, because this is what it is in* [Southern region Police]. *This is how it looks like. This is how you are protected. This is what we ask you to do. This is your escalation*… (P4)

Linking with wider policy directions

Implementation of proactive peer support, it was strongly argued, needs to be supported by making the case align organisationally with two wider policy aspects: rising focus on preventative mental health care; and service spending reductions. With resource cuts, stressors increase, and there is a business case for preventative action through peer support. Existing provision e.g. through Occupational Health, was seen as primarily for long-term sick people, whereas this preventative model has good fit with these policy priorities.

> *If* [Southern region Police] *wants to pace the Government on how they are viewing mental health care we are going to have to look at prevention and at being proactive. Because we can't wait till the whole force falls over, or 90% of it falls over which is what the stats. say is going to happen. The only way sensibly to maintain service delivery with reduced resourcing is to look after what you have got. So I think my role will be becoming increasingly proactive, and Blue Light is giving me evidence to support why that is necessary. Currently it's not part of my role…my line manager has let me run with it* (P4)

In one Police service, it was said, because of concern that, when time-limited funding stops, the organisation would be unclear about supporting the peer supporters, the organisation had initially been cautious to fully engage. The reasonable concern was that without appropriate systems peer supporters could themselves be more vulnerable. There were also concerns it could develop into a 'welfare issue'. While Occupational Health support the process, it was perceived that full leadership buy-in still depended on addressing these issues.

> *The messages aren't reinforced by the head people. And I think if those messages were pushed by them they might be greater impact on getting people on board* (P5)

> *Because there is a time limit of funding, I think* [Southern region Police] *just a little reserved with the peer support at the moment…*[They] *are worried who supports the peer supporters. There is a risk of the peer supporters then becoming more vulnerable to mental health if they're taking on something that's been told to them and not disclosing. If* [Southern region Police] *understand what it is and that the peer supporters do know their limit, then it will be great* (P1)

It was said that organisational clarity about the role and implementation required gaining Human Resources support and integrating the work. In the [Urban Police], liability questions could occur for actions taken by a Peer Support Champion in their own time. There was also the challenge - 'a natural thing', to be worked with - that Occupational Health might want to control the change, putting in safeguards. It was vital that the whole force has clarity about roles, responsibilities and boundaries. Criteria for onward referrals need to be clarified.

> *The natural thing that OH would like to do is probably take some control because it's a mental health function and you know, they may want to put in safeguards* (P2)

> *Because the* [Urban Police] *would say sorry this is an officer acting on their own; they'd probably say he wasn't acting as a Police officer at the time, you know a volunteer. But you know the stewards inquire….who said he should be doing this? How did we assess him?* (P2)

> *Think the person needs to be clear beforehand and that's why we should promote it - I am peer support, this is what I do.… I think with peer supporters that anyone who is talking to a peer supporter, they should know that if they've got that peer support skill or that peer support training that they might refer you on to welfare department* (P1)

Different contexts, different models

Logistical boundaries were discussed as needing thought. It was suggested that different contexts require different models e.g. for different Police departments. This has to take account of people serving abroad, working in covert operations, or working from home, with flexible arrangements.

> *Doesn't have to be one model…Peer support doesn't have to be the same in every department; we have got a lot of people serving abroad… people that work from home; a lot of flexible working, particularly Police staffs* (P3)

4.11.5 Implementation factors: culture

Organisational culture was said to be a key challenge for implementation. The cultural setting was woven in with gendered rules, strongly regulating individuals' relations and behaviour, and with different procedural (written and unwritten) rules for action. There were distinct, hierarchical cultural aspects within the management and the front-line. It was recognised that organisational cultural change is not likely to be fast, and that 'managed' change is mandatory.

Different organisations may have different procedural rules, it was suggested; for example concerning confidentiality.

> *If somebody came to me in this role and said I've got real problems…and I've been stealing things from a property store, I'd be completely obliged to break confidentiality. As I'm sure the Ambulance service would if somebody said I've been taking pharmaceuticals* (P2)

Participants from Fire services referred to a masculine culture, of mainly younger men, which can 'make outsiders weep', and often characterised by 'black humour'. In one Police force it was also said that there is an 'alpha male environment' where people act as if they wear a 'cape of invincibility'. There was a view that people don't act tough out of whim: their mind-sets are pulled that way within the organisational culture, even while group norms are hurting individuals. The challenge is to help them allow themselves to think they can access support.

> [Chaplins] *they're volunteers from the community…I think we've had about four of them go off crying already…this isn't me trying to say oh people just want to come out and throw me a parade every week. Our mind-sets are forced that way* (F1)

> *A lot of black humour. Great to a point but sometimes it's completely inappropriate* (F3)

> *How do we introduce the Champion role in a way where people that work in a real alpha male environment, maybe public order riot training or the specialist Fireman officers, who…not all, but have this cape they put on and they're invincible and they're never going to tell anyone anything that is bothering them. Nothing can touch them. How do we allow those people to think that they can access an appropriate service and what does that look like?* (P3)

Getting Mind to understand the culture of one Police service was said to have been a challenge. There is still a very cautious, by-the-book management culture at some levels, it was suggested. Getting the organisation to take the Pledge, or to fully sign up to implementing peer support, was not easy, without 'full buy-in' at high levels. It was said to be harder to influence leadership than other levels. Superintendent level support could lead to accelerated progress. However, with restructuring and rapid role change, a hand-over package was needed when new people come into the (senior) role. [Southern region] Police were said to be lucky in employing mental health nurse staff; elsewhere, Occupational Health were mistrusted. Culture change depends on a gradual ('drip-feed') approach to win senior support. Big plans would not succeed until top-level support is forthcoming.

> *I think culture change is gradual. We are leading from the back and slowly converting people. The barrier is going to keeping that momentum going, it's not going to be any great 'aren't we successful'. I think what works best for the organisation is a drip feed approach, so I don't think any big launch of 'da da, we are the peer supporters'* (P4)

> *We haven't pledged yet because we had to do the work to get the support in order to make the Pledge….Culture is such that it's been tried and failed probably many times It's harder to get in at the top, much harder. Particularly when people are moving…part of my agenda is…if they move on will they include that in a hand over package* (P4)

> *The management … a bunch of tick boxes and I know they do it, I can sit in a meeting and go* really*? I know what the next question is going to be. Tick. But not because you give a stuff about the condition I'm suffering,…about the individual* (P6)

Working positively within organisational culture – Police service examples

A number of themes around working with the organisational culture to change practice emerged from interviews with Peer Support Champions in Police services. With culture change perceived as gradual, a positive view was that recent young Police graduates might be more open to talk about mental health, suggesting potential for targeting some young people as potential agents of change.

> *The youngsters coming through, have a completely different mind-set. So I was talking to some graduate entrants…and they weren't afraid to talk. …We were talking*

about self-harming and bulimia and all sorts of different things. They had a completely different outlook and you know culture is really hard to change isn't it? What we do know is culture takes a long, long time to change, the culture of an organisation (P3)

A further aspect of organisational culture was said to be how it handles change. The [Urban] Police was said to be 'not resistant to change' but 'likes to manage change', formally, with existing structures. So, progress would occur through altering the contours of a culture, not by attempting to ignore it. The [Urban] force was described as a 'large animal' but 'realistic', requiring system change to be introduced in a controlled top-down way. The Management Board had to be signed up, as was expected to happen. Planning required a structured approach e.g. a six month plan to achieve 'quick wins' such as an intranet presence, which was achievable, and then the Pledge signed. It was not realistic to try to do everything at once.

The [Urban Police] *is a very large animal; doesn't do change very well. It's not nervous about change, not resistant to change, but it likes to manage change. So a couple of people who are 'mad' running off saying things, that wouldn't necessarily appeal…it'd have to be 'this is what we propose', very laid out structure and agreed in advance. Certainly not insurmountable* (P2)

Don't think for instance we should start off high and say 'this is a telephone number for 24-7 support' because that's not really what it's for…Almost baby steps really; let's get something on the intranet, let's get something if you search 'Blue Light' this comes up, and something that maybe signposts others… you know even that signposting to other agencies that aren't OH or aren't [Urban Police] *is a quite a big step or quite a big win….See it as a stepping stone to OH and/or de-stigmatising or informing or just grounding people really. But I think within 6 months, we'll be able to say 'yeah we've now got this series of presentations in you know phase 1, series of presentations at this level, raising awareness, an intranet page* (P2)

Promoting peer support on the basis of productivity was said to be effective within this culture. It was necessary to bring key groups on board, respecting organisational planning and the need to leave an organisational legacy, not focusing all strategic thinking on delivery of one-to-one support. A large, complex organisation requires wider planning, for example integrating peer support within the Wellness steering group. Building networks across staff associations was important. It was vital to have managers on board. Thinking strategically could include winning the support of the training academy, delivering peer support training to new recruits. Interagency working should be prioritised.

And for us we've sold it on the basis of productivity; you know if you can keep people well and keep people in work, then that's economically that's really good (P3)

So it's opening conversation as a bigger reach in the organisation. The Wellness steering group is the strategic group, at director level, where it needs to be to get anything done (P3)

What we were talking about in peer support is how that could develop into a network of people within the Blue Lights, and sharing resources, sharing information, getting together. We don't do it so much in the [Urban Police] *but I think we probably will do more and more. In the counties you'll find, Police station next to an Ambulance station next to Fire station co-located so it really makes sense if you're doing something about wellness, do it altogether because you all work shifts, you all deal with traumatic stuff, in a service delivery type public sector role* (P3)

4.11.6 Implementation factors: cascading learning and developing peer networks

A need for greater numbers of Peer Support Champions to be involved was highlighted. Proposals for spreading peer support through organisations focused on: internal training; involving the wider Blue Light Champions; drawing in people who are not already open about mental health experience; including key senior roles; validating the role.

A risk for Champions, with small numbers trained, is that they become anxious about being ineffective. For example, in the Fire services in [Northern and Southern] areas it was impossible to cover all different departments, and office-based and shift-based staff, ensuring 24 hour coverage. In the [Urban] Police service more peer supporters were needed to cover shifts. The [Northern] Ambulance service covers a very wide area, it was problematic having a Champion in [far north town C] speaking to someone in [town B].

> *But I think the more people that sign up, then the less pressure would be…if you had a mix, if we had one for each shift* (P1)

> *Say someone in* [C] *is speaking to somebody who's down here in* [B], *if someone is quite local they're more likely to open up, and we can then arrange to meet that person if they wish to do so* (A2)

A wider network

A view frequently expressed was that the trained Champions could create a wider network of people to 'get the message out'. This network might draw on/connect with existing Blue Light Champions. Suggestions for increasing coverage and impact included: active recruiting; building up a network of peer supporters by training more people, including those who do not have mental health experience (those with experience acting as coordinators). It was argued that people 'without', not yet owning, mental health experience, can potentially influence peers by changing their own practice. It should be possible to influence people at the top, for example, in the Fire brigade, health and wellbeing programme organisers, to arrange a training day. This could be done centrally, for people from different districts.

> *You could even run a special day for people that haven't got mental health but are willing to help and let them speak to Fire, Police, and Ambulance men at the front* (A3)

> *I think what would have been very, very helpful would've been getting people that maybe have never suffered any mental health problems, explaining to them and then letting them go with being peer support…all I've done is put a hat on saying Champion and nothing else will change and it isn't breaking stigma…, because I've already accepted and acknowledged* (F1)

> *It would be easy if you went through the top of the brigade, the people who organise Health and Wellbeing to program in a training day, even a central training day, where people come from all over the brigade, pay a day's pay to become peer support, go back to their stations and watches, they have a list of names of people in the brigade saying this person for* [W], *this person for* [T] (F1)

There were concerns organisationally about validating newly trained peer supporters to train others. In one region, a participant from the Fire service proposed with a colleague to develop an in-house training package, but they were not yet allowed to deliver it. Some learning on the Mind course had been very fresh. It was admitted, for example, a participant had learned about post-traumatic stress which they 'didn't have a clue about'.

> *We're not allowed to go out there and do it yet because the service don't want us to. I think that would help if we just went out, we're just normal Firefighters, and did*

something like that. Even if it just opens the door for people and they sit and think I'm feeling like that (F4)

We didn't have a clue about post-traumatic stress and things like that (F4)

In one Police service, as mentioned above, a mental health nurse was driving change by organising training internally, for both Blue Light Champions and Peer Support Champions. So the peer support practice would be cascaded deeper into the organisation through the Blue Light Champions. The training focus was not to be 'peer support training' but organisationally enabling factors. The distinct roles 'Blue Light Champion' and 'Peer Support Champion' would be clarified at this event. Through this, more peer supporters might step forward. It was planned to pair people up as peer supporters to protect against isolation and vulnerability.

We've got an internal blue light Champions training day…It won't be peer support training. It will be more around this is what it is, what it's going to look like in [Southern region Police]…(P4)

One person saying that really helped, how can I get involved when I'm feeling in a position to? …will keep the momentum going…Obviously I'm in quite a good position to ask people if they would like peer support, and pair them up, and keep an overview of contacts (P4)

4.11.7 Implementation factors: peer vulnerability

The potential vulnerability of Peer Support Champions with mental health experience, adding this role to their workload is an important concern. There is an expressed need to have organisational systems for risk assessment, and for peer, monitoring, management and resource support.

It was questioned whether it might be 'too soon' in the recovery journey for some participants to engage in peer support. More than one participant said this could be the case. Some wondered before training whether they were mentally strong enough to take on others' problems. Training and subsequent communication had helped provide tools to support peer supporters meet this challenge.

I did think am I mentally well enough to be taking on other people's problems? I had to think long and hard about that and then me and [name] *sat down and I said I'm going to have to set boundaries here. I can't do this on my days off, this is not going to be a 24/7 service* (F4)

I think it definitely depends where they are in their recovery… I definitely think we maybe should have been assessed ourselves before we did the course….It was offered to everybody at [Southern region Police]. *A blanket email went out* (P5)

Newly trained peer supporters had become positively aware of their vulnerabilities, and more confident, but remained vulnerable and required effective support. Isolation was a threat, and work circumstances could quickly make the newly trained Peer Support Champion feel at risk. A danger was described of taking backward steps, doing too much. This might be detrimental to the peer supporter and, potentially, to the person being supported.

It's easier for someone that's been there and done it to identify it but there is a real risk …I know this from experience, that we try to do too much. So, quite early in recovery…or when you feel in a good place, you over-compensate…I'm as delicate now as before but I'm more aware of my vulnerabilities and my potential to do too much…(P2)

> *It's great to be able to release him into his sphere of influence where he works but you've got to do that in a way that's healthy for him, and so he doesn't take on too much. But if he does still have some demons, to make sure that doesn't come through in what he's trying to do…Last year I did that too much, I was finding myself thinking 'I've taken on too many people', they're emailing you updates and how they're feeling, different medications, and you're thinking I can't, I am not physically well enough to answer all these emails* (P3)

> *I've had to take a slightly backwards step because I was going through a few issues* (A2)

It is paramount therefore to ask who supports the Peer Support Champions. Within the Police force, it was said, there need to be guidelines, and tools to identify if a peer supporter him/her self was becoming unwell. Peer support was not implemented in a service until there was 'protective casing around it'. It was viewed as vital, in one Police force, that the organisation take ownership of peer supporters' wellbeing, as Police will follow that lead, rather than the clinical lead of an 'activator', like a mental health nurse. Following the Mind peer support training day a further process - including a peer support workshop - would develop a service-specific framework and code of conduct. The service at senior levels would be signed up to a list of resources, an agreed escalation route, Peer Support Champions developing their own wellness action plans, and regular use of self-assessment questionnaires to support Champions to remain supported and well, and to step back if they need to.

> *Peer support isn't up and running yet, because we haven't got protective casing round it* (P4)

> *The ones that have done the training have already formed a working party. So as part of the training day that we've got coming up, I'm putting together a peer support workshop. And I'm putting together policies that will affect how we do this, almost a code of conduct. Almost a 'what to do if the wheel comes off'. List of resources that you might want to use, all the way through 'You're not a councillor….don't hold anything'. 'This is the escalation route', which will be me or my colleague in the welfare department. 'This is how you are going to be supported'. 'Make sure you have got your own wellness action plans'. 'Make sure you use the self-assessment questionnaires that Mind have provided regularly to make sure you are in a place to keep doing this'. And 'don't be afraid to say when you need to step back if you need to step back'. So it's…putting that framework…it needs to be something the organisation owns…* (P4)

> *Give people parameters and boundaries to work within* (P3)

> *You have to be aware of your own limitations…* (F2)

4.11.8 Implementation factors: ongoing support

A variety of ongoing support needs for Peer Support Champions were mentioned. These included networking within and across services, using social network groups; refresher events; support around the Champions' own welfare; lines of accountability. Ongoing support would mainly have to be developed within organisations.

Emphasising the need for support networks, some participants already had good contact through existing organisational online networks with Blue Light Champion colleagues.

> *Other Champions, without a doubt, yeah. Yeah, I mean I talk to* [J] *a lot who is the other Champion who's helped me drive it forward* (A1)

> *But the* [Y]*, the* [service] *social network site, that's a useful tool people have been using to raise attention about how things are within* [Northern region]*, … only three of us are Peer Support Champions but we are trying to create a bigger network because* [Northern region] *stretches from the* [U] *border up to the* [Y] *border and then from the* [M] *sea to* [B-shire] *and we're trying to get people in different areas so they're local* (A2)

Other participants thought that their services had not developed strong enough networks of Blue Light Champions more generally, given the geographical spread of areas to cover.

> *You get a generic email saying this is what we're doing but I wouldn't know what one Blue Light Champion is doing in* [H or in W or in R]… *We've never met each other* (P1)

In [Southern region Police] people who had been trained were keeping in touch through a new WhatsApp group they had set up with managed boundaries, and by exchanging emails. Only 11 people from the service had been trained, so they all need support.

> *We set up a WhatsApp group... We've invited in the ones that were on separate courses. We've got an email group going, there's eleven of us…in a huge force* (P4)

The main long-term support must come from within their organisations, participants recognised. If trained people find the work too demanding, an organisation which had signed the Pledge should be supporting them.

> *If we identify that actually of those dozen people, 6 are finding it too much, we're going to have to solve it in-house really. That's better than a year ago when there was nothing. So at least there will be, there is the sneak of, there is a Pledge to it, there is management board level buy-in* (P2)

There was concern how the role would be supported within the organisation; it was felt, by a participant from the Police, that an organisational named person should be a point of contact if the Peer Support Champion needs to consult about a dilemma of peer support practice.

> *What might be an idea is that within each force, there's someone within human resources so that if a person come to speak to me about a, b, and c. and I'm wondering what to do the organisation has got someone who is the point of contact* (P2)

The take-away materials and the online option from the Mind-run training were highly valuable. These materials needed to be supplemented by in-house signposting information.

> *I mean the great stuff is the majority of it is online* (P5)

> *It could do with having an extra document with the signposting on, but I think that would have to be done in-house…So every organisation would be different, ..or it would be the same but you've have your own variation* (F2)

Some participants had maintained good contacts with Mind through the Blue Light programme. Some wished for ongoing contact with Mind. A six-month follow-up session was suggested, or online training, to exchange experiences and strengthen mutual support.

> *The training was enough, maybe refreshers or online training now and again would be great to remind people…. You're not welfare, you're not counsellors* (P1)

> *Maybe it's something for Mind to consider, but a 6 month get-together,….I think that's a must because there will be some really good practices, that can be shared* (P2)

4.11.9 Implementation factors: role clarification

Clarifying the Peer Support Champion role within the organisation was an identified challenge. This involves identifying boundaries around practice; relationship to other health roles; resolving any role conflicts; publicising the role. In the [Urban] Police, it was important to ensure the organisation approves the role, and that staff know who the Peer Support Champions are. There were concerns that the role had not yet been established with clear parameters, or certified qualifications.

> *There's no suitable… it's an informal role but there is no pass or fail. There is no assessment if you like of the people who are being put forward* (P2)

> *The person needs to be clear beforehand and I think that's why we should promote it you know – I am peer support, this is what I do. So it's not a bit of a shock that if somebody says lots of things and you say 'well I can't be dealing with this…'* (P1)

The Peer Support Champion role, it was said, should be viewed as clearly different from Occupational Health roles, as it is early warning-focused and preventative.

> *I think the Champions is more about those early indicators* (P5)

A challenge of perceived role conflict has arisen between the occupational role a person holds and the Peer Support Champion role (e.g. if the person has authority within a restructuring process).

> *We're going through a restructure. It's not very nice. So people know that I'm a Champion…but the majority of the people are kind of in the space that 'hang on a minute, you're about to make me redundant or you're going to put me in a new role and now you want to support me*' (P5)

The importance of promoting the role to staff was also highlighted by Ambulance service participants. This could be done through emails, posters, and perhaps staff wearing identification badges.

> *There needs to be something on noticeboards for named people so you know who to contact or a badge,* [EM] *are running their own system and they have a badge on* (A3)

In the Fire service, besides publicizing the role, it was necessary to clarify procedures concerning anonymity, given overall lack of privacy and physical proximity. There was also the challenge of understanding where the role stops.

> *Another problem would be anonymity, people might not want to get in touch with me because they might think 'what about if he tells other people'? I'd have to spell that out* (F1)

> *When do we stop being this Champion? Are people going to be phoning at home?* (F3)

4.11.10 Implementation factors: resources

Across the services, pressure on resources threatens implementation of peer support. The Ambulance service was said to be dealing with rising numbers of call-outs with the same resources to respond. Human Resources were alleged to be anxious that if more people talk about mental health this would lead to more sickness absences.

> *The number of calls has continued to rise and yet we're still running on the same resources as what we had and we've got a busy period now coming up* (A2)

The [Urban] Police service were said to be facing competing resource agendas including combatting terrorism and implementing service cuts, so that peer support would need to be justified through a clear business case. Crises, which aggravate trauma, divert energies from strategic mental health prevention work. Government-imposed, force-imposed, departmental and area targets all create a stressful atmosphere.

> *There is Government targets, force targets, departmental targets, area targets, and the typical logistics of Police* …[Southern region] *is a classic…Which inspector is on because that'll be one set of targets, another set of targets for somebody else* (P6)

> *Soon as another bomb goes off, everything you know….whereas actually if a bomb goes off, that's the time when we really need to deliver the peer support* (P3)

Intersecting resource pressures meant that for Police communications staff multi-tasking around decisions was very intense. There was allegedly pressure around litigation, ('the right to sue'), and from restructuring service work e.g. towards supporting Fire and Ambulance services, and a perception of imperfect management support. The overall experience can be de-personalising, it was emphasised. Many young people stay a very short period, with high annual turnover.

> *I can see these kids going to breaking point very fast. They don't stay more than eighteen months, two years. They are just coming to the stage where they are, sounds awful, useful for the organisation, but they break, and they say I'm not doing this* (P6)

> *You know you are talking six thousand 999 calls a week. We only deal with the fast track stuff, there's two and a half thousand jobs sat on your desk* (P6)

> *They're up and down, up and down, because they are made to be afraid by the right to sue, they're made to be afraid by the organisation to say no….Unfortunately our management support is not the best. It's like*, '*oh well that's protocol*' (P6)

> *Sometimes you can end up with forty, thirty five forty life or death or balls in the air at once. Because as an organisation the Police are becoming more and more responsible to support the Fire and the Ambulance. The logistics then are do you go out on an immediate Police job or an immediate Ambulance job? …. while your head's doing that you're trying to ignore the other thirty nine jobs that are sitting there going flash flash flash, flash flash flash* (P6)

For civilians within an emergency service additional status disadvantages could persist e.g. communications call operators feeling not fully supported around stress.

> *Because they just go* [makes gasp noise] *because the organisation will go 'oh, civi.' and put you out as the cannon fodder and everybody else steps back* (P6)

The need to develop sufficient peer support capacity is paramount. With few Police Peer Support Champions, it was said, they may be on different shifts from those wanting to talk, and effectively beyond reach.

> *Shift work, if an officer wants to speak to me and they're on a completely different shift, it's almost like you'd have to plan it. But the more people that sign up, the less pressure would be …if you had a mix, one for each shift, you'd have 24 hour coverage* (P1)

The size of an organisation like the [Urban] Police (with perhaps 35,000 people) posed resource demands, with the small number of trained Peer Support Champions, working long hours in their day job. A Peer Support Champion could already be working 60 hours a week,

so lacking time. Coverage for 1-1 support is currently impossible, although more general impact could be gained using media; e.g. intranet.

> *We're an organisation of 35 thousand people… you need to have things in place to then deliver… I think certainly the* [Urban Police] *would be very positive and say 'yes you can use work time to do this' and that's a no-brainer. But then the reality kicks in which is I tend to do 60 hours a week as it is…if you're just on normal staff* (P2)

Fire service participants highlighted the wide geographical spread of services and need for more peer supporters county-wide. Personality factors might affect people's willingness to contact specific Champions. One participant stated that '*if the brigade are not going to embrace it*' then '*even though we can offer that service on a local level, we can't offer it any further than the station*' (F4). Local interest in peer support training resulted in local managers realising the complexities of implementation, without strong brigade-wide leadership or support.

> *If they had a problem with my personality or my friend's…that's why I think there needs to be many more people. I don't think it can work county wide with just two people* (F3)

4.11.11 Implementation factors: embedding in the front-line

Providing peer support on the front-line involves managing competing real-time pressures, such as divided attention, demand overload, issues of control over the environment, and lack of privacy. Across services this raises the issue that it is a big challenge to shape peer support, with the emotional work this requires, around intensive front-line work duties. Skills such as active listening have to be practiced in contexts where multi-tasking and divided attention is 'normal', it was pointed out by a Police practitioner. Police were said to often listen to the radio in their vehicle, and talk with colleagues one-to-one at the same time. It was necessary to un-learn cultural norms and trained habits, for example *removing the ear-piece*, to practice effective active listening.

> *I learnt a lot, things like the active listening.…In our culture with the Police we're almost listening to 2 things at once the whole time, even when dealing with members of the public, you're still listening to your radio and talking to colleagues on a one-to-one basis in a car, you're always listening to radio whilst having that conversation. If you're doing the peer support, it's a case of take off your ear piece and be on a one-to-one and listening just to what they have to say. …It's almost like a new bit of training* (P1)

For communications staff (e.g. call operators) in civilian roles within the Police there is the challenge of embedding peer support within an open-plan call environment. One participant worked in a department with 400-450 women, in rooms containing 40 staff. The pressure of handling phone calls and radio operating, with ongoing risk around committing resources quickly, it was suggested, leaves almost no time for other talk. There is a lack of control over the environment and lack of unmonitored time. It is a challenge to implement peer support in operational environments perceived as de-personalised. There is no quiet space, it was said. The only place to retreat might be a car outside. If people leave the room to return considerably later, the cultural norm might not be to check how they are.

> *There is nowhere private. When I was going through this sort of lost thing the other day, in work, I went into four different areas and at some stage somebody came in. And I ended up sat in my car in the car park…. But nobody* [acknowledged this]*, and they were there when I came back…it would be nice if 'this is the quiet room', not the electronics room, not the iPhone room, not the tele-room* (P6)

> *You sit in a room of forty….I know the American Police services do it very differently. …there's somewhere private just to go* [lets out a sigh of relief]. *Sometimes I'll see somebody going past and I'll go 'ok'? … I've sat with a colleague who's twenty years in, herself and me, and we've not spoken to each other for six and a half hours* (P6)

> *We do have high demands on youngsters. And without the time sometimes. The only time they get where they can be controlling of their environment is when they are being tutored.… We need to move to a bit of awareness of the humanity. I do say that we lack humanity to each other. Certainly in my department. It's like, it's a number, a machine* (P6)

A front-line concern in the Fire service is the very public, shared enterprise, making confidentiality problematic, especially if the station was not providing official support for the Peer Support Champion. It might be easier to talk to peer supporters who are not front-line colleagues, it was said. Ideally, there should be some choice for front-line Fire staff, so they could see either operational or support staff, away from their team, in a confidential space. However, resource barriers obstruct Champions from taking time away from a Watch.

> *If someone approaches me; if they come to the station, it's not anonymous. So they are less likely to want to do that…I can't particularly have time away from the Watch because they are cutting down on personnel* (F3)

> *The idea was to have it in and around when we are on duty. However, because of the confidentiality issue we couldn't do it on station. Obviously people would see someone turn up and then me and* [a person] *would go in there and they would know straight away…We need to be able to go somewhere private to have a chat with someone if they need our help* (F4)

> *I'm guessing for the operational side, …they may find it easier to speak to somebody who's non-operational…. we will probably say we've got this pool of supporters, operational and non-operational* (F2)

4.12 Sustaining the programme

Key themes have emerged in previous sections for making the Peer Support Champion role sustainable and expanding capacity. These themes, briefly reinforced below, include: building momentum from having *committed core advocates* within organisations; getting *senior management support* to promote structural and cultural change; *further training within* organisations; developing *policy documents* supported by senior management; *peer support for peer supporters*; attention to *resource requirements* e.g. confidential space; getting *line managers' support*; *networking* more widely; developing *liaison between regional forces*; and developing *evidence* of effectiveness. The 'big picture' is that *health-promoting, mental health-promoting organisational settings* have to be developed if individuals are to support mental health effectively.

Sustaining the programme implies supporting its expansion (e.g. through further internal training) and making sure it can be implemented in service contexts (e.g. through peer-to-peer, leadership and management support, and channelling resources). The importance of a small organisational core group, 'activators', championing the process from positions of influence was recognised. The 'activators', around Blue Light Champions, peer support, and resilience work, for example, should persevere and promote gradual culture change while canvassing for necessary leadership support.

> *It's about keeping tight as a little group. Keeping consistent. Even though we are making the divide between peer supporters and Champions we are still a group. Bringing people together for regular training events, giving them opportunities, making sure they are emailed every so often with updates. It's worked so far* (P4)

Support from organisational leaders (e.g. Chief Executives, Human Resource Directors, Superintendents) has to be won, to drive change down through hierarchies, endorse the role, and challenge stigma. Organisations need to 'own the change' at Board level. Guidance and structures are needed, with mental health professional input, to support peer supporters with mental health experience to stay safe. Occupational Health, Human Resources and Managers need suitable mental health awareness training, to develop a healthy environment for peer support. The healthy environment needs to challenge stigma, protect confidentiality, with private spaces and codes of conduct, and ensure line managers' support.

> *In terms of sustainability unless we get some key messages out from the powers that be, I'm not convinced that we will have the momentum to carry it on* (P5)

Further training could be driven within organisations, with development of policy and practice guidance. Comments about the slow process of culture change, and observations that younger Police officers have less stigmatizing assumptions imply that training must focus on organisational specifics, and might involve new entrants. Gendered aspects within service cultures were highlighted, suggesting the potential for including gender awareness in mental health and peer support training.

It was recognised as very important to expand networks, linking Blue Light and Peer Support Champions. Sustainability involves overcoming geographical dispersion of services and small numbers of trained Champions. Social media networks within some services could extend information and support, alongside email bulletins. A northern Ambulance service have a social media network which includes a Mind Blue Light group, while a Police group of Champions set one up (via WhatsApp).

> *We set up a Mind Blue Light group,…information on there about Mind, about Time to Change, we put a lot of encouraging things up* (A1)

> *We've got the main one which is the social networking, but we've also put articles in the weekly bulletins to all members of staff as email. We've had posters, booklets that we've distributed…a lot more work to do; only three of us and a huge, huge area* (A2)

Networking between Peer Support Champions across forces was seen as momentum-building.

> *It would be really good to have some networking with other forces moving forward* (P4)

Proactive peer support needs to be supported by aligning with two wider policy aspects: focus on preventative mental health care; and spending reviews. Evidence of effectiveness would assist towards embedding sustainable peer support in organisations.

> *To have some academic underpinning that this is effective, this can make it better …in the current climate we're not going to get anywhere without that evidence* (P4)

Sustaining the Peer Support Champions initiative, as participants' accounts suggested, therefore depends on developing mental health promoting organisations, so peer support practice can be effective. Approaches would vary by service context, but with common features. The prevailing view is that driving this internally involves joining-up initiatives so that: organisations challenge stigma and value the peer support role; Blue Light Champions

work with peer supporters; and training for managers and Occupational Health and Human Resources staff focuses on mental health and peer support. A structured approach is needed, e.g. a six month plan; internal training; an intranet presence; agreed guidance; and signed Pledge. This involves groups of activators working for positive organisational cultural change in specific services with traditional and gendered values, and ways of operating. These cultural values persist through organisational instability, resource strains, and intense demands on the work-force. Sustaining the programme therefore depends on working through these shaping contexts to support Peer Support Champions.

5 Notebooks

Key messages from Notebooks

- Participants reported **improved confidence in making an approach** when they thought a colleague may be distressed or require support. This presented itself in two distinct ways; **improved identification of issues,** and **improved techniques of engagement**
- Training had **empowered** some Peer Support Champions not only to recognise a potential issue but to recognise the right to take the time to engage with the individual to help
- Several participants reported **increased confidence once they had engaged** with people
- This increased confidence in interactions was predicated on **several practical elements**; active listening, being positive and active in support, greater knowledge of available resources, appropriate use of own experiences and understanding own needs, the importance of 'checking in', and how to appropriately disengage.
- **Skills in active listening were central** to practice, and participants reflected on what this involved
- The need to find **quiet and/or private safe places** was noted, and some participants also took advantage of settings that could facilitate quality or prolonged engagement
- **Raising issues subtly** rather than directly was also used on occasions to make conversations about mental health more appropriate and natural
- It was important to **know when *not* to engage**, or when to withdraw from attempting to engage
- As well as learning to **show positivity**, the course had given some the confidence to **be proactive** in **raising mental health more widely** within their work setting
- Participants wrote about an increased **awareness of resources and services** that they could use in their Champion role
- Participants drew positively on their **own experiences in supporting others**. This included sharing useful resources, experiences and coping mechanisms that worked
- Participants had learnt to **recognise and care for their own mental wellbeing**, recognising that the role involved supporting others to find solutions for themselves
- Participants were **recognising their own limitations and sharing concerns** when these limits were being stretched
- It is important to ensure that those working as Peer Support Champions have sufficient **access to support** for themselves
- Participants had recognised following the training that **support** is not necessarily a 'one-off' encounter but more often an **on-going process**. Some participants made it clear to colleagues when and how they would be available if further contact were needed
- Another important skill learnt through the training was around **disengagement**
- The various **skills learnt** through the training tend to be **integrated in practice**, to provide the required support

5.1 Introduction

Further to the individual interviews, the 'notebook' aspect of the evaluation aimed to engage 8-10 Peer Support Champions in completing a reflective diary for four weeks, post-training. The objective was to add further depth to the interview data by allowing these Champions to write freely about specific episodes of support they have been involved in since the training, and to consider how the training contributed to these experiences. Whilst participants were free to determine what they wrote, a steer was provided (as instructions within a notebook template – Appendix 5) to ensure the approach captured outcomes relating to how empowered they felt in dealing with these episodes, the confidence they had in doing so, and whether the knowledge they had gained from training contributed to the situation.

5.2 Findings

Eight participants returned completed notebooks. 5 men initially expressed willingness to complete notebooks and were contacted. 1 man was interviewed instead, 3 men did not respond to further contact, and 1 man did not return the notebook. 10 women initially expressed willingness to complete notebooks and were contacted, 1 woman was interviewed instead, 1 woman did not complete the notebook.

- All 8 completed notebooks were from female participants.
- 7 were from the Police service (coded in quotes below as [NP1-7]) and 1 from Search & Rescue (coded [NS&R1]).
- The number of completed episodes varied from one episode (2 people) to eight episodes (1 person) the mean being 4.5. Episodes within each notebook are numbered in quotes below, e.g. [ep1]
- Episode length descriptions varied from approximately 60-400 words (the mean around 150 words)

The process of analysis (coding, categorising and drawing out themes – see Appendix 6) suggested two overarching themes within the notebook data - improving initial engagement and increased confidence in interactions – each of these, and their associated sub-themes, are discussed below.

5.2.1 Improving initial engagement

Participants reported improved confidence in actually making an approach when they thought a colleague may be distressed or require support:

> *I was more confident speaking and approaching the person that I did not know very well* [NP1, ep4]

> *I feel that I am more confident talking to people about how they are doing* [NS&R1, ep1]

This increased confidence in engaging presented itself in two distinct ways; improved identification of issues and improved techniques of engagement.

Improved identification of issues

Some participants gave accounts and examples of an improved ability to note when others may be distressed and how this might require them to intervene. One participant reported how a colleague:

> *acted out of character, started an argument unprovoked and stormed out of a briefing* [later noting] *how the training helped – noticing when people act out of character and not just ignoring it* [NP1, ep3]

Another Police officer gave an example relating to a possible drink driving 'suspect' (rather than a colleague[2]):

> *I believed that the "suspect" was drinking for a reason and I persevered to try and find out what was going on to cause the behaviour. I was able to find out that the individual had been a* [civilian role]

[2] This suggests that the course may not only be of value in terms of peer support but may also improve the Champions' ability to perform their regular duties suggesting a 'ripple effect' of the impact of the training.

(before leaving that job 2 yrs previously) and had dealt with a number of gruesome murder cases for many years. I believed that the individual was suffering from some form of trauma issue [NP2, ep6]

In this situation, in addition to the training giving her the ability and confidence to recognise this possible issue and address it, she states that "*the training has given me the ability to justify going the extra mile with an individual*" in a work situation where she would normally be "*expected to collect evidence and then move on*". In this sense, the training has empowered her not only to recognise the potential issue but also to highlight that she then has a right to take the time to engage with the individual to help. However, as noted in the previous section where participant interviews are reported, this can then create role tensions.

Improved techniques of engagement

There was increased recognition following the training that, having identified that people might be distressed, the way approaches were subsequently made was important and needed to be done sensitively:

It's often difficult to find the right moment to open up, the right place to go to talk, and that the environment and person have to be right for the person to be able to open up and talk [NP7, ep3]

The need to find quiet and/or private places was noted by many participants and some also provided examples of how they specifically took advantage of other settings that could facilitate quality or prolonged engagement:

We were on a 5 mile fitness walk so it gave us a chance to really talk [NS&R1, ep1]

Raising issues subtly rather than directly was also used on occasions when this seemed more appropriate:

Noticed a colleague seemed really over-tired more than usual and slightly irritable. Started a discussion on sleep patterns and how much the team has […] *How the training helped – as* [X] *is very private it was more productive to start the conversation as a casual chat with a few of us and when they started talking let them speak and listen* [NP1, ep5]

An indirect or generalised approach was also recognised as a way of making conversations around mental health more common and natural (normalised):

While out on patrol spoke to a fellow team member about a colleague who isn't usual self […] *Sometimes it's easier for somebody else to start the chat, and others will participate and once this becomes 'ok' then conversations like this will be normal* [NP7, ep2]

Linked to finding appropriate places and techniques was the importance of knowing when *not* to engage, or when to withdraw from attempting to engage. Several examples were given of approaches made where it was apparent people did not want to talk, or not at that point in time:

There is a possibility he could lose his home but he said he was 'getting there'. I decided not to push him because from his replies I could tell he did not want to talk any further [NS&R1, ep1]

In such situations some participants reported increased confidence in following up on these 'failed' attempts at engagement as in the example above where the participant made a 'successful' engagement with this colleague a couple of weeks later.

Also of interest here is the balance between the participants initiating an approach to colleagues or vice versa. Across the episodes where this was reported[3], or sufficiently implied, there were more instances (approximately 2/3rds) where participants made the initial engagement, suggesting they are more confident in doing this following the training[4].

[3] It was not clear for all episodes (though it was for most) and some participants reported episodes of 'awareness raising' around mental health that do not involve directly raising issues with colleagues or others.

[4] It may be that this balance will change over time as colleagues become increasingly aware of the Peer Support Champion role that these colleagues are involved in and approach them more often.

5.2.2 Increased confidence in interactions

Linked to improved initial engagement, many participants also reported increased confidence once they had engaged with people:

> *My training helped me to recognise her needs and gave me the confidence to discuss some very difficult issues* [NP4, ep3]

> *The Peer Supporter training has helped to provide me with the confidence, coupled with my own experience, to be able to encourage and hold this nature of conversation* [*difficult, emotional and confidential*] *with a view to offering help and support to my colleagues, regardless of their rank* [NP5, ep1]

The second of these examples implies not only increased confidence but empowerment in a context where issues of 'rank' could easily constrain conversations because of the power invested in particular roles.

This increased confidence in interactions was predicated on several practical elements; active listening, being positive and active in support, greater knowledge of available resources, appropriate use of own experiences and understanding own needs, the importance of 'checking in' and how to appropriately disengage.

Active listening

Obtaining or advancing skills in active listening was reported by most participants. While many just listed this improved skill, others identified more precisely what it entailed. One participant identified the importance of making time, despite the busy work setting, as integral to active listening:

> *Colleague from another area came into the parade room and was clearly distressed about something. I asked if they were Ok and if they needed time out to talk. They began telling me about the stresses they are under at work and how they are struggling to stay on top of things. I simply listened to my colleague, it was clear that he just needed to off-load to someone. My training helped me hear as I felt more aware of his needs, I stopped my work completely and just gave him 20 minutes of my time* [NP4, ep2]

As also implied here, the skill of not feeling a need to 'step in' to a conversation was an important ability that formed part of active listening and is highlighted well by another participant:

> *I was more mindful of letting the conversation take a natural direction and allowing it to flow than I would otherwise have been. I feel that my active listening skills have improved as a result of this training, though I think they were initially good, I feel they are now better and I am more practised at listening to hear what the person is really saying in that moment as opposed to listening with the intent to reply!* [NP5, ep1]

Being positive and active in support

Linked to active listening were skills learnt around being positive and active in any responses after allowing colleagues to talk. This was about both helping colleagues explore what might be positive in an otherwise difficult situation and in providing practical support (not just passive signposting). In one example, a participant writes about supporting a colleague who has had to move station:

> *I was approached by him to initially chat, gave him time to let off steam. We went in a quiet office where we wouldn't be disturbed. Helped him with travel timetables and best routes into the city as he is unfamiliar with the new area. Advised him on some positives about the new station i.e. free parking, free gym, and earlier finishes due to location. Advised him to discuss his concerns with the sergeant and that I would happily accompany him if he felt he needed support. How the training helped – I probably wouldn't have thought to offer to accompany him to a meeting before I had the training. Reminded me to be positive* [NP1, ep1]

A further example was given of positive reinforcement being provided in a follow-up discussion with a colleague:

Dinner with Y and the opportunity to talk about how they are getting on away from the pressures of work in a relaxed, social environment yet at the same time, not a crowded area. Focus drawn to the positive changes that Y is making in areas they want to improve in their life and reinforced that this is a really helpful step in the right direction. Highlighted some of the nice activities that Y has planned during the course of the year to provide a positive focus relative to something that is enjoyable. The Strength-Based questions as stated in the handout titled 'Mind Blue Light Peer Support training handbook' were helpful at this stage [NP5, ep4]

As well as positivity in conversation, the course had given some the confidence to be proactive in raising mental health more widely within their work setting. One participant [NP2, ep2, ep3] strategically placed mental health information sheets in toilets and developed a 'mental health for policing' pack for senior officers – though they were disappointed with a lack of feedback from this. Similarly, another participant [NP7, ep4, ep6] used International Women's Day as a mechanism to raise mental health awareness and also opened up discussions about the need for more 'social' time for the team that might facilitate talking opportunities.

Greater knowledge of available resources

Almost all participants wrote about an increased awareness of resources and services that they could utilise in their Champion role and provided examples of this:

I was approached by a line manager who had just returned from a long period of sickness due to a mental health illness. He had heard that I had been working with the Blue Light program and that I had some booklets. I gave him the relevant booklets, and I listened to him as he told me how he was feeling. I told him he could talk to me at any time in confidence if he needed anything, and I also gave him details of local help groups [NP3, ep1]

Wellness Action Plan forwarded via email to Y as considered a helpful tool that can be used as they introduce a phased return to work following a period of sick absence due to ill mental health […] *Without the mind Peer Supporter training day, I wouldn't have been aware of this resource* [NP5, ep4]

Some had developed greater awareness of the wider range of services that people could be signposted to, including some innovative thinking about signposting opportunities:

How the training helped – signposting to outside agencies, not just in-house [NP1, ep4]

I referred the individual [a "suspect" possibly suffering PTSD] *to their GP through a report for an assessment. When I left their home the individual whispered to me that they did want help. I also sent the individual info on the* [S] *Trust who look for volunteers to walk elderly persons dogs etc as I felt this would help the individuals "caring" needs as they enjoyed dog walking* [NP2, ep6]

As seen in the following section, many participants also drew on their own knowledge and experiences of resources and services when engaging with colleagues.

Appropriate use of own experiences and understanding own needs

The training had helped people recognise how to draw positively on their own experiences in supporting others. This included sharing useful resources but also sharing experiences and coping mechanisms that had worked positively for them in similar situations:

Some Work/Reading Sheets relative to positive thoughts and self-esteem provided to Y. Shared as the result of my own previous experience of similar feelings, during which the sheets were used with a degree of success. The Peer Supporter training helped to boost my confidence to a level that I feel I can now offer resources that I personally found beneficial, with the caveat that different things can work for different people as we are all unique [NP5, ep4]

A colleague is really struggling and I have been a pair or ears to them for some time as they haven't got anyone to talk to at home. I suggested that they sought some professional counselling through the employee support line. I have also provided them with some techniques I have tried as they are

wishing to shut themselves away and provided them with some online links to some helpful resources [NP6, ep1]

Through the process of reflecting on one's own experiences in order to share positive aspects, some participants had also learnt to recognise and care for their own mental wellbeing. For some, this was about recognising that they were not responsible for finding solutions for people, but that the role was about supporting and helping them develop solutions themselves:

Individual sought me out to speak to me, as they were experiencing some health problems. I listened to them and suggested that they seek professional medical advice. The training made me realise that I do not have to take on responsibility to solve problems that I am there to listen and support them [NP6, ep2]

The training has made me realise that I do not own the problem, I am there to support the wellbeing of the individual [NP6, ep5]

Participants were also recognising their own limitations and sharing concerns when these points were being stretched:

I met with another peer supporter after some joint training on mental health and she made me aware that she was going through some personal issues outside of work. We spent half an hour discussing her issues and looking at some coping mechanisms. I also shared with her some of my current working stresses and issues. I felt happy speaking with her and I believe that our discussion gave her some solace too [NP4, ep3]

Chat with supervisor regarding personal stuff I had going on, which spurred a chat about what we can do to help each other. By initiating the chat, and letting her know my feelings and thoughts I recognise that I am not super-human and sometimes need to talk about stuff too [NP7, ep,3]

It is clearly important then to ensure that those working as Peer Support Champions have sufficient access to support themselves to ensure their own mental wellbeing is maintained.

The importance of 'checking in' and how to appropriately disengage

Many of the notebook entries provided good examples of repeated episodes of contact with the same colleague, strongly suggesting that participants had recognised following the training that support is not necessarily a 'one-off' encounter but more often an on-going process:

I checked on the individual a few days later to see if they were OK [NP6, ep2]

Sent him a message to ask how he was doing [NS&R1, ep1]

This was often linked to examples where the participants made it clear to colleagues exactly when and how they would be available if further contact were needed:

Asked what time X was on duty the following day and let X know that I would be there around that time to pop and have a chat and that I would call by once on duty. […] *reiterated support by letting them know that if they did feel that they wanted to talk about anything, I would be back at work the following day* [NP5, ep3]

This entry makes it apparent that participants also understood that providing concrete detail or definite plans can often be more effective (seen as more genuine) than more abstract offers of help and support. However, the importance of more general (rather than episode specific) 'checking-in' was also recognised if the concern was more protracted in nature:

Situation –colleague (N) suffers with depression and stress and has had time off work due to this in the past. The workplace situation at present for this person is highly stressful. Involvement - engaging in conversation with them about general everyday things, asking how they are and what they have been up to this week. How the training helped – It doesn't always matter how small the interaction, people don't want to feel forgotten about or that nobody cares [NP1, ep5]

Another important skill learnt through the training was around disengagement. An example was provided of recognising early on that on-going engagement was not appropriate, but also that this needed to be handled in a way that still ensured the colleague had support:

> *Colleague expressed concerns over* [X] *case that they are under investigation for, stated they are feeling low. I took time out to give my colleague some listening time. We sat and chatted for a short while, I advised them to speak with Occ. Health as the matter will continue for some time ahead and I felt they needed more support. My training helped me in this situation as I was able to signpost my colleague on to Occ. Health for support. As I am aware of the investigation I felt it was not possible [inappropriate] for me to engage further with him, however, I gave him details of another peer supporter* [NP4, ep1]

Linked to this was the skill to know when confidences needed to be broken and others alerted, when situations escalated and offered support was not seen to be sufficient:

> *As I started my shift I saw T walking to the* [Z] *room and appeared very angry. Other colleagues told me he's walked out in a rage. I entered the* [Z] *room and attempted to engage with T whom I have an excellent relationship with. They would not engage with me other than to say they had had enough and if they stay at work they will* [commit dangerous act]*. I suggested they have a cup of tea and chat about it for 5 minutes just so they can calm down before driving home. They would not agree to this and left driving away in their vehicle in an extremely vulnerable state. How the training helped – Actively listen, let them talk. Due to the history of T (whereby getting so worked up regarding work pressures they* [previously acted in way involving high risk] *I felt I should inform the line manager of this as a concern for safety and was worthy of breaking the confidence* [NP1, ep7]

Finally, it is clear from many of the examples provided above that the various aspects and skills learnt through the training tend to be integrated, and work synergistically in order to provide the required support. This is captured neatly in the final example from the notebooks:

> *Further chat with Officer who is currently on restricted duties and pregnant and worried about coping when she returns to work. Just listening to concerns and signposting to support, talking through choices upon return to work, sharing my experiences. Knowing my remit, knowing when to direct to others for guidance and advice* [NP7, ep5]

The findings from notebooks show very clearly that pockets of excellent practice were being developed following the Peer Support Champion training, within environments that were very challenging, in ways that have been explored in the previous section based on interview findings. The skills being applied by Peer Support Champions drew on their experience, and on the training that they had participated in, and tended to be integrated in effective practice. To sustain and expand on these exemplars of positive individual practice will involve ongoing work towards developing health promoting organisational environments.

6 Conclusions and Recommendations

Achievements

This report has highlighted the baseline, post- and three months follow-up survey findings and main themes from interviews and from notebooks. Survey findings show significant gains between baseline and follow-up in peer support knowledge and understanding, and self-confidence, although not wellbeing. Very high proportions of participants found the training met their expectations in full and was very useful. The opportunity to meet and share experiences with others was widely welcomed. Open-ended comments from questionnaires also highlighted that participants particularly valued the balanced course approach; and very much appreciated sharing experiences with others across agencies in a relaxed environment.

Interview findings highlight the positive experiences many participants enjoyed of Peer Support Champion training. The course process was very rewarding for many participants, and a range of impacts around confidence, wellbeing, awareness of peer support skills such as active listening were reported. Participants valued highly the mix of group activities and taught components, and sharing experience across services. Barriers and enablers to implementing peer support are context-dependent, varying by service. Given the scale and complexity of organisations and the small number of trained supporters, the Peer Support Champion approach requires obtaining leadership support, and cascading through expanding networks. The initiative can be extended by further internally-driven training that takes account of the specific organisational environments and cultures, and the complexity of operations and staff roles; resource constraints and structural pressures. Managed cultural change is needed, in order to challenge stigma and facilitate peer support practice. Systems approaches are needed to protect and support peer supporters with experience, and clarify and endorse their role.

Notebook findings show pockets of excellent practice being developed. Among the aspects of good practice were improved identification of issues and improved techniques of engagement; increased confidence in interactions; skills of active listening; understanding of the importance of settings that could facilitate quality or prolonged engagement; knowing when to withdraw from engagement; awareness of resources and services that they could utilise; understanding the value of their own experience; learning to recognise and care for their own mental wellbeing; supporting others to find solutions for themselves. Support was seen as an ongoing process, and the various aspects and skills learnt through the training tend to be integrated in practice, to provide the required support. To sustain and expand on these exemplars of positive individual practice will involve ongoing work towards developing health promoting organisational environments.

Issues arising

A small number of key issues arise for the Peer Support Champion training.

Firstly, the course *trained far more people from Police services* than Fire and Ambulance services (mostly in the Midlands and South), with very few Search and Rescue personnel involved. Although uneven, the implementation of peer support within the Police service was perceived to be more advanced, with more leadership support. Inter-agency networking and shared learning in this area could be beneficial to different organisations, especially those with further to travel.

Second, interview findings suggest that *organisational contexts* for delivery still *present serious challenges* to trained Peer Support Champions. Trained individuals may struggle to practice in still insufficiently mental health-promoting environments.

Third, while twice as many front-line staff were trained as support staff, *cultural and practical challenges for implementation were raised* particularly on the front-line, but also in some office contexts, e.g. call operators, concerning *confidentiality, trust and safe space* for contacts**.** Within particular services, it seems important not only to consider training sufficient numbers but also to develop working space and safe practices to ensure coverage, for front-line and for office staff.

Fourth, while similar numbers of men and women were trained, overall, enrolment data indicates that fewer than one-fifth of support staff trained were male, whereas over a third of front-line staff trained were female.

The proportion of males who having completed baseline questionnaires also completed follow-up questionnaires (53%) showed a greater fall-off than the proportion of females doing likewise (71%). *Gender issues* need careful consideration, given how cultural concerns around stigma and talking about vulnerability at work intersect with and may reinforce normative practices of 'traditional masculinity'. Men and women need to be supported in gender-aware ways to develop excellent relational, peer support communication practices.

Fifth, there is a *risk* that *Peer Support Champions may struggle with their own vulnerability* if they are *over-stretched and insufficiently supported*. Despite excellent (notebook) exemplars of innovative practice in peer support, fall-off (in questionnaire results) during the month after training concerning gains in peer support knowledge/understanding, and also lowered proportions retaining strong confidence to undertake a peer support role in the workplace, access resources, and signpost colleagues to relevant services, all suggests participants' isolation in the role. Almost 30% of those who had provided peer support since the course, at one month follow-up required additional support to continue in the role. Responses to open-ended items in the questionnaire also showed concerns about a possible need for ongoing guidance and support for peer supporters, recognition of the role in organisations, and possibly follow-on training. Peer support for Peer Support Champions needs to be developed and strengthened in workplaces. Managers need to be trained, boundaries clarified, and networks of support developed.

Sixth, the vast majority of those trained were *aged over 30*, almost half being aged 41-50. As peer support is developed within organisations, consideration needs to be given to what form of mental health awareness training is appropriate for *young entrants*, who can be agents of cultural change.

Seventh, *a limitation*, stated above, is that this evaluation has not directly studied the organisational environments, the shaping contexts in which peer support is situated. However, our evidence from notebooks exemplifies pockets of outstanding local practice, while our interview data shows that mental health-promoting organisational environments have to be developed if individuals are to become successful trained Peer Support Champions.

Recommendations

- Development of health promoting - including mental health-promoting - organisational environments should be further integrated with development of Peer Support Champions in emergency services
- Support should be provided for internal, context-sensitive development of positive Peer Support Champion practice. This could include ongoing support (e.g. from Mind) for committed activators within organisations to build peer support groups, while working for positive organisational frameworks
- Leadership support and systems approaches are needed to include Peer Support Champions within organisational practice
- Peer Support Champions need further peer support in their places of work. Further training, internally driven and based, could expand the networks of Peer Support Champions
- Training should include a strong focus on cultural factors and gender-awareness, alongside skills for context-specific practice which are developed through practice-based scenarios
- Systems or frameworks for encouraging Peer Support Champions with experience to thrive need to be in place alongside the peer support training, with managers, and key staff e.g. in leadership, HR and Occupational Health roles trained, and support networks developed.
- Best practice, resources and evidence should be shared across emergency services, and inter-agency support networks encouraged.
- Evidence is needed, grounded in specific contexts, of effectiveness in practice over a period of time.

Appendices

Appendix 1: References

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Appendix 2: Interview Participants

Table A.

Stakeholders	
Training location	**Role and sex**
Manchester	1. Ambulance service (male) 2. Ambulance service (male) 3. Ambulance service (female) 4. Fire service (male) 5. Fire service (male)
London	1. Police service (male) 2. Police service (male) 3. Police service (male)
Oxford	1. Police service (female) 2. Police service (female) 3. Police service (female)
Winchester	4. Fire service (male) 5. Fire service (male)

Codes in quotations (section 4)

Quotations by participants in section 4 are anonymised. Codes appearing after the quotes identify the service the participant works within, followed by a number for each participant. Codes A(1-3 indicate Ambulance service participants, codes P1-6 indicate Police service participants, codes F1-4 indicate Fire service participants.

Therefore (F4) indicates the participant quoted (number 4) works for the Fire service.

(A1) indicants the participant (number 1) works for the Ambulance service.

(P3) indicates the participant (number 3) works for the Police service

Appendix 3: Questionnaire

The Blue Light Programme:
Peer Support Champion
Pre-Training Questionnaire

Thank you for reading the participant information sheet and agreeing to complete the questionnaire. Please answer as many questions as you can. However, if there is anything you would rather not answer, just leave it blank.

Please note, by completing the questionnaire you are consenting to take part in the evaluation.

We ask that you include your name below for reference purposes only. In the report, all data will be anonymised.

Name: …… Date:……

What service do you work/ volunteer for? *Please tick **one** box*

- ☐ Ambulance
- ☐ Fire
- ☐ Police
- ☐ Search and Rescue

Peer support

1. Below are a set of statements relating to peer support. To what extent do you agree or disagree with the following statements? *Please tick **one** box for **each** statement*

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
I am able to explain what is meant by peer support					
I am able to describe the benefits of peer support in the workplace					
I understand the role of self-management in mental health					
I am able to identify the key skills required of a Peer Support Champion					
I am able to identify a range of support techniques I can use in my role as a Peer Support Champion					
I am aware of the boundaries and limits to peer support in the workplace					
I know where to go if I need to access help or support in my role as a Peer Support Champion					

Self-confidence

2. Below are a set of statements relating to confidence. To what extent do you agree or disagree with the following statements? *Please tick **one** box for **each** statement*

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
I am confident in my ability to undertake a peer supporting role in the workplace					
I am confident in my ability to use my own personal experiences to provide support to others					
I am confident in my ability to be an active listener					
I am confident in my ability to access resources to support others in my peer support role					
I am confident in my ability to signpost colleagues to relevant services and organisations					
I am confident in my ability to deal with challenges as a Peer Support Champion					

Wellbeing

3. Below are some statements about feelings and thoughts. *Please tick **one** box that best describes your experiences of **each** statement over the last 2 weeks*.

	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future					
I've been feeling useful					
I've been feeling relaxed					
I've been dealing with problems well					
I've been thinking clearly					
I've been feeling close to other people					
I've been able to make up my own mind about things					

Personal information

4. How old are you? *Please tick **one** box*

- ☐ Under 18
- ☐ 18-24
- ☐ 25-30
- ☐ 31-40
- ☐ 41-50
- ☐ 51-60
- ☐ 61+

5. What is your gender? *Please tick **one** box*

- ☐ Female
- ☐ Male

6. Have you ever identified as transgender, now or in the past? *Please tick **one** box*

- ☐ Yes
- ☐ No

7. How would you describe your sexuality? *Please tick **one** box*

- ☐ Bisexual
- ☐ Gay
- ☐ Heterosexual/ Straight
- ☐ Lesbian
- ☐ Other *(please specify)* ……

8. How would you describe you ethnicity? *Please tick **one** box*

Asian or Asian British

- ☐ Asian British
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Indian
- ☐ Pakistani
- ☐ Another Asian background

Black or Black British

- ☐ Black British
- ☐ African
- ☐ Caribbean
- ☐ Another Black background

Other ethnic group

- ☐ Arab
- ☐ Gypsy or Traveller

Mixed

- ☐ White & Asian
- ☐ White & Black African
- ☐ White & Black Caribbean
- ☐ Another mixed background

White

- ☐ White British
- ☐ White Irish
- ☐ Eastern European
- ☐ Another white background

☐ Another background (please specify)…….

9. Where do you live? *Please tick **one** box*

☐ London (inc. Greater London)	☐ Wales
☐ South East	☐ Yorkshire and Humberside
☐ South West	☐ North East
☐ East of England	☐ North West
☐ East Midlands	☐ Scotland
☐ West Midlands	☐ Northern Ireland

10. Which of these categories best represents your experience of mental health problems? *Please tick **all** that apply*

☐ I have personal experience of mental health problems

☐ I use / have used mental health services

☐ I use / have used the services of a local Mind

☐ I am a family member of somebody who has experienced mental health problems

☐ I am a friend to someone who has experienced mental health problems

☐ I care or look after someone who has mental health problems

☐ None of the above

Thank you for completing this questionnaire. Please insert the completed questionnaire into the envelope provided and seal. The training provider will collect all the envelopes and return them to the evaluation team.

Appendix 4: Interview Schedule

Mind Blue Light programme: Peer Support Champions
Interview schedule

Thank you for agreeing to be interviewed.
My name is . . . . . and I am part of the Project Team at Leeds Beckett University and I am currently undertaking interviews as part of the evaluation of Mind's Blue Light Programme: Peer Support Champions. We are interested in finding out about your experiences of the training. Are you still happy to be interviewed? You have read the information sheet.
Your responses will remain **anonymous**. You can withdraw at any time. Are you happy for the interview to be **recorded?** The interview should take approximately 45-60 minutes.

Interview topics

1. **Can you tell me a little about your work?**
   (POSSIBLE PROMPTSAND FOLLOW-UPS) What work you do? Front-line? How long have you been doing this? Responsibilities? Routine contacts with others? Recent changes? Challenges of role (in what ways, and main pressures)?

2. **How did you come to be involved in the training day?**
   (POSSIBLE PROMPTS AND FOLLOW-UPS) How did you get involved as a Champion? What made you interested in particular peer support role? Have you already acted as a Champion in any way? Did you find out about course from word of mouth, or by other information or media? Was it easy to get support of your employer to take part?

3. **What were your expectations of the training day?**
   (POSSIBLE PROMPTSAND FOLLOW-UPS) What were you looking for? Any particular information or activities? Group participation? How were you feeling at the time about doing this?

4. **What does the training content have to offer you?**
   (POSSIBLE PROMPTS AND FOLLOW-UPS) Main parts e.g. about recovery, self-management, peer support, resources? Support for your role? Engaging? Relevant to you? Met expectations? Any gaps, for you, in the content?

5. **What did you learn about the Peer Support Champion role from the training? How will you take on the role of Peer Support Champion?**
   (POSSIBLE PROMPTSAND FOLLOW-UPS) Main aspects? Using personal experience? Knowledge and skills? Awareness e.g. of own strengths and limitations? Signposting to services? Providing support? Running groups? Confidentiality issues? Aware of role challenges and boundaries?

6. **How do you feel about the training methods?**
   (POSSIBLE PROMPTSAND FOLLOW-UPS) Right structure and pace for you? Facilitation? Length? Interactive? Pair and group-work? Materials – visual and print? Activities e.g. Scenarios?

7. **Did you feel supported by the trainer and training participants on the day?**
   (POSSIBLE PROMPTSAND FOLLOW-UPS) Able to ask any questions? Individual attention? Peer Champion group support? Contacts for follow-up
   How did this Peer Support training compare with any other Champions training you have attended? Any overall gaps in support?

8. **When did you take part in the training? Since receiving the training, have you applied what you have learned to support people at work? If so, how well prepared by the training did you feel? If not, why not?**
   (POSSIBLE PROMPTS AND FOLLOW-UPS)? Did you feel this went well? How did the training help you with this? Example? Any particular benefits for you, any issues?

9. **How confident do you now feel to apply what you have learned to support colleagues?**
   (POSSIBLE PROMPTS AND FOLLOW-UPS) Feel well prepared? Empowered? Enough knowledge? Drawing on strengths and experience? Feel able to respond to incidents? Able to manage situations emotionally and practically? Able to respond, communicate effectively and provide support? Able to run groups?

10. **What impact has the training had on your own feeling of wellbeing?**
    (POSSIBLE PROMPTS) Any impact on your own sense of purpose, identity at work? Do you feel an 'Expert by Experience' - able to talk confidently about and with mental health experience?

11. **Are there any particular challenges putting the training into practice in your workplace?**
    (POSSIBLE PROMPTS AND FOLLOW-UPS) Anything about your workplace that makes specific demands? Stigma? Workload? Other roles? Organisational factors? How could this be improved?

12. **Are you sufficiently supported in your workplace to carry out the peer Champion role?**
    (POSSIBLE PROMPTS AND FOLLOW-UPS) Do you feel supported by peers? By employer? By Mind? By other experts? By information?

13. **Overall, what do you think have been the best features of the training?**
    (POSSIBLE PROMPTS AND FOLLOW-UPS) In terms of new things learned, impact on your role, identity and practice?

14. **Is there any way the training could be improved for the future?**
    (POSSIBLE PROMPTS AND FOLLOW-UPS) Time? Content? Process? Group arrangements? Any different priorities? Different offers of support? Choice? Further resources, activities? Please explain?

15. **Would you recommend the Champion role to other colleagues in the emergency services? (POSSIBLE PROMPTS AND FOLLOW-UPS)** Why/ why not?

Are there any further areas you would like to mention?

THANK YOU

[Check wellbeing at end of interview. Signpost to mind website, infoline, GP or Samaritans as appropriate]

http://www.mind.org.uk/

http://www.samaritans.org/

Appendix 5: Notebook Template

Notebook

Thank you for agreeing to complete this notebook following your involvement in the Mind Peer Support Champions Training. As you know, this training aimed to prepare you to provide mental health peer support when working alongside your colleagues, focusing on the practical issues they face and helping them access appropriate help and support to improve their mental health and wellbeing

The idea of this notebook is to capture your experiences of how the training helped prepare you (or not) to provide this support. We would like you to keep a written record for the four weeks following completion of the training where you make notes of any episodes of support you provide, no matter how big or small, and reflect on how the training made a difference to the support you provided. We do not want to restrict what you tell us about how the training prepared you to support colleagues (or what more it could have done to prepare you), but you might want to provide specific examples of:

- **How you have used the knowledge you gained on the course to help direct people to specific resources**
- **Times when the skills you gained during the training helped you notice when someone was having difficulties**
- **Whether the training improved your confidence in approaching, engaging and helping people when you noticed a potential problem**
- **How you drew on your own mental health experiences to help understand the situation and/or to guide your actions (and how the training helped you do this effectively)**
- **Any other skills and abilities you feel you gained through the training, and how these been put into action**
- **Any areas where you would have liked more support or preparation from the training**
- **Any other comments you would like to make**

The notebook is your opportunity to tell us what you gained from the training and recommend any areas of improvement.

You can structure your notes however you like, but you may find it easiest to describe specific instances of support you have been involved in noting 1) what the situation was 2) what your involvement was 3) how the training helped you when you became involved (or what more the training might have done to prepare you). You should try to write the notes about any instances of support you have provided as soon as possible. This will help you capture as accurately as possible the nature of the event *and* your thoughts and feelings about how the training helped.

[NB IMPORTANT – when describing situations please do not use people's real names. If you need to refer to people please either give them a pseudonym (false name) or refer to them as 'X' ie. "I noticed X was looking a little stressed…"].

If you would like to ask any questions about keeping this notebook please contact

Mark Robinson**, Faculty of Health and Social Sciences, Leeds Beckett University, Email: m.r.robinson@leedsbeckett.ac.uk**

Notebook

You may write about as many episodes as you like, and please write as much or as little as you like for each episode. **You can write several times on different days about one ongoing episode if you like. NB remember, an 'episode' may be a very small event - a quiet word or passing on a piece of information - rather than a major event.**

Episode 1(date)	1) what the situation was 2) what your involvement was 3) how the training helped you
Episode 2 (date)	1) what the situation was 2) what your involvement was 3) how the training helped you
Episode 3 (date)	1) what the situation was 2) what your involvement was 3) how the training helped you
Episode 4 (date)	1) what the situation was 2) what your involvement was 3) how the training helped you
Episode 5 (date)	1) what the situation was 2) what your involvement was 3) how the training helped you
Episode 5 (date)	1) what the situation was 2) what your involvement was 3) how the training helped you
Episode 6 (date)	1) what the situation was 2) what your involvement was 3) how the training helped you
Episode 7 (date)	1) what the situation was 2) what your involvement was 3) how the training helped you
Episode 8 (date)	1) what the situation was 2) what your involvement was 3) how the training helped you

Appendix 6: Notebook Coding

Initial codes identified:

1. Being more directly, actively supportive or involved
2. Being positive/dealing positively
3. Understanding active listening
4. Identifying when people are acting out of character/ where there might be something underlying behaviour
5. Where to signpost/having knowledge of resources available
6. More Confidence in approaching people
7. Using subtle ways to facilitate conversation about possible issues
8. Remembering to 'check-in' with people who have had issues
9. Learning how Shared experiences can help both practically and emotionally
10. Knowing when to break confidence and/or pass concerns on
11. Knowing when to stop asking/probing
12. Greater confidence in understanding people and to know what to say or how to support
13. Remembering the importance of confidentiality
14. Recognising that providing support can work both ways and that need to be aware of own MH needs

Early collapsing of codes/categories:

1. More confidence in initial engagement with people
   Identifying when people are acting out of character
   Using subtle ways to facilitate conversation
2. Greater confidence in interactions once engaged
   Active listening
   Being directly/actively supportive
   Being positive in approach
   Using own/shared experiences
   Knowing when to disengage
   Knowing when to pass concerns on
   Knowledge of resources/signposting
   Importance of ‘checking-in’ after initial engagement
   Importance of confidentiality
3. Being aware of own mental health needs

Final themes/categories:

1. Improving initial engagement
   Confidence in engaging
   Identifying potential issues
   Techniques to engage
2. Confidence in interactions
   Importance of active listening
   Being positive and active in support
   Greater knowledge of available resources
   Understanding one’s own needs and appropriate use of own experiences
   How to appropriately disengage and the importance of ‘checking in’